Monday, 17 March 2025

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning. Some months ago arrangements were made for closing submissions to be heard in this Inquiry today, and that's what's going to happen.

Shortly before the last hearing of the last witness in London, there was an application or rather a request made by counsel for the executives, Mr Harvey, Mr Chambers, Ms Kelly and Ms Hodkinson for the hearing to be paused -- for the Inquiry to be paused, and there was also a letter sent to the Secretary of State seeking a suspension of the Inquiry. There are two different powers. Some of you will be aware, Mr David Davis has written in similar terms. For that reason, I directed that submissions would be heard on that topic as well as on the closing submissions this morning, and that's what we'll do.

A few moments ago, I received a letter from a new firm of solicitors on behalf of Lucy Letby. I've not had the time to read it but I can see from the second paragraph it's a request that I should suspend the Inquiry. I've asked that that letter be sent to all Core Participants. It was sent almost as soon as I received it.

So that's an update, and now if we may we'll start the business of the day with submissions from Mr Sheldon.

Closing submissions by MR SHELDON

MR SHELDON: My Lady, as you will be aware, I appear on behalf of the Department of Health and Social Care --

LADY JUSTICE THIRLWALL: Yes.

MR SHELDON: -- and we are grateful to you for the opportunity to make these closing submissions at the conclusion your hearings.

We have provided you with a set of written closing submissions and you will no doubt to be relieved to hear that I don't propose to traverse the detail of those this morning.

We have sought to address in those written submissions the aspect of the Department's involvement which we anticipate will be of most central concern to the Inquiry and to answer the specific questions that you had posed in your directions.

Before I turn to a brief summary of the relevant aspects of a number of the key policy areas which fall within the Department's area of responsibility and which bear on the critical questions this Inquiry has been established to answer, it's right that I deal with two matters of fundamental importance at the outset, if

I may.

The first is to address directly the task with which we are all engaged. My Lady, you do not need me to tell you of the unfathomable grief and devastation suffered by the Families at the heart of this Inquiry. You've heard from them directly and you'll be hearing from their representatives shortly.

To lose a baby is the greatest sorrow imaginable but to lose a baby in these circumstances is unconscionable. Expressions of sympathy, however they may be expressed, will inevitably sound inadequate but it's important that I provide you and everyone with an interest in this Inquiry with a reassurance that none of us involved in this Inquiry on behalf of the Department, the Secretary of State, the officials who have provided evidence, the legal team, all of us, have lost sight for a moment of why we are here and the overriding obligations we have to the Inquiry, to the bereaved families and to the public, who rely upon the NHS to keep them safe when they are at their most vulnerable.

As to how those obligations are to be discharged by a responsible public body in an Inquiry such as this, I repeat the commitments made to you in our opening statement. A responsible public body must give a full

and frank account of itself, it must provide the investigation with complete and unequivocal co-operation, it must be objective and self-critical in its evidence, and it must remain open-minded and willing to learn lessons throughout. My Lady, we stand by those obligations and we acknowledge that we should be judged by them.

Second, my Lady, an apology is required and I make it unequivocally. Through the Secretary of State, the Department bears ultimate responsibility for the healthcare system both at the times of the events being examined and now. It discharges that responsibility through a range of bodies and systems that are designed to establish and monitor an effective and above all a safe healthcare system. Those oversight mechanisms did not protect the babies born at the Countess of Chester Hospital and the Department apologises for that to all those affected by these terrible events and above all to the Families who have suffered such profound loss.

The Department also acknowledges that there has been a long-standing failure to learn the lessons of past inquiries and investigations, and to implement those lessons recommendations have been made but insufficient action has been taken.

The Secretary of State accepts unequivocally that this must change. He has described the NHS as "broken", and has announced that it is the mission of the Government to build an NHS that is fit for the future. Learning from past failings and implementing effective reform is a central part of that mission.

Your Inquiry has been very effective in scrutinising the events of the Countess of Chester Hospital and how Letby was able to offend and continue to offend in a way that should never have been possible. The Inquiry has uncovered extensive evidence of failures of leadership and oversight within the Countess of Chester NHS Foundation Trust but the evidence has been broader in scope than simply the failures of governance in this one hospital. It suggests wider and more fundamental issues for patient safety and safeguarding within the NHS as a whole.

There is, therefore, a need for a frank and unsparing assessment, not just of what went wrong in this hospital during this period but whether there are systemic deficiencies in the way safeguarding, monitoring and patient safety are delivered across the NHS and what needs to be done to ensure that the framework of policies and procedures designed to achieve those fundamental objectives are as robust and effective

as possible, and it's to that issue, my Lady, that I intend to address the balance of my submissions this morning.

In particular, my Lady, I wish to address you on four key areas which in our submission are of central importance in ensuring that this is never allowed to happen again.

But before I turn to those four areas, can I deal briefly with a procedural issue which has a bearing on any recommendations you may choose to make, and it arises from the announcement of the Prime Minister of the abolition of NHS England and any potential practical issues that that might generate as to the status of any recommendations you may address to NHS England.

The Department, with NHS England, has given consideration to this issue, and the appropriate way forward, we submit, would be for any recommendations you may wish to address to NHS England as currently constituted to also be addressed to the Department. NHS England will then take forward any such recommendations during the period in which it remains in existence, with responsibility for any outstanding work then passed to the Department as co-recipient of the recommendation. That will ensure that there is no shortfall or ambiguity in accountability for work to be

done in respect of any of your recommendations after NHS England ceases to exist.

LADY JUSTICE THIRLWALL: I'm sorry, just to interrupt at that point --

MR SHELDON: Of course, my Lady.

LADY JUSTICE THIRLWALL: -- this is helpful, and obviously as soon as the announcement was made it seemed to me this was something you would be dealing with this morning but -- and this may be premature -- but I think I'd want to have some very clear, more than reassurance, that this is actually going to happen, given what you already said about the failure to implement recommendations, and I note in your written submission there's reference to the reasons why sometimes they're not implemented, which I understand, but I would need to be very clear about what the process was going to be and who was going to be responsible for it by name.

MR SHELDON: I entirely understand, my Lady. At the moment, and in the relatively limited time available since the announcement was made, we've taken an in-principle decision --

LADY JUSTICE THIRLWALL: Of course, yes.

MR SHELDON: -- to make the recommendation that we've made to you today but we will, of course, work out the finer detail and perhaps if I can suggest that we write to you

with those details as soon as they've been finalised.

LADY JUSTICE THIRLWALL: Yes, of course. I wasn't expecting you to be able to answer that today. I just wanted you to know that that's what I want to know.

MR SHELDON: Well, we entirely understand the concern, my Lady, and I hope it's of some reassurance that we've already given some thought to the matter.

LADY JUSTICE THIRLWALL: Yes, thank you.

MR SHELDON: My Lady, in addition to that proposal of the Department and NHS being co-recipients of recommendations, there is also the point of which you will be well aware that the Secretary of State will receive your report and will have responsibility through his Department for overseeing all its recommendations, regardless of their specific assignation. That's in the usual established way.

The delivery of those recommendations specifically assigned to NHS England will, therefore, additionally fall to the Department, in light of the abolition of NHS England. I hope that provides a twofold reassurance, even if it is only a general one at this point.

First, if any recommendations you may wish to address to NHS England as currently constituted are also addressed to the Department, there's no danger in any

gap in accountability for those recommendations, and, secondly, all recommendations, including those assigned to NHS England, will be overseen by the Department regardless of future organisational reforms.

My Lady, having dealt with that procedural issue, can I turn then to the four substantive aspects of my submissions, and the first is the issue of reporting and monitoring, which is, of course, fundamental to effective oversight and to ensuring evidence-driven improvements over time. As such, tools to enhance reporting and monitoring have been at the centre of many patient safety initiatives implemented since the time of these events, and there are two which I would respectfully invite your attention to in particular this morning.

First, one of the key components of the NHS patient safety strategy has been the introduction of the Patient Safety Incident Response Framework, the PSIRF, I'm going to keep the acronyms to a minimum if can.

LADY JUSTICE THIRLWALL: Yes, please do. I'm sometimes at a loss to know why we have a new acronym every time.

MR SHELDON: Well, this is an area that I think suffers particularly from that flaw and, as I say, I will try and avoid it.

LADY JUSTICE THIRLWALL: Thank you.

MR SHELDON: But the Patient Safety Incident Response Framework, which provides a new approach for responding to patient safety incidents and is anchored in the principles of openness, fair accountability, learning and continuous improvement, became a contractual obligation for all providers of NHS services from 1 April last year. The feedback on the framework received to date has been positive, and you may recall the evidence of Professor Dixon-Woods to the effect that so far it represents an improvement on previous processes in this important area.

Second, and the detail in this regard is inevitably set out in our written submissions, the Department and NHS England have together introduced a number of significant changes to the investigatory, reporting and review processes within maternal and neonatal care specifically over the last several years. They include the Perinatal Quality Surveillance Model, the national Perinatal Mortality Review Tool, the Maternity Services Dashboard, the Maternity Outcomes Signal System, and the MBRRACE-UK Real Time Data Monitoring Tool.

Now, my Lady, we accept, as Professor Spiegelhalter noted, building systems which can effectively identify aberrations in incidents

involving neonates poses unique challenges but there has been significant advances in data monitoring within the NHS in recent years, which promises real benefits to patient safety, and the Department and its partner agencies have undertaken significant work to improve reporting, monitoring and investigation in respect of patient safety.

That said, it is self-evident that reporting tools must be properly and consistently used if they are to be effective, as well as being supported by robust risk management and governance processes. There has to be wide ownership of data at a local level, with staff encouraged not just to report but also to monitor, analyse and respond to trends as they occur, and when trends or concerns are identified, there has to be appropriate action. Data or statistical analysis can tell you that something is unusual but it can't tell you why it occurred and is thus a trigger for investigation, not the end point of analysis.

So good reporting practices are part of the solution, but not the whole solution.

LADY JUSTICE THIRLWALL: And on that topic, on the topic of good reporting practices, is it recognised that there needs to be some emphasis on training and also an emphasis on not having to put the same information in

more than once?

MR SHELDON: Absolutely, my Lady, and those points are well understood and we take them on board entirely.

It's also important that that data analysis work is backed up by a culture within trusts that encourages the understanding of data and that is open and sensitive enough to respond to concerns when they are raised.

And really that brings me to the second area which I wish to address briefly, which is whistleblowing and the importance of ensuring that staff are encouraged and supported to raise concerns when they are identified, whether through reporting and monitoring tools of the type I've just identified or otherwise.

LADY JUSTICE THIRLWALL: Mr Sheldon, before you get to that, and it's an important topic, but I just think I'd like to raise something to sort of finish the earlier point that you --

MR SHELDON: Of course, my Lady.

LADY JUSTICE THIRLWALL: -- were making in relation to inputting into data systems and the evidence that we heard, which I don't think it's dealt with in your written submission, that there is a problem with MBRRACE being -- I beg your pardon, not MBRRACE, BadgerNet being used across systems. In other words, we are back in a situation where one system in the NHS is not speaking

to another one. I don't know how widespread it was but it is something that was raised by a number of witnesses, and certainly Professor Spiegelhalter expressed dismay that this was still happening. I'm not expecting you to answer that on your feet, unless anyone has briefed you about it before, but if we could have an answer on what's to happen about that --

MR SHELDON: Of course, my Lady.

LADY JUSTICE THIRLWALL: -- that would be helpful.

MR SHELDON: Thank you very much for raising it, and I apologise we didn't deal with it specifically in our written submissions but we will deal with it.

LADY JUSTICE THIRLWALL: Whistleblowing.

MR SHELDON: Can I turn back to whistleblowing and acknowledge, of course, that a number of previous inquiries such as this have identified that an essential element in promoting patient safety is the ability of staff to escalate concerns. The health of an institution may be judged by the way it treats whistleblowers.

This is an area to which the Department has devoted significant attention and resource over the last few years. In 2022 a Freedom to Speak Up policy was published by NHS England, and on 18 August 2023 all organisations providing NHS services were written to, in

light of the events at the Countess of Chester Hospital, and required to adopt the policy by January 2024. Martha's Rule, which is being currently rolled out in 143 hospital sites, gives patients and their families the ability to initiate a rapid review of their case 24 hours a day from someone outside their immediate care team. And there is also the formal NHS complaints system which provides a process for complaints to be addressed and investigated at a local level.

My Lady, these are important developments and it is both hoped and expected that they will make a significant contribution to ensuring that staff, as well as patients and their families, are empowered to raise concerns and are supported when they do.

Now, that said, it is quite clear that policies and procedures, however robust and comprehensive they may be, are not sufficient of themselves. You have heard deeply troubling evidence of how those who raised concerns in this case were treated. We've set out examples of some of that evidence in our written submissions but you'll be very conscious of all of it. It's an aspect of the evidence, though, that we as a department have followed with particular concern.

There was a speaking up policy in place in this hospital but it does not appear to have been followed.

It's not clear that staff recognised the purpose or value of using formal processes to raise and investigate concerns. Even staff clearly well versed in the applicable policies -- and you'll recall the evidence of Dr Holt who kept a copy of the NHS whistleblowing policy on her desk -- still felt unable to be heard, despite being senior clinicians in what one might have thought would be a position of relative power.

There was also evidence that, contrary to policies in place at the time, there was a widespread misconception that those raising concerns had to prove or evidence them before they could or should be acted on. There was a tendency amongst middle and senior management to focus on the motivations of those who raised concerns, rather than the concerns themselves, and Professor Dixon-Woods has noted this credibility gap is a recurrent finding in inquiries and investigations, particularly when the concerns relate to highly transgressive behaviour, such as deliberate harm.

And perhaps most troubling of all, my Lady, was the evidence that most of those raising concerns also felt bullied or intimidated as a result, and some feared, with justification, that they may lose their employment. Senior managers considered steps which would be contrary to basic principles of whistleblowing

protection, both then and now, including looking to manage out the consultants, threats of referral to the GMC and apparently considering how the protections within the Speak Out Safely policy could be "mitigated".

My Lady, this evidence compels the conclusion that it is not enough simply to institute and disseminate policies and procedures to support whistleblowing. The issues I've just summarised arose despite the legislation and policies in place at the time, which Professor Bowers judged to have been broadly adequate, effective implementation is vital and the Department acknowledges that this is an ongoing task.

The Inquiry has demonstrated to the Department, and we hope trusts throughout the country, that there is a great deal of work to do in ensuring that staff really do feel able to raise concerns and are properly supported when they do. A culture of openness and honesty is vital for patient safety and the Secretary of State has been clear that the Government will not tolerate NHS managers who silence whistleblowers or attempt to do so. And the Government will consider what further actions are required to make speaking up the norm in the NHS.

My Lady, that links to the third issue I wish to address this morning, which is culture and leadership.

A healthy, positive workplace culture is a critical factor in the success of the NHS and in patient safety. The culture of an organisation and its workforce, along with other factors, of course, shapes the decisions, actions and behaviours that staff exhibit. This in turn affects the quality and safety of the service provided and ultimately patient outcomes.

Poor leadership and workforce cultural issues have been raised repeatedly in previous investigations, inquiries and reports of maternity and neonatal services, and it is clear that solutions are required which all trusts can implement and consistently adopt.

However, it seems to us that identifying the appropriate solution necessarily requires identifying correctly the problem, and one of the notable features of the evidence in this Inquiry is that it doesn't generally suggest that the culture at the Countess of Chester was particularly poor or unusually bad. In fact, many members of staff told you, particularly junior doctors and nurses, that it was a friendly and relatively supportive atmosphere in which they worked and they said they would have felt comfortable raising concerns.

What appears to have been lacking, in our submission, is the sort of strong, open-minded

leadership that is curious, objective and confident enough to do the right thing when concerns are raised.

As Mr Vineall put it to you during his evidence:

"... I think it does come back, as we said in these statements, to having boards that are ... curious rather than looking for security ... as the board in this instance wasn't ... [that] are sensitive about quality of patient care, do listen to patient stories, aren't defensive and don't enable tribalism amongst their different groups of professionals, which [was clearly] the case here."

My Lady, yours is not the first Inquiry to identify this issue. Previous reviews and inquiries have painted a broadly consistent picture of incurious boards unresponsive to key patient safety concerns, of defensive and on some occasions bullying behaviour and of professional tribalism with associated tolerance of poor behaviour and poor care.

This Inquiry may consider that some of the evidence heard, particularly concerning the treatment of those who raised concerns, is suggestive of a similar pattern.

The centrality of good leadership to patient safety and culture more generally cannot be overstated. You'll recall the mother of Child K put it succinctly

and powerfully to you in her evidence:

"If you don't change the behaviour of the management then it doesn't matter what other safeguards are in place."

This is an issue that the NHS has been aware of and has been working on for some time. In his 2022 report, Sir Gordon Messenger referred to:

"... an institutional inadequacy in the way that leadership and management is trained, developed and valued."

He described encountering:

"... too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance."

The recommendations made by Sir Gordon were accepted and NHS England is currently taking forward their delivery.

There are a number of other respects in which the Department and NHS England are working to build strong leadership as a means of improving culture and they are set out in paragraph 64 of our written submissions. I won't take up time now listing them. The point for present purposes is that we recognise this will be an area of particular concern to you in the Inquiry. It's an area where a significant amount of work is

already being done but we acknowledge there is much more to do in ensuring that leadership of trusts is strengthened and improved.

Can I just briefly touch on two specific respects in which work is being done to improve leadership and make managers more accountable in the NHS which we would invite you to note when considering what further actions might be required in this regard.

The first is the very important issue of manager regulation. The events examined in this Inquiry have brought a renewed focus on whether additional measures are required to enhance the accountability of senior NHS managers, including by way of regulation. The Government committed in its manifesto to introduce professional standards for and regulation of NHS managers, ensuring that those who commit serious misconduct can never do so again.

The consultation on manager regulation closed on 18 February this year and it received strong engagement across the sector and the wider public. We received just under 5,000 responses in total, and the Department is already considering all of those responses before setting out the next steps for implementation.

As many witnesses have explained, regulation should be accompanied by support and proper training.

The Government also recognises this and the Secretary of State has committed to establishing a College of Executive and Clinical Leadership to support the development of NHS managers and leaders.

Regulation is an opportunity to promote higher standards, enhance accountability and support better NHS leaders. However, as Mr Vineall explained in his evidence, the establishment of a regulatory framework, whilst important, does not remove the obligation on trust boards to take responsibility for the performance of their managers at local level. Ministers can set policy and officials can devise guidance but it is boards who are responsible for the day-to-day performance of their organisations, and so managerial regulation is a powerful addition to board oversight but not a substitute for it.

LADY JUSTICE THIRLWALL: And I suppose, Mr Sheldon, you can regulate all you like but it depends on the quality of the people that you recruit in the first place and then how you develop them. I think that's an uncontroversial statement.

MR SHELDON: Yes, my Lady.

LADY JUSTICE THIRLWALL: And one of the points that was made by more than one witness is that there is an excellent graduate training scheme for a certain number but that

the training for the rest is not of the same quality, and one of the questions I think I asked more than once was why could -- whatever your route in, and there can be many reasons why you don't go through the graduate scheme, but let's say someone who has been in the NHS for some time and has experience, why is it that it's not possible, if it isn't possible, that those people should have the same opportunities and level of rigorous training that the graduate entries have?

MR SHELDON: My Lady, we accept that entirely and part of the rationale for the institution of the College of Executive and Clinical Leadership is to precisely to fill that gap and to provide guidance and frameworks within which effective treatment can be delivered more broadly than has previously been the case.

LADY JUSTICE THIRLWALL: It will be interesting to see what the syllabus is in due course. I'm not asking for it now but just to see how effective that could be. It's obviously very necessary.

MR SHELDON: Understood, my Lady.

LADY JUSTICE THIRLWALL: Thank you.

MR SHELDON: Thank you.

My Lady, the second specific area to touch on just very briefly in this regard is candour. You'll be aware that the Government has announced an intention to

legislate to introduce a duty of candour for public servants to promote a more open and accountable culture.

In the healthcare context, of course, there is already a statutory duty of candour which applies to all providers registered with the CQC. However, a review commenced by the Department in December 2023, including a call for evidence, the results of which were published in November last year, indicated that whilst this existing duty was functioning effectively in some places, it was somewhat underwhelming in its totality.

There is, therefore, an opportunity to revisit the operation of a duty of candour in the healthcare context, and views have been sought on this question in the context of the consultation on manager regulation. The Government will use the findings from the consultation and call for evidence to inform its final response to its review of the statutory duty of candour, for which legislation will be introduced shortly.

My Lady, the final topic for me to address in these submissions is the issue of regulation and oversight and in particular the introduction of the medical examiner scheme.

The events of Countess of Chester raise profound questions for the regulatory and oversight systems in place within the NHS. The Inquiry has rightly examined

in detail the question of how these incidents went undetected and unprevented for as long as they did, and the evidence suggests, we would respectfully submit, that there were a number of contributory factors and any response will have to be multifactorial.

We've summarised the steps being taken to strengthen regulatory and oversight systems at paragraph 78 of our written submissions, which I adopt but don't repeat. But I do wish to draw the Inquiry's particular attention to the medical examiner scheme, which is one of the most significant of these developments.

As we've acknowledged in our written submissions, it took a long time to implement the statutory medical examiner scheme due to a number of factors, including the need to introduce the required legislation and resolve funding issues. However, the scheme now in place should serve as a valuable tool, not least in swiftly identifying cases of deliberate harm by healthcare professionals. That was and is central to its aims and focus.

Now, you've heard evidence from many quarters in support of the valuable contribution the scheme could make to patient safety, including from your experts Professor Dixon-Woods and Sir Robert Francis, and also

from staff on the ground, such as Dr McCormack, who commended medical examiners for offering:

"... a dedicated and confidential forum for discussing concerns and expertise on matters such as the coronial process, and [assisting] by educating and reminding staff of cases such as Allitt and Stepping Hill."

Both the National Medical Examiner Dr Fletcher and Jeremy Hunt MP considered that the system would likely result in earlier detection and so prevention of acts such as Letby's were similar events to occur now.

Now, my Lady, regulation and oversight is a complex and detailed area with a number of component parts and there's no prospect of me doing justice to it in the time remaining this morning. Can I just flag in very headline terms the following areas in which the need for further work has been identified and some progress made.

First, the Department is working to develop the digital medical certificate for causes of death and has secured funding to evaluate the effectiveness of the reforms.

Secondly, since assuming full responsibility for the child death review process in 2018, the Department has had oversight of the child death review guidance,

and accompanying guidance at local level is in place to support individuals in the reporting process. There have been some improvements in this regard, for example digitising the form completion process, but the Department recognises that the guidance needs to be reviewed and updated.

Third, and in response to the Williams review, a new memorandum of understanding, "Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm", has been agreed between 13 signatory agencies to help support the development of a just culture in healthcare and ensure that investigations and patient safety learning responses take place effectively and efficiently where criminal activity is suspected.

And, fourth, my Lady, as you'll be aware, the Secretary of State has commissioned Dr Penny Dash to carry out a review of patient safety organisations across the healthcare landscape in England within the context of wider regulation and improvement of quality of care, and that review is expected to be published shortly.

My Lady, that's all the time I propose to take up this morning, and we're conscious you've got many more Core Participants from whom you will wish to hear. We

commend our written closing submissions to you and you'll have seen that we have endeavoured at least to answer the specific questions you pose to the institutional Core Participants, including importantly those relating to the safeguarding of children.

We've also sought to address frankly and candidly the issue of implementation of recommendations by previous inquiries and investigations, which you've already raised with me, and we've set out a table of recommendations of a number of previous inquiries at paragraph 8 of our written submissions.

There is no doubt that this analysis and indeed the more extensive analysis that your Inquiry team performed at the outset of these hearings demonstrates that the record of effective implementation of past recommendations so as to deliver real and lasting improvement has been mixed, and we have to get better at this.

There are a variety of reasons touched on in our written submissions why past recommendations have not been accepted or where accepted have not produced the intended results but the bottom line is that the Secretary of State is determined to ensure that the Department improves its record in this regard.

The tragic events at the Countess of Chester

should not have been allowed to happen in the first place and I've sought to outline this morning the steps that the Department is already taking pending any further recommendations you may make but when they do, the lessons have to be learned and real lasting change has to be implemented, and I can assure you, my Lady, and the public of the commitment of the Secretary of State and his Department to ensuring that this is achieved in this case.

Could I make two very short observations by way of conclusion. The first includes the Inquiry team, including but by no means limited to your legal team. My Lady, you'll know better than anyone that this Inquiry has run to a demanding timetable which has required everybody to work under considerable pressure. Notwithstanding those pressures, the Department has been treated throughout this process with the highest standards of professionalism and courtesy by the legal team as a whole and we would wish to record our thanks and appreciation for that.

Finally, the Department would wish to conclude these closing submissions by addressing the bereaved families.

The Department has followed this Inquiry with close attention from the outset and has listened

carefully to evidence much of which must have been incredibly difficult for those families to hear. The dignity and resilience that they have shown throughout this Inquiry has been remarkable. All of those involved in this Inquiry both within and on behalf of the Department of Health and Social Care, including the Secretary of State, would wish to pay tribute to them.

My Lady, thank you very much.

LADY JUSTICE THIRLWALL: Thank you, Mr Sheldon, and, for the record, you are making no submissions in respect of the request to pause the Inquiry.

MR SHELDON: Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you.

Mr Beer.

Just before Mr Beer settles down, there seems to be a bit of feedback on the link. Can everyone hear properly? Can everyone in the public gallery hear properly? Everyone else? All right. Then it may have just been my imagination.

Mr Beer.

Closing submissions by MR BEER

MR BEER: Thank you very much, my Lady. NHS England has engaged actively with the Inquiry. It has listened, reflected and acted upon the evidence that it has heard. In its written closing submissions, NHS England has

proposed a number of potential recommendations for you to consider, as well as reflecting on some earlier proposals made in our opening submissions, and has explained why it no longer considered these required a recommendation. In many cases, this is because work is already under way to address the issue. However, NHS England has carefully considered the recommendations proposed by other Core Participants, and where NHS England does not support the proposals made, it has been guided by wanting to assist the Inquiry to identify those likely to lead to real improvements in keeping babies safe in hospital and well looked after.

Evidence it has given to the Inquiry, including in the form of some 24 witness statements from a range of individuals at NHS England, both those involved in responding to these events in the region and those responsible for managing relative policies, has covered the role, functions and work of the NHS in the period from its establishment to date, including the role of its regional teams and regional directors in the appointment of senior leaders, has covered neonatal care between 2015 and 2017 and now, the improvements made since then and ongoing priority areas for further improvement through the three-year delivery plan for maternity and neonatal services, safeguarding and child

death review, insulin, CCTV and the work of MOSS, the medical examiner system, the role, responsibilities and priorities of the neonatal and neonatal clinical -- neonatal nurse and neonatal clinical director, and the implementation of recommendations from previous inquiries, investigations and reviews.

Throughout the Inquiry, NHS England has sought openly to acknowledge areas for potential improvement, including in the proposed recommendations set out in our closing submissions, and has sought to assist the Inquiry by sharing its reflections and thoughts on the evidence that the Inquiry has heard, particularly the evidence from the Families and their thoughtful proposals on potential recommendations. It has come today ready to continue to share its views and thoughts, having carefully considered and reflected on the closing submissions made by other Core Participants in the Inquiry.

The announcement on Thursday of last week by the Secretary of State that NHS England will be abolished has two consequences for our participation in this phase of the Inquiry's work.

Firstly, it means that any recommendations that you make which would otherwise have been appropriately addressed to NHS England ought in the present

circumstances also to be addressed to the Secretary of State for Health and Social Care as Mr Sheldon has said a moment ago.

There are three reasons why it's now necessary for the Secretary of State to be named as a co-respondent in relation to such recommendations as would otherwise have been addressed to us alone.

Firstly, and most obviously, there's going to come a time when NHS England will cease to exist, and it's not in the public interest for the Inquiry to make recommendations to a body which it is understood at some point in the future will cease to exist, and neither is it fair for the Inquiry to be in a situation where it is making recommendations that name a body as being responsible for addressing a recommendation which it is told at some point in the future will cease to exist. The Inquiry and the public need to have certainty that the Inquiry's recommendations will be addressed.

Secondly, many of the functions which NHS England discharges derive from statutory powers or statutory responsibilities. The Secretary of State has announced that he will seek to legislate to transfer those powers, either to himself or to others, but --

LADY JUSTICE THIRLWALL: I suppose, Mr Beer, I'm sorry to interrupt --

MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- but it's one thing to say at some point in the future the organisation will cease to exist but the impression one has from reporting, and I don't know whether this is an accurate impression, is that there will be reductions in the number of people working for NHS England before the organisation ceases to exist, and so that's the reason for my question earlier as to who actually is going to be responsible for whichever recommendation, and I appreciate it may be that NHS England's input may be less than that of the Department but it is something which is of concern.
MR BEER: Yes, as to that, I would say three things.
Firstly, we may not be the best person to ask now in terms of the relationship as it now exists.
And, secondly, in any event, we're very early in the process.
LADY JUSTICE THIRLWALL: Yes.
MR BEER: This happened on Thursday, and we're now on Monday.
And the third thing is you may not get an answer in time for the writing of your report to know where each relevant function may sit as between NHS England, the Department or some other body, in which case you may wish to include in your recommendations a recommendation

about an implementation board or *in extremis* not close your Inquiry and yourself act as such a body by not closing the Inquiry under section 14.
LADY JUSTICE THIRLWALL: Yes, I understand.
MR BEER: They're not things I positively urge upon you but are matters for you to consider.
LADY JUSTICE THIRLWALL: Thank you.
MR BEER: The speed of the transition of powers and functions or the order in which powers and functions is to occur is presently unclear. Other functions are discharged by NHS England pursuant to its general powers, so not specific statutory powers, and again these will have to be transferred to the Secretary of State or to others. Again, by reason of the timing of the Prime Minister's announcement, there's presently no timetable or order in which such functions are to be transferred, save for the mention of a long-stop period of two years.
The Inquiry should be supported, we submit, in the preparation of its report, so over the coming months it does not need to check which body or person presently has the legal, functional or operational responsibility for the discharge of a function and, therefore, which body or person to whom a recommendation is directed.
The third point I would make on this is that the

abolition of NHS England does not change the evidence or the reflections that it has given, nor diminish the value of its participation to date. If anything, it's all the more important that NHS England formally records the learning that it has derived from the events at the Countess of Chester and from its participation as a Core Participants in this Inquiry.
Professor Sir Stephen Powis, from whom the Inquiry heard, Duncan Burton, the chief nursing officer for England, which is a joint Department of Health and Social Care and NHS role, who has given three witness statements to the Inquiry, and Sarah-Jane Marsh, the deputy chief operating officer, still remain directly and actively involved with NHS England's response to this Inquiry.
The Inquiry will understand that alongside very experienced NHS managers, NHS England employs professors, senior doctors and other clinicians who contribute valuable practical knowledge from the NHS front line into policy roles and who will provide corporate memory in the course of the transition.
LADY JUSTICE THIRLWALL: Just before you move into --
MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- perhaps to develop some of that in relation to transition, I wonder if I could just ask

you about the change in view from NHS England about CCTV --
MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- because when Professor Sir Stephen Powis gave evidence -- it's your paragraph 46 --
MR BEER: It is.
LADY JUSTICE THIRLWALL: -- he indicated NHS England's intention to explore the issue of CCTV through the commissioning of pilots.
MR BEER: Yes.
LADY JUSTICE THIRLWALL: When we get to paragraph 47, we see a decision has been taken not to do that, and, given that this is a suggestion that was made very early in this process by and on behalf of the parents, I think it would be useful to have a bit more of an explanation than appears in the written document as to why that decision has been taken.
MR BEER: Yes. I think Sir Stephen's view was that it was necessary to conduct some pilots to find out the answers to some fundamental questions on the benefits and any disadvantages of using cot cameras or cot monitors, and he suggested that this could be taken forward through the work of the chief nursing officer or the national medical director for neonatal care.

LADY JUSTICE THIRLWALL: Yes.
MR BEER: In fact, both of those people have undertaken a review of what transpires to be existing pilot studies on those issues --
LADY JUSTICE THIRLWALL: Ah.
MR BEER: -- and in particular you may remember in the written submissions there's a cross reference to work done in particular by the neonatal unit at University College London, which is in fact published quite extensively on this issue and overall, and this is my summary --
LADY JUSTICE THIRLWALL: Yes, that would be helpful.
MR BEER: -- what that shows is, firstly, there wasn't an identifiable gain in patient safety terms by having cot cams.
LADY JUSTICE THIRLWALL: How was that assessed?
MR BEER: Well, there was no change to the outcomes for babies. There was, secondly, however, a positive reception from the families concerned. So they --
LADY JUSTICE THIRLWALL: Sorry, just so I can understand --
MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- the families felt it was a good thing?
MR BEER: Yes, the families felt that it was a good thing. They felt reassured --

LADY JUSTICE THIRLWALL: Yes.
MR BEER: -- it gave them a feeling of greater safety.
LADY JUSTICE THIRLWALL: A justified feeling --
MR BEER: Sorry?
LADY JUSTICE THIRLWALL: Presumably a justified feeling of greater safety --
MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- and reassurance? Yes.
MR BEER: Yes. But, thirdly, it led to increased workload, in particular because parents believed that they could see issues on the cot cams that required attending to, ie some clinical response.

And, fourthly -- and again this is my summary -- the necessary training, supervision and resource demands that the introduction of cot cams led to were significant.

LADY JUSTICE THIRLWALL: Because -- what would the training be for?
MR BEER: The training was in relation to when to respond to an issue. So quite often it was said that parents called in and said that they had seen something that required attending to, whether that was to be responded to or not.
LADY JUSTICE THIRLWALL: Oh, I see, not training but in the use of the cot cams *(unclear)* point.

MR BEER: No, I imagine there would be a marginal --
LADY JUSTICE THIRLWALL: Minimal, yes.
MR BEER: -- point on that, but that's probably by the by.
LADY JUSTICE THIRLWALL: So it's the parents would see something on the camera that was of concern to them --
MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- and they would get in touch, and I suppose if a parent was standing next to the cot and saw something which was of concern, presumably they'd do the same thing?
MR BEER: Yes. But by way of discussion and there could be dialogue with the clinical indicators in front of each them as they speak, so that there could be a discussion and if necessary bringing in of other staff. I'm simply at the moment reflecting in my understanding the outcome of the research that has taken place.
LADY JUSTICE THIRLWALL: No, no, that's very helpful. Yes, it just seemed to me those were questions that anyone who was interested in this would want to know the answers to. And where are the detailed answers found? Is this in the work from UCH or --
MR BEER: UCL.
LADY JUSTICE THIRLWALL: UCL.
MR BEER: Yes. Yes, we can give you the citations of the academic papers --

LADY JUSTICE THIRLWALL: Well, perhaps --
MR BEER: -- it's not restricted to UCL.
LADY JUSTICE THIRLWALL: Yes, I can see Mr Suter saying we've got them. So that's something we can have a look at, because I think it's an interesting question and if there are issues, I'd like to know what they are --
MR BEER: Yes.
LADY JUSTICE THIRLWALL: -- before making my recommendations. Thank you.

Sorry, Mr Beer, I took you off course.

MR BEER: No, no, of course.

Going back to where I was, I was submitting that NHS employs senior professors, doctors and clinicians who contribute valuable practical knowledge from the front line into policy roles and that in the light of the announcement to the abolition of NHS England, it's important, we submit, that there should be a backstop in the form of the Secretary of State to provide assurance to the Inquiry that recommendations will not fall into a vacuum, because the Inquiry should not be left in a position after today, whilst it is writing its report, of needing regular updates on which functions have or have not been transferred.

The second overall consequence of the decision that NHS England will be abolished is the effect that it

might have on NHS England's standing to make submissions or the appropriateness of me doing so, and we've given careful consideration to those issues, in particular whether it's appropriate to make submissions of substance on proposed recommendations in circumstances where we are to be abolished.

Subject to the Inquiry's view, we think it's appropriate to do so because we've engaged actively in the Inquiry to date, because of our subject matter experts, many of whom are clinicians, speaking through me may be able to assist the Inquiry on some of the recommendations that are proposed.

LADY JUSTICE THIRLWALL: Thank you.

MR BEER: We can assure the Inquiry and the Families that NHS England stands ready and committed to actioning any recommendations directed to it in the immediate period following publication of the report. The Secretary of State's announcement makes it clear that the abolition will take some time to implement in full, as I've said with a two-year long-stop for complete abolition. The work of the committed and dedicated individuals within NHS England whose evidence the Inquiry has received continues with the benefit of closer integration with the Department to enable progress.

We're strongly supportive of the proposals to

establish a repository of Inquiry recommendations to ensure accountability and transparency of implementation, as well as clarifying prioritisation to those tasked with actioning them. NHS England has included this as one of its proposed recommendations in our written submissions with the Government, the Department and NHS England all suggested as having a role to play.

The decision to abolish NHS England underscores the importance of any such repository being hosted by a permanent part of the structure. In a health context that inevitably means the Department.

Prior to the abolition being announced, NHS England and the Department had been working closely together, including on issues explored by the Inquiry, such as the question of responsibility and for funding of a review of the SUDIC Guidelines and through their joint updates on the table of previous inquiry recommendations and that joint working will continue together. NHS England will work with the Department to ensure them that between us the Inquiry's recommendations are addressed.

Can I turn then to some reflections on other Core Participants' proposed recommendations.

We have considered carefully and reflected on the

recommendations that have been proposed by other Core Participants through the lens proposed in the HSSIB report of smart recommendations and the overarching aim in accordance with the Inquiry's Terms of Reference to identify improvements that will help keep babies safe in hospital and well looked after. Overall there seems to be a strong consensus around a number of key areas for recommendations. I don't intend to respond to all proposed recommendations, instead to focus on those either directed to NHS England or where assistance may be of most help.

We've adopted a Families-first approach, recognising the common topics raised by all three Family Groups, and we've collated the proposed recommendations in what I'm about to say by topic.

So, firstly, reporting concerns. And so, firstly, on the proposal by Family Group 1 that the Department and/or NHS England should publish a single short document that clearly and unambiguously sets out the steps that must be taken immediately when information arises that indicates that a healthcare professional has or may have deliberately harmed a patient. We agree that this has merit. As we explain in paragraph 189 of our closing submissions, our view is that this would be best taken forward as part of the review of the Child

Death Review Statutory Guidance and the SUDIC Guidelines, which the Department has agreed are in need of review and update. Several Core Participants, including NHS England itself, have emphasised the need for any such review to be co-ordinated with a view to simplifying and consolidating the guidance where possible.

Patient safety incident reporting and definitions is a topic where all three Family Groups have proposed recommendations. Although slightly different in emphasis and wording, our understanding is that they are all focused on the same issue, the mandatory reporting for neonatal death and sudden and unexpected collapse. Family Group 1 have specifically questioned whether the definition of a "patient safety incident" is sufficiently clear to ensure that incidents where no event can be identified can be reported and investigated under PSIRF, Patient Safety Incident Report Framework.

We understand why these recommendations have been proposed. However, NHS England does not consider that such a recommendation is necessary because, firstly, providers are required to notify the CQC of all service user deaths in any event, as well as injuries to all service users: see Regulations 16 and 18 of the CQC (Registration) Regulations 2009.

Secondly, the PSIRF encourages an open approach to reporting and investigation. It makes clear that where an outcome of concern occurs and it is not clear why, that should be recorded as a patient safety incident and considered further, especially where the outcome is a death.

Thirdly, the introduction of the medical examiner system means that all neonatal deaths will now be examined by a medical examiner and/or a coroner.

Fourthly, the Perinatal Mortality Review Tool provides a structured standardised review process for babies' deaths.

And, lastly, the proposed review and update of the CDR guidance and the SUDIC Guidelines will provide an opportunity to ensure that the child death review process for in-hospital neonatal deaths is clear.

So if the Inquiry was interested in exploring mandatory reporting of neonatal deaths, we would say that the more appropriate route might be through the expansion of the maternity and newborn safety investigations programme hosted by the CQC.

Can I turn to two issues which NHS England recognises the importance to the families of, namely recommendations concerning insulin and CCTV or cot cams, which we've mentioned already.

Turning, firstly, to insulin. At various points throughout the Inquiry we have considered whether additional patient safety measures are required in relation to insulin. Having done so, its view, which is set out in our closing written submissions and in the third witness statement of Duncan Burton, the chief nursing officer, is that no further measures are needed. However, we expect continued improvements in the management of all medications as a result of further developments in the digital infrastructure, automation and use of data. You'll see the detailed reasons in paragraphs 39 to 41 of our written submissions in relation to insulin.

In relation to cot cameras and the possibility of their introduction to cots or incubators, we have discussed already the evidence given by Sir Stephen Powis and the commissioning of pilots under the auspices of the chief nursing officer. As I've said, having sought the views of neonatal experts and reviewed the published scientific literature on the issue, our view was that a pilot of cot cams would not be appropriate taking into account other priorities to improve neonatal services and the findings of the scientific research on this topic to date.

LADY JUSTICE THIRLWALL: And when you refer to the

scientific research, you're talking about the UCL paper?

MR BEER: Yes. In fact it's broader and if somebody does a deep dive into this they'll find that there's some learning from America and on the Continent too, but principally in the domestic context the UCL.

LADY JUSTICE THIRLWALL: Thank you.

MR BEER: Family Group 1 has also proposed that CCTV should be extended to cover drug dispensary areas. It's currently open to hospitals to install and operate CCTV in drug dispensary areas, with the placement of CCTV on hospital sites being a matter for local determination. However, for reasons fully explained in our third witness statement from the chief nursing officer, but summarised in our written submissions at paragraphs 46 to 48, we don't presently consider this to be necessary to be taken forward as a recommendation. In particular, there are other forms of technology, as we explain, that are or may be more effective safeguards in drug dispensary locations. CCTV is just one type of a suite of potential measures that could be used at a local level in such a setting.

LADY JUSTICE THIRLWALL: So in terms of other forms of technology, I appreciate you've written a lot of this down, I think it would just be quite helpful to hear what you mean --

MR BEER: Yes, it's --

LADY JUSTICE THIRLWALL: -- about other forms of technology.

MR BEER: It's essentially systems that prevent access without the submission of some biometric data, so fingerprint or retinal scans. So rather than having CCTV watch whether or not somebody accesses a drug dispensary, the automated discharge of drugs upon provision by the requester of some biometric data.

Our overarching point, my Lady, as I've said, however, is that these are facilities that are available for trusts at a local level to implement, and many of them have, and our position was not this is to be an area where a national mandated framework was to be imposed.

The Families make two additional proposals around insulin.

Firstly, that blood test results, including high insulin/low C-peptide in a baby death being cared for on a neonatal unit should be a Never Event. The status and role of Never Events has been tested quite a lot by the Inquiry in the evidence. However, our position was that such an event, high insulin/low C-peptide, is not an event that would meet the definition of a Never Event, which is intended instead to focus on wholly preventable occurrences.

Secondly, that there should be clearer processes and governance around how test results of this nature are actioned, and here we note that the Royal College of Paediatrics and Child Health has proposed a related recommendation concerning measurement and reporting of high insulin/low C-peptide results. We would be very willing to support work to consider that proposal by the Royal College further through the chief scientific officer and the chief pharmaceutical officer.

Can I turn to invited reviews. Another area where several Core Participants propose recommendations or reviews of existing arrangements relates to how invited reviews [into] increased mortality and/or suspected deliberate harm are reported to external agencies.

To summarise, the collective proposals seem to be strengthen requirements about when, how and to whom the information should be shared.

Secondly, there are a range of ways that could be facilitated, whether through a statutory duty, and we have previously suggested that an expanded statutory duty of candour could be a way of enhancing this obligation, a contractual duty, the Families point to the NHS Standard Contract as being a mechanism through which this could occur, and the emerging concerns protocol which provides a mechanism to support

information-sharing between healthcare regulatory bodies.

The CQC correctly notes that this issue has been raised in previous inquiries, most notably Morecambe Bay. In its joint update table on Morecambe Bay NHS England and the Department noted that the Academy of Royal Colleges published an updated invited review framework in March 2022 which the CQC contributed to and which does include strengthened information-sharing with regulators.

The Royal College also summarises key changes that have been made to its invited review process in the period since the events in question, the most important of which is the formal arrangements entered into between the Royal College and relevant regulatory inspectorate or bodies involved in patient safety and quality improvement.

We explain -- it's paragraph 189 of our submissions -- the updates to the oversight framework and the guidance contained in the insightful board document that makes clear expectations concerning information-sharing. Overall, our view is that any further duty in this context ought best to be considered as part of the Government's review, the wider review of the duty of candour and the regulation of managers.

Can I turn to data intra-operability and access to data. These are also areas that a number of Core Participants propose recommendations on. You mentioned yourself BadgerNet to Mr Sheldon earlier.

The CQC question whether they will have access to data generated by MBRRACE-UK Real Time Data Monitoring Tool and MOSS, and the short answer is that they will, via the perinatal quality oversight model, and we explain that in our written submissions.

The Families raise concerns about whether work is under way to address issues about intra-operability of data and emphasise the need for combined, compatible and comprehensive data systems. We agree that intra-operability is important, but it will be wrong to conclude that no work is under way, but there is no easy, quick solution to resolve the intra-operability challenges.

LADY JUSTICE THIRLWALL: Is there a timescale for it?

MR BEER: Sorry?

LADY JUSTICE THIRLWALL: Is there even a timescale for it (a) which challenge and when is it going to be met?

MR BEER: I think my Lady ought to see the issue of data intra-operability in the neonatal context within a wider context of NHS data-sharing, and albeit I think it's something you haven't heard much evidence about, the

NHS -- in particular NHS England -- has developed software -- the suggestion is the development of a "software patch", I think was the phrase used, within three months by I think this is the Royal College again, to ensure a data flow between patient records, so electronic patient records (EPRs), and the national neonatal audit programme and the Perinatal Mortality Review Tool.

These are complex data questions and also engage some of the issues which are the subject matter of the recent announcement about the abolition of NHS England, the extent to which local providers ought to be able to commission their local systems or whether the centre mandates or the electronic patient record system that they procure with different systems around the country, it's not as simple as saying there is an immediate fix available.

So the short answer is, no, there's not a timetable for it because it's a national issue --

LADY JUSTICE THIRLWALL: Yes.

MR BEER: -- it doesn't just concern neonatal health --

LADY JUSTICE THIRLWALL: No, I --

MR BEER: -- and it engages issues that go to the very heart of the extent to which the centre should control things.

LADY JUSTICE THIRLWALL: Yes, and that I understand, and

I suppose the more data we have and the greater the urge to look at big data sets, the greater the likelihood that you need systems in different places which can speak to each other as a minimum. The alternative is to have one massive system. And those are the issues, are they, which are being considered?

MR BEER: Yes.

LADY JUSTICE THIRLWALL: Yes.

MR BEER: Yes. In short, yes.

LADY JUSTICE THIRLWALL: Yes. And presumably there must be some board or someone or other who is actually looking at this with some sort of time frame.

MR BEER: Yes, there's a whole division that's about to be abolished.

LADY JUSTICE THIRLWALL: Yes, I dare say. So the issue will be where's that work going to be done? And I suppose you're going to say, well, I would have to ask the Department. But Mr Sheldon is here and can hear the question and I look forward to a note about that in due course. Perhaps you and he can discuss it.

MR BEER: Yes, as do we, I think.

LADY JUSTICE THIRLWALL: Thank you.

MR BEER: The Royal College makes a number of proposals about the prioritisation of child health, informed by their important role in advocating for babies and

children. However, having considered these proposals our view is that recommendations on these points are not needed for the following reasons.

First, training for those using MBRRACE-UK Real Time Monitoring Tool. This is the responsibility of neonatal and maternity units, noting the clear recommendations in a neonatal context under the neonatal critical care specification for units to ensure sufficient time is allowed in job plans for the completion of the tool.

Secondly, ICB performance assessment. ICB is already subject to statutory duties under the NHS Act 2006 in relation to children and young people. This includes requirements to cover this group's particular needs in their joint forward plan, so a statutory requirement. We've published guidance on this for ICBs, and our annual assessment of ICBs is underpinned by four main questions, one of which is how far the ICB has achieved its local ambitions articulated in its joint forward plan.

Thirdly, waiting times for children's care. The waiting time targets in NHS England's priorities and operational planning guidance are general and apply to all ages.

Fourthly, the development of a national outcomes

framework for children's health. The development, we say, of any such national framework for children's health would be a matter for government and not for us, and that was irrespective of recent events.

Review of the children's health data underpinning NHS England's long-term workforce plan. The Government has confirmed that the long-term workforce plan will be refreshed this summer.

Specific investment in the neonatal workforce. We've described in detail in our evidence the investment that's been made and which continues to be a priority area under the overall governance of the Three-year Delivery Plan for maternity and neonatal services in our evidence.

LADY JUSTICE THIRLWALL: And I can't remember whether you were here, I think you were, Mr Beer, when Dr Longdon was giving evidence and she was saying that --

MR BEER: Dr Longdon or Dr Kingdon?

LADY JUSTICE THIRLWALL: Kingdon, I beg your pardon, yes.

MR BEER: You had me there because --

LADY JUSTICE THIRLWALL: Yes, I'm sorry --

MR BEER: -- that's not a witness name who I recognise.

LADY JUSTICE THIRLWALL: -- I just wanted to make sure you were listening, Mr Beer.

MR BEER: Dr Kingdon from the Royal College.

LADY JUSTICE THIRLWALL: Dr Kingdon, yes, and she made the point that there was no provision in the new national work plan, as it then stood, for additional nurses in the neonatal units, so I just simply raise that as something that I will want to follow up on.

MR BEER: Yes. I mean, I think from memory, when you go back and look, topics tend to be addressed generically under the plan --

LADY JUSTICE THIRLWALL: Yes.

MR BEER: -- rather than -- ie uplifts or similar under the plan, rather than by specialist area.

LADY JUSTICE THIRLWALL: Yes, well, she seemed to be pretty confident that there won't be any more neonatal nurses, so it may be that needs to be clarified because if there are that's something that she obviously would approve of, and if there aren't, then her evidence is accurate, but it's something that it would be helpful to have the answer to. Thank you.

MR BEER: Yes, thank you.

It is proposed by the Royal College that there be introduced a children's health investment standard. Again, we would say -- and this is irrespective of recent events -- a matter for the Government to address.

It is suggested, lastly, that there be a children's lead at the highest level of every NHS

organisation, but we've explained in our witness evidence from Sir Andrew Morris its view on the role of a designated champion or lead roles. We agree that a non-executive director with suitable oversight of children and young people is important, but respectfully suggest that a specific role is not needed because locally it's open to providers to allocate this role to an individual if they wish.

Can I turn in the time I'm allowed to medical examiners. In relation to this, we're pleased to be able to confirm that the planned update to the National Medical Examiners Good Practice guidelines on neonatal and child deaths, which has been developed with neonatal experts and BAPM, has now been published. In relation to that and following on from that, we suggest respectfully that no recommendation is, therefore, needed in relation to it. It's been done.

We note that the Royal College makes suggestions in relation to regional paediatric or neonatal specialists. The Department has confirmed in its closing submissions, paragraph 86, that it has secured funding to evaluate the effectiveness of this system and it may, therefore, be appropriate for this issue to be considered as part of that review.

And then, finally, in relation to social media,

we're pleased to note that the NMC has formally committed to further work to strengthen its professional regulatory guidance about social media, an issue of importance both to the Families and to NHS England. The NMC's position reflects our view that leadership on this important issue needs to come from the professional regulators.

Can I conclude these submissions by recording our deep gratitude to the Inquiry for the searching work that it has undertaken. NHS England's abolition will mean that it will principally be for others, particularly in the long-term, to ensure that the Inquiry's recommendations are implemented so as to ensure improvements to patient safety.

Until its abolition, however, NHS England remains committed to continuing its active work to improve neonatal care, including through its implementation of any recommendations that are directed to it.

Thank you.

LADY JUSTICE THIRLWALL: Thank you. Insofar as the request to pause the Inquiry, you deal with that in paragraph 4 of your closing submissions, which I think by now are probably on the website. Do you want to say anything more than that?

MR BEER: No, I don't think so, my Lady. In summary, it's

a section 13 issue for the Secretary of State. Your views as a consultee are important and this is a good opportunity to inform those views by taking submissions from Core Participants. As to the substance, we take a neutral position.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Beer.

So we'll take the morning break now and we'll start again at quarter to 12.

(11.25 am)

(A short break)

(11.46 am)

LADY JUSTICE THIRLWALL: Who is next? So who is representing the CQC? Ms Richards, I'm so sorry. Yes, I saw you there.

Closing submissions by MS RICHARDS

MS RICHARDS: So, my Lady, my submissions are made on behalf of the Care Quality Commission and I want to start by addressing the issue of disclosure.

The written closing submissions on behalf of Family Group 1 record the evidence of Mother A and B that "all we want do is find out what happened, and we never want it to happen again".

And the written closing submissions on behalf of Family Groups 2 and 3 record, entirely understandably,

dismay regarding gaps in the Care Quality Commission's disclosure.

My Lady, as the Inquiry knows, whilst the Care Quality Commission has disclosed a substantial number of documents to the Inquiry, including, I should make clear, the full inspection notes covering the inspection of the neonatal unit and the wider children's and young person's core service, there are specific contemporaneous documents that the Care Quality Commission has been unable to locate. Counsel to the Inquiry went through those specific documents with Ann Ford during her evidence and I won't list them again.

Although the Care Quality Commission as an organisation has no reason to think that the documents which have not been found would have contained information relating directly to the neonatal unit, some of them may well have included information relevant to the broader culture of the hospital, and in particular your Ladyship knows that the record of the focus group meeting with hospital consultants on 17 February is one of the documents that has not been found and, as such, the Inquiry had only such limited information as Julie Hughes of the CQC was able to provide through her diary and oral evidence regarding the nature and extent

of the concerns raised during that meeting.

Ann Ford and Chris Dzikiti of the CQC have already apologised in their evidence for this deficiency in disclosure, but I repeat that apology today on behalf of the CQC and directly to the Families. We are sorry and we understand that any gap in documentation impairs the Families' ability to, in Mother A and B's words, "find out what happened".

My Lady, conscious of the need to learn from this, the CQC has recently engaged an information management expert organisation called Metataxis to conduct a detailed review of its information and records management practices and more generally to evaluate the level of compliance with information governance and to make recommendations for improvement. This required an assessment of current information governance structures and ownership within CQC, the quality of records management practice, digital and physical storage arrangements and the provision of access to records in response to the needs of public inquiries. I understand, my Lady, a report has now been provided to the CQC's executive team for them to review its content and recommend appropriate actions and next steps.

LADY JUSTICE THIRLWALL: Thank you.

MS RICHARDS: My Lady, staying with the focus group meeting

with consultants in February 2016, the Care Quality Commission has accepted in its written submissions a number of respects in which it should have done better or differently and, in relation to that focus group meeting, the Care Quality Commission accepts that as well as reporting those concerns to the medical director, the issue should have been followed up and escalated to the chair of the Countess of Chester Hospital if a problem remained, and there is no evidence to suggest that that was done.

When the Countess of Chester finally told the Care Quality Commission about the increased neonatal mortality, and that was on 29 and 30 June 2016, the Care Quality Commission was reassured in terms of the ongoing safety of the unit as to the steps and actions that were proposed by the hospital, but CQC should have requested sight of the thematic review and of any other views that had been carried out, and having considered those and having noted the dates upon which they had been commissioned and received, CQC should in particular have explored with the Countess of Chester Hospital why this information had not been provided to it sooner. It did not do so.

LADY JUSTICE THIRLWALL: Ms Richards, just before you move on, but on the topic of neonatal mortality, and it

wasn't explored at all during the inspection, and I understand no one said anything about it, but is that usual, just the fact that it's not mentioned? Does that mean, therefore, that it's not even looked at, the question of mortality?

MS RICHARDS: My Lady, it would not have been part of the ordinary processes of the Care Quality Commission at that time as part of a comprehensive inspection to routinely ask questions about mortality data in the absence of something that gave rise to a specific concern. So the focus would have been on asking about the processes that would be followed in relation to neonatal mortality and indeed other aspects of incidents.

LADY JUSTICE THIRLWALL: So just by way of an example, then, what would be the question that would elicit the response, "We've had so many deaths this year and we had so many deaths last year"? Would that be a question you'd expect to ask?

MS RICHARDS: So, my Lady, there are two ways in which that information could have been elicited in terms of how this inspection actually was conducted.

LADY JUSTICE THIRLWALL: Sure.

MS RICHARDS: The first is that there was a discussion about the neonatal mortality meetings. So there was

a specific discussion about the processes for considering neonatal mortality within the hospital.

LADY JUSTICE THIRLWALL: Yes, that was why I was wondering why they wouldn't have asked, "Well, you know, where's the mortality data? What are the records?" It doesn't look as though that was done, does it?

MS RICHARDS: My Lady, it's not what was done. This was part of the CQC's comprehensive inspection process at that time. So these were big, set piece inspections sometimes for the first time, certainly for the first time under the new key lines of inquiry of services across the range of an entire hospital, and so there are a number of obviously outcomes questions that could be asked. The approach, however, was not specifically to ask each of those questions unless, of course, there was a specific reason to do so, either because of the data or because what was being observed by the inspectors gave rise to concerns.

So, my Lady, that's one way in which the information could and we say should have been provided by some of those at the Countess of Chester Hospital during the inspection.

LADY JUSTICE THIRLWALL: I understand very well what's said about what they should have done. What I'm just kind of interested to tease out --

MS RICHARDS: Yes.
LADY JUSTICE THIRLWALL: -- is what perhaps the CQC should have done. But, anyway, in the course of a comprehensive inspection that sort of question about neonatal unit wouldn't have been routinely asked.
MS RICHARDS: It wouldn't have been routinely asked.
LADY JUSTICE THIRLWALL: I understand.
MS RICHARDS: My Lady, the second way in which the questions would have been asked that might have given rise to relevant answers but didn't are the open questions that you heard from a number of the witnesses would have been part and parcel of the inspection process. So at the end of a meeting, "Is there something further that you want to say? Are there any specific concerns or particular concerns that you have?"
LADY JUSTICE THIRLWALL: Yes, and I've got your evidence about that, yes.
MS RICHARDS: My Lady, I'm grateful.
My Lady, I should say -- and you'll have seen this from quite a lot of the CQC's written evidence -- the CQC's approach to inspection has changed at various stages, and one of the changes post-dating the period with which your Ladyship is concerned is a shift to more risk-based inspection. So rather than the set piece comprehensive routine inspections looking across all

services, CQC has over the following years moved towards inspections that may be tailored to specific concerns that have been raised with it or have come to its attention, and those types of inspections, those risk-based inspections, may be more bespoke in character and may, of course, lead to more in-depth investigation because they have been specifically triggered by the raising of some form of concern.
LADY JUSTICE THIRLWALL: Yes. So at the time of the inspection with which we're concerned, it was about process but not about actually what was going on unless the hospital raised it?
MS RICHARDS: Well, my Lady, I wouldn't say it was not about what was actually going on but, my Lady, may I come back to that --
LADY JUSTICE THIRLWALL: Yes, of course, take your time.
MS RICHARDS: -- because I am going to deal with that point in a little while.
So, my Lady, just still dealing with some of the deficiencies of approach which CQC has accepted. Following the June 2016 sharing of information, it was not until May 2017 that the hospital finally told the Care Quality Commission about the possibility of criminal conduct and the involvement of the police, and CQC looking at the position now accepts it was

deferential to that. It was rightly concerned not to interfere with or prejudice the police investigation but that should not have stopped it from considering whether it needed to carry out its own investigations into whether there had been regulatory breaches and should not have stopped it from taking a decision as to whether a specific enforcement action should be contemplated, and that's particularly important because, as your Ladyship knows, there are statutory limits on the CQC's ability to take enforcement action.
You may have picked up, it's in a footnote in our written submissions, I'm afraid I can't remember which one, that the CQC has previously approached the Department of Health and Social Care with a view to exploring whether there could be an extension of those time periods which would require statutory amendment, but that hasn't been done. It is the Commission's experience that those time limits can be problematic in complex investigations.
LADY JUSTICE THIRLWALL: Has there been a response?
MS RICHARDS: My Lady, I don't know whether there's -- I'm not sure there's been a lack of formal response, but there was no change made in response to those overtures, is my understanding.
LADY JUSTICE THIRLWALL: All right, thank you.

MS RICHARDS: It's not that they were ignored but there hasn't been a substantive change.
LADY JUSTICE THIRLWALL: Thank you.
MS RICHARDS: So, my Lady, drawing those threads together, the Care Quality Commission accepts it should have shown greater professional curiosity once it was informed of the increase in deaths and having carried out further enquiries should have considered enforcement action, and it wishes to apologise to the Families for those deficiencies.
My Lady, turning then back to the February 2016 inspection, we have, I hope, made clear in our submissions that at no point before, during and after the inspection prior to the publication of the report on 29 June did anyone at the hospital, be it manager, executive, doctor or nurse, tell CQC that there were concerns regarding deaths on the neonatal unit, and there were ample opportunities to do so, really from the period of the engagement meeting on 21 July 2015 onwards.
There was a follow-up meeting on 13 October 2015, again a routine engagement meeting, a pre-inspection engagement meeting in late November. The data packs were sent to the hospital in both draft form and final form prior to the inspection. There was the inspection

itself and the meetings during that process.

The CQC then wrote to Mr Chambers on 29 February with an overview of its preliminary findings, including that there were no immediate patient safety concerns -- so the CQC's understanding of the position and incomplete though it was would have been apparent -- and, of course, the CQC returned for a follow-up visit on 4 March, two days after the final version of the thematic review had been circulated internally. None of those opportunities were taken and neither the thematic review nor any of the other reviews were provided to the CQC.

My Lady, we've set out a number of references to the evidence in our written submissions and I anticipate it's neither necessary nor helpful for me to rehearse or repeat that evidence now.

We do note that Mr Kennedy KC in his submissions on behalf of the hospital has accepted -- and this is paragraphs 269 to 275 -- that there was a failure to be fully open and transparent with the CQC prior to and after the inspection. We say there was an equal lack of transparency on the part of the hospital during the inspection.

My Lady, we emphasise that which is set out in paragraph 6 of our written submissions, and I'll just

make brief reference to that. What we explain there is that an inspection visit by its very nature is focused, intense, it takes place over a fixed and short period. To some extent, it is an inevitable snapshot in time.

LADY JUSTICE THIRLWALL: It is very, very short, isn't it?

MS RICHARDS: It is very short, my Lady. It's four-day inspection.

LADY JUSTICE THIRLWALL: Yes, and the specialist advisers, as they're described, get very little, if anything, beforehand and they don't have any input afterwards.

MS RICHARDS: My Lady, that's right. So the specialist advisers are often practising clinicians who can give to the CQC a relatively limited amount of their time. I say "often", it won't always be the case. And the CQC's assessment has been that they are most valuable during the visit itself in helping with the clinical observations, the observations of the environment, of the practices, observations of the handovers, the discussions with clinicians, that that is the most valuable use of their time.

In terms of the information that they receive beforehand, they would receive all the data packs and they would receive and be present for the data analyst's presentation on the first day of the inspection. Beyond that your Ladyship is right that certainly at that time

there wasn't any kind of routine provision of any further information to the specialist adviser. The expectation was that if the specialist advisers wanted to see material they can ask the inspector for it. If the inspector thought that there was material that the specialist adviser could assist with, they could share it. There was no prohibition upon that material being shared and those kind of exchanges taking place. But that was the system.

Your Ladyship will have seen from our written submissions that there is -- or there was a little later on -- and this is after CQC Insight was introduced, which was October 2016, so after this inspection, there was a handbook produced for specialist advisers which encouraged specialist advisers to review CQC Insight before the inspection, and the references to that are provided in our written submissions.

So that's still not providing the specialist advisers with all of the information that the inspectors have or that the CQC as whole have but it was an encouragement to the specialist advisers to look at what data was held on CQC Insight at the time, but that post-dates this inspection because the CQC Insight had not yet been set up.

So, my Lady, given the very short nature of the

inspection visits, inevitably there are limitations on what can be gleaned during the inspection process, and CQC is dependent upon and expects providers to be honest and open and forthcoming with CQC, and is entitled, we say, to rely, at least until given reason not to, on the candour and co-operation of hospitals being inspected.

In this particular case, as at February 2016, CQC had no reason to consider that the Countess of Chester Hospital would not be open with it. On the contrary, there had been previously identified through CQC's outliers programme a maternity outlier alert for puerperal sepsis that had been the subject of dialogue and information-sharing between CQC and the hospital.

If your Ladyship looks back at the minutes of the engagement meeting that took place between CQC and the hospital on 21 July 2015 -- and the reference is in our written submissions -- CQC was told on that occasion about reviews that the hospital were undertaking. So it was told that there was a review of the breast service being undertaken by the Royal College of Surgeons following incidents of delayed diagnosis, and it was told that there was an interventional radiology review following a serious incident, looking at processes, management and indeed culture. That's exactly the exchange of information that CQC would expect to have

taken place, and that reinforced the Commission's expectation that this was a trust that was forthcoming with what was happening and forthcoming with relevant information.

My Lady, your counsel have explored aspects of the inspection process with CQC witnesses during their evidence, and we've addressed a number of those aspects in our written submissions. I don't propose to repeat those matters there.

There are, undoubtedly, respects in which the inspection could have been undertaken differently, there are questions that could have been asked that weren't, and it would be for your Ladyship to assess whether, having regard to the information available at the time, rather than everything that was known now, whether it should have been undertaken differently, but it was an inspection carried out in good faith in accordance with the Commission's processes and guidance at the time and at a stage when its comprehensive inspection programme in relation to NHS trusts was still at a relatively early stage.

My Lady, can I deal with two aspects of the observations regarding the inspection made and the submissions on behalf of the Families, and I hope in so doing to answer a question your Ladyship asked me a few

moments ago. I do so with a degree of diffidence and recognising, as we do, how difficult it must be for the Families to know that the CQC inspectors were in the hospital at a key time and did not detect anything, and also recognising how jarring it must be for the Families to read of an inspection report which assesses the Trust in relatively positive terms in circumstances where the evidence before this Inquiry has revealed in a number of respects a significantly different picture.

My Lady, the two points I wanted to deal with are, first of all, the observation in the written closing submissions on behalf of Family Group 1, which draw attention to the Commission's finding in its inspection report that incidents were reported appropriately, and the Families understandably draw attention to the evidence which this Inquiry has heard to the contrary.

Then the second point is the point made in the written closing submissions on behalf of Family Groups 2 and 3 which question the suggestion that the Commission's role is to ensure the proper observance of processes, rather than investigating individual examples of incidents.

My Lady, on the first of these issues as to how the Commission reached the judgement that incidents were reported appropriately, you have the evidence of

Helen Cain with whom this issue was explored during her oral evidence on 14 November, and there are references to that in footnotes 42 and 61 of our written submissions. But essentially that's a judgement drawn from discussions with staff, from looking at the policy and procedures in place and from considering a sample of inspection reports.

And if your Ladyship looks again at the inspection report in relation to all the core services that were inspected in February 2016, you will see that is the process that was undertaken. For each core service, critical care, end of life, surgery, et cetera, the report reflects consideration of what the policies and processes were for incident reporting, it reflects discussions with staff about their knowledge and understanding of how and when to report incidents, it reflects consideration of the extent to which learning or feedback was disseminated following investigations, and it reflects the review of documentation in relation to a sample of incident reports. And where there have been Never Events, as there had been not in relation to children and young people but in relation to one or more of the other services, the inspection report shows inspectors looked to see if there's been a root cause analysis and what has been done to address it, rather

than undertaking their own assessment or investigation of what had gone wrong of the Never Event itself.

My Lady, of course, if the answers given by staff or the documents, the sample that are revealed or indeed any other matters observed or revealed during the inspection give rise to wider concerns, then those should be followed up, but that methodology in relation to looking at incident reporting is, we submit, a reasonable one.

We understand, of course, that a different picture has emerged in this Inquiry of the adequacy of reporting. But the depth and nature of the forensic investigation that this Inquiry has undertaken over a number of months into the neonatal unit is of a radically different nature and magnitude to the inspection which takes place over four days of eight core services.

LADY JUSTICE THIRLWALL: Are you going to deal separately with this STEIS report, the death of Child D?

MS RICHARDS: My Lady, I wasn't proposing to add anything to what's already in the written submissions but I'm very happy to answer any questions your Ladyship has.

LADY JUSTICE THIRLWALL: Because obviously the inspectors came along to give evidence and after that we got a statement from Lyn Andrews which asserted that the CQC

hadn't missed that report, it wasn't in the data pack, as you know, because it was included in the data for maternity services. But that's not something that any of the inspectors seemed to be aware of, and I just wondered how anybody would know that they should be looking somewhere else for information about the death of a neonate.

MS RICHARDS: So, my Lady, my understanding, based upon the evidence of Ms Andrews and reflected in our written submissions, is that the way in which information was distributed in the data packs at the time that was the normal process. So the inclusion of data in relation to neonatal services at that time was included in the maternity and gynaecology data pack, even though the inspection itself was organised into different teams.

LADY JUSTICE THIRLWALL: It's curious, you see. I accept that is what Ms Andrews says in her statement but none of the inspectors were aware of that, and they were being asked questions on the basis that, you know "You've missed it."

MS RICHARDS: Yes.

LADY JUSTICE THIRLWALL: And there was no question of, "Oh, well, you know, I was looking in the wrong place."

MS RICHARDS: Yes. My Lady, the sequence of timing of the way in which the evidence has come to the Inquiry's

attention is less than satisfactory in that respect because obviously we didn't know until the statement was taken from Lyn Andrews what the actual position was, and that was after the inspectors had given evidence.

Again, all data packs, maternity and gynaecology included, go to all inspectors and indeed to all specialist advisers. And, again, that's the evidence of Lyn Andrews. And so they would have access to all of them. And our written submissions have observed, if you look at the maternity and gynaecology data pack, you can see it is expressly dealing with neonatal services. So that was the position --

LADY JUSTICE THIRLWALL: I am sorry to cut across you, so does it mean, then, that it was there and the inspectors missed it and didn't see its relevance when looking at the neonatal unit?

MS RICHARDS: Well, my Lady, the CQC's expectation is that inspectors should know that the maternity and gynaecology data pack included data related to neonatal services because that was the normal process.

LADY JUSTICE THIRLWALL: So --

MS RICHARDS: It is right, however, and I should make this absolutely clear, that when you look at the data in the neonatal and gynaecology pack it refers to the numbers of serious incidents, but there's no way just through

looking at the sentence alone or the graphs alone of knowing from that that there's a neonatal death included in there.

And, my Lady --

LADY JUSTICE THIRLWALL: Oh, I see. So they weren't ever going to spot it, then?

MS RICHARDS: Well, my Lady, it would have been incumbent upon the maternity inspectors to interrogate such data as they thought appropriate and to share that as they thought appropriate. We have no evidence specifically that that was done.

Although it is our position that the way in which the data was organised in the data packs was reasonable because that was the normal process and ought to have known to everyone, I have to accept that the report itself, when looking at the children and young person's services, includes that sentence, as your Ladyship will recall, "No serious incidents reported", and so it is clear that whoever's responsibility it was, that position had not been correctly appreciated by those undertaking the inspection, and, my Lady, I accept that.

LADY JUSTICE THIRLWALL: All right. Thank you.

MS RICHARDS: My Lady, the second issue emerging from the Families' submissions that I just wanted to touch on is the focus on systems and processes in place rather than

an investigation of individual incidents. CQC's position is and remains, as summarised in our written submissions at paragraph 27, the primary responsibility for investigating clinical concerns or incidents rests with the provider, the hospital trust, and what CQC will generally look to see is whether there is a process in place to ensure that incidents are reported, identified and investigated and lessons learnt and learning disseminated.

And, my Lady, in considering the reasonableness of CQC's approach, I ask the Inquiry to note that CQC regulates approximately 36,000 providers across over 55,000 locations. And if your Ladyship looks at the figures in the statement of Lisa Annaly at paragraph 5.3, these give the figures for 2023, CQC received an average of 50,000 reported incidents per week in 2023 and 56,000 reported incidents per week in 2024.

LADY JUSTICE THIRLWALL: So does that mean that the CQC is under-resourced? Is that the point of that?

MS RICHARDS: My Lady, the point more is that the Care Quality Commission is not and never has been expected to be the primary investigator of incidents. That's never been its responsibility under any iterations of the serious incident frameworks that was

one -- updated or published in 2015. Obviously there have been changes to that since. That's never been its role, and it's never been expected to equip itself to undertake that role.

The published figures, as I understand, and these are publicly available figures, and we can provide the necessary link to your team if required, for the new LFPSE system in 2024 recorded over two and a half million incidents reported nationally across England, and so it's simply never been part of CQC's role to investigate those underlying incidents unless there is something which leads it to consider that there may have been regulatory breaches. And we say every hospital trust should know and understand that that's the position and that reinforces the important onus on the hospital provider to be forthcoming with CQC.

LADY JUSTICE THIRLWALL: And from the perspective of the public, I think it follows from what you're saying is that we shouldn't expect the CQC actually to be investigating or looking at, but if a hospital tells them something they will in that situation investigate, otherwise it's up to the hospital?

MS RICHARDS: My Lady, yes. There is a primary obligation on the hospital provider to undertake investigations under the appropriate framework or guidance. There are

oversight mechanisms through NHS England in relation to that both regionally and nationally in relation to the undertaking of serious incident investigations.

Now, clearly if CQC were to receive particular information from whatever source, it might be from whistleblowing, it might be from some other source, to suggest that there is something unsafe happening at a hospital, that is precisely the kind of information that might now lead it to undertake one of its bespoke risk-focused inspections but, in those circumstances, it still wouldn't expect to be the primary investigator. It would look to see what investigations have been carried out by the hospital trust.

So if there has been a surgical Never Event, the CQC would expect to be informed of that. It would not expect itself to investigate the circumstances which gave rise to that Never Event, but it would expect to be provided with the root cause analysis that had been undertaken by the hospital provider. It would then ask staff what learning there had been in relation to that and what steps had been taken to ensure that that Never Event never happened again, and there is an example of that in the 2016 inspection report in relation to one of the different core services.

There may, of course, then be information that

comes to CQC from that focused inspection or from other sources, again whistleblowing or reports from other agencies, which leads CQC to be concerned as to whether there is an ongoing lack of safety at a hospital, a lack of safe systems and processes, and in that event there is now -- and this again post-dates 2016 -- there is now the specific incident guidance which we've referred to in the written submissions and sought to summarise, and your Ladyship has copies of the relevant guidance through the disclosure process. But that is now a specific process that CQC will undertake if there is reason to believe not that there are individual clinical failings but there are breaches or potential breaches by the provider, so a failure to ensure safe systems, and that may then lead to enforcement action.

So, my Lady, that is the process now. It's a process that's developed and refined over the years since 2016.

My Lady, it doesn't follow, however, from what I've described that the CQC is an organisation concerned only with assessing the merits of administrative exercises, which is, as I say, it's the understandable way in which it's described in the Families' submissions, but looking at the Trust's systems for incident reporting, responding to incidents, learning

from incidents and so on, is but one part of what CQC does on an inspection or indeed as part of its routine monitoring. And so, again, if your Ladyship looks at any of the inspection reports in relation to the Countess of Chester Hospital, or any of the inspection reports that are published on CQC's website, you will see that in addition to looking at the incident reporting, CQC will, as part of the assessment process, be looking at the adequacy of the environment, the adequacy of the equipment, it will sample medical records. It will observe staff handovers. It will talk to patients.

There are a whole range of substantive not purely procedural observations which CQC undertakes but they are necessarily limited because they are observations undertaken through the course of spending a few days at the hospital.

LADY JUSTICE THIRLWALL: Can I just ask you one last thing, Ms Richards --

MS RICHARDS: Yes, of course.

LADY JUSTICE THIRLWALL: -- and then I'll let you take your course. But you were mentioning a little while ago that this was a hospital which had been historically, so far as CQC could tell, open, sharing difficulties, then confronting problems. I just wonder if one of the

unintended consequences of that sort of good relationship, which one would think, you know, ought to be fostered, is perhaps less impetus on the inspectors consciously or unconsciously to probe, to be curious, because they know this is a good hospital.

MS RICHARDS: Well, your Ladyship makes a potentially very valid point and, as it were, the unconscious biases that can creep in and, indeed, the very nature of the risk-focus basis of inspections that CQC now undertakes primarily responding to concerns in part, I hope, would address that. But your Ladyship may be right, that if you have a hospital that you have always had candid provision of information from, that may reinforce consciously or otherwise inspectors' expectations that that is a *status quo* that will continue.

LADY JUSTICE THIRLWALL: Thank you.

MS RICHARDS: My Lady, that is all I was proposing to say about the February 2016 inspection --

LADY JUSTICE THIRLWALL: Very well.

MS RICHARDS: -- and I just wanted to turn finally to a handful of points where there have been changes made or there are changes under consideration, and I'm not going to repeat what we've said in our submissions about safeguarding, CCTV and the other matters which you asked us to address but just six brief points.

The first is this, your Ladyship will know from the Dash review, that is the review that was undertaken specifically in relation to the Care Quality Commission, rather than the more widespread patient safety review that Dr Penny Dash is now undertaking, and following the review which the Care Quality Commission then itself commissioned from Professor Sir Mike Richards, the Commission is to some extent in a state of flux. It has new leadership and it is responding to the concerns expressed in those reviews and examining the best way to improve its processes. It has been undertaking a number of pilots in consultation with some NHS trusts looking at new tools with a greater focus on patient outcomes and experiences, but that's a process that's still ongoing and the outcome of those consultation and piloting processes is still being evaluated and considered, so I cannot, I'm afraid, be more specific in terms of the CQC's future direction but that is work that is actively under consideration at the moment.

My Lady, the second point effectively is a point I've already made and that's the change in approach to inspection from 2016 which was part of the comprehensive process looking at core services to the risk-based and thus more bespoke inspections that now often take place responding to specific concerns that have been flagged,

and that may lead to a more in-depth assessment of particular services or particular aspects of those services.

Thirdly, my Lady, enforcement. Your Ladyship has some information in the second statement of Mr Dzikiti regarding duty of candour prosecutions but I should make clear there has been an increasing use of the CQC's criminal enforcement powers in relation to NHS trusts over recent years. And, again, these are all publicly documented on the CQC's website.

There were failures of care that were the subject of successful prosecution in relation to mothers and babies at East Kent Hospitals University Foundation Trust in 2021.

There was, in 2022, a prosecution regarding safeguarding referral failures at Rotherham NHS Foundation Trust.

And most recently, earlier this year, there were three cases concerning three separate infant deaths at Nottingham University Hospitals NHS Trust. Those were deaths that had taken place over a three-month period in 2021. That resulted in a prosecution for regulatory breaches and the imposition of a £1.6 million fine on that particular hospital trust.

So enforcement is something of which the CQC is

increasingly focused on in terms of seeking to uphold regulatory standards.

My Lady, fourthly, the memorandum of understanding. That's been referred to by others already and we've addressed it in our written submissions. But you will see that the Care Quality Commission is signatory to the memorandum of understanding signed in December 2024. That gives specific guidance on the investigation of healthcare incidents where there is suspected criminal activity. It sets out a clear process for the establishment of an incident co-ordination group, it ensures that the police will be involved, and it requires that the Care Quality Commission be informed of that investigation.

You will see, however -- and it's consistent, I hope, with the submissions I've already made -- from the memorandum of understanding that the focus for the Care Quality Commission is not the primary responsibility for the investigation of that incident. Its focus in the explicit terms of the memorandum is to consider whether to carry out parallel but separate investigations into the possibility of wider systems failures.

My Lady, fifthly and briefly, Freedom to Speak Up. NHS England's written submissions identify the

collaboration that has been ongoing between NHS England and the Care Quality Commission on a process for the sharing and escalation of Freedom to Speak Up concerns, and we hope that that is work that will continue, notwithstanding the intended abolition of NHS England.

Then, my Lady, sixthly and finally, access to data. My Lady, we've explained in paragraphs 79 and 80 of our written submissions that CQC was unaware whether it would have access to, and currently hasn't had access to, the additional MBRRACE tool and the MOSS data, and it had been my intention to invite your Ladyship to consider that. It was, therefore, very welcome news to hear from Mr Beer on behalf of NHS England that CQC will be afforded access to that data.

My Lady, finally, then, on the question of pausing the Inquiry.

LADY JUSTICE THIRLWALL: Yes.

MS RICHARDS: We sought to make some brief submissions in writing on the legal framework only. We make no submissions as to the substantive question. We consider that's a matter in which the voices of others, most notably the Families, are more important to be heard.

So, my Lady --

LADY JUSTICE THIRLWALL: Again, this is just for the record, those submissions are at paragraphs 90 to 93.

MS RICHARDS: My Lady, yes, and we draw attention to relatively recent authority in relation to the exercise of the Secretary of State's power to suspend --

LADY JUSTICE THIRLWALL: Yes.

MS RICHARDS: -- and what if any relevance that might have for the extent to which your Ladyship considers a request to pause the Inquiry, but we recognise the application of those principles is a matter for you.

LADY JUSTICE THIRLWALL: Thank you.

MS RICHARDS: My Lady it's perhaps inevitable that the submissions I've made have focused on consideration of systems and processes, but I wanted to end by recognising on behalf of the Care Quality Commission its understanding of the tragic losses and the horrific suffering that the Families have endured and continues to endure that that lies at the centre of this Inquiry's work, and want to provide an assurance on behalf of the Care Quality Commission that when this Inquiry reports, the findings and recommendations that you make, my Lady, will be considered by the Care Quality Commission with the utmost care with the aim of ensuring that lessons are indeed learned for the future.

My Lady, unless I can assist you further, those are my submissions.

LADY JUSTICE THIRLWALL: Thank you very much indeed,

Ms Richards.

Ms Butler-Cole, I've got a closing statement. Is this your document?

MS BUTLER-COLE: It wasn't written by me, but it's a closing submissions on behalf of the Nursing and Midwifery Council.

LADY JUSTICE THIRLWALL: Very well. I notice that your name doesn't appear --

MS BUTLER-COLE: No, it doesn't.

LADY JUSTICE THIRLWALL: -- so I just wanted to make sure it is your document.

MS BUTLER-COLE: Yes, it's the NMC's document.

LADY JUSTICE THIRLWALL: Thank you.

Closing submissions by MS BUTLER-COLE

MS BUTLER-COLE: My Lady, I'm instructed by the Nursing and Midwifery Council and I want to start my submissions by, as Ms Richards has just done, recognising the impact of these awful events on the Families and expressing again the Nursing and Midwifery Council's condolences to them.

The written submissions address in some detail the matters that we think the Inquiry is likely to be concerned with so far as the NMC's concerned. I plan just to highlight a few of the more important points and also to respond briefly to the some of the points made

in the other closing submissions, particularly those of the Families.

LADY JUSTICE THIRLWALL: Can I just check, Ms Butler-Cole, can people hear at the back? That's all right. I can certainly hear you. I just wanted to check. Thank you.

MS BUTLER-COLE: Just to clarify, also the NMC is not advancing a position on the question of whether the Inquiry should be paused.

LADY JUSTICE THIRLWALL: No.

MS BUTLER-COLE: My Lady, as you're aware, the NMC became involved in July 2016 when Alison Kelly at the Countess of Chester Hospital had a telephone call which discussed Lucy Letby, and, by that stage, she had been taken off the neonatal unit and she didn't return to working with patients again.

Usually, when the NMC receives an enquiry from a hospital, or receives a fitness to practise referral, the person making that enquiry shares as much information as they can about their concerns.

In this case, at each stage, even when the fitness to practise referral was made, not only was information not shared but there was ambivalence from the professionals in the hospital who communicated with the NMC about whether it was actually the case that Lucy Letby was thought to have deliberately harmed the

babies. We now know, thanks to the Inquiry, that those at the hospital had much more information about what was happening than was shared with the NMC at the time and that there were a number of people who not only suspected that Lucy Letby had deliberately harmed babies but also believed they had evidence to support their views.

None of that was shared with the NMC, it should have been, but the NMC accepts that it should also have done more to probe what it was told to try and get a fuller picture, and if more information had been shared it may be that a referral would have been made sooner or that other steps were taken.

LADY JUSTICE THIRLWALL: So they were told that there were no concerns about clinical competence, that Letby was present at nearly all of the incidents and that the executive team were due to meet to decide whether to report her to the police --

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: -- I'm just wondering what inference could be drawn other than that this was a matter where there was a potential criminal investigation.

MS BUTLER-COLE: Yes. Well, you'll probably recall Mr Newman's evidence. He was the person who took that

call. He said that he thought it was an unusual call and that was why he wrote a note of it afterwards and emailed it back to the hospital.

LADY JUSTICE THIRLWALL: Yes.

MS BUTLER-COLE: But the impression he was left with was that there was this increase in deaths, that there was the sort of -- the only common link or the only thing that had been raised was that Lucy Letby had been present but that there was no evidence to suggest that anything untoward had actually happened beyond her mere presence, and so when Ms Kelly said, "We're having a meeting. We're looking into these and we're going to make a decision imminently about whether to make a referral to the police", his response was, "Well, we would like to know the outcome of that."

LADY JUSTICE THIRLWALL: Yes.

MS BUTLER-COLE: Of course, we know that what then happened was that I think that decision wasn't taken -- well, other decisions were taken as to what steps should be taken.

LADY JUSTICE THIRLWALL: Yes.

MS BUTLER-COLE: And although the NMC did then get further information from the hospital over the coming months, usually that was because the NMC was contacting the hospital, having heard reports in the press and so on,

not because the hospital was sharing the information with it proactively.

LADY JUSTICE THIRLWALL: Yes, thank you.

MS BUTLER-COLE: And my Lady has heard that the NMC has now published some further guidance for its staff about professional curiosity which is specifically aimed addressing that concern and encouraging people to ask those questions and probe more thoroughly into what they're being told. Even in, as I say, an unusual situation like this where there's an ambivalence about what's being reported, usually people come to the NMC because they have a concern and that's what they want to get across to people, rather than this much more ambivalent view of something may be happening, but there's nothing direct that we can tell you about it.

LADY JUSTICE THIRLWALL: I suppose if we take the first point, people usually come to the NMC because there's something they want to report.

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: So I think that definitely happened and then it's a question of asking, "Why you're thinking of going to the police", I suppose --

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: -- and that might be one question that you might ask. And you deal with it, I appreciate,

over a couple of paragraphs, but I think it comes to the same thing, doesn't it?

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: That questions weren't asked and so the full information wasn't obtained, assuming that it would have been given had it been asked for --

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: -- which I appreciate is another step.

MS BUTLER-COLE: Yes, yes.

After the NMC received the fitness to practise referral, one of the issues that the NMC itself reviewed prior to the Inquiry was the decision about when to apply for an Interim Order, and the NMC has accepted many months ago now that there was a delay in applying for an Interim Order, and the Inquiry will have seen that there were different views within the organisation about what the law was on that topic and what the NMC's powers were.

In light of those differences of views, the NMC has amended its guidance on Interim Orders and it now says that in a case where the allegations against a nurse or a midwife are of the most serious kind, it may be possible to obtain an Interim Order even where there's very little direct evidence available to the

NMC. That guidance was published about a year ago now.

It hasn't yet been considered by the High Court, and my Lady will know that registrants have a right of appeal to the High Court in respect of any Interim Order that is made, so we can't say for certain whether if that guidance were applied in a similar situation it would be upheld by the High Court. We do know from other areas of case law in respect of regulatory and disciplinary proceedings that anything said by an Inquiry such as this will eventually make its way into that case law and so if the Inquiry does have any views about that question of Interim Orders, then that may be something which can be fed into the process.

The difficulty is that when one goes to look at the case law there are ten or 15 different explanations by different judges about what the test is and what sort of evidence is required, and so one can see how that led to people having different opinions about what they could and couldn't do, and obviously the NMC's hope is that the amended guidance will be upheld if it is challenged.

There's also within the NMC now a new process of holding case conferences in the most difficult cases, and there's going to be a new internal decision-making document for staff as well to try and make sure that in

very difficult and complex cases there's at least a clear process for who is making the decision and when, for example, it might be necessary to obtain external legal advice.

Another topic, my Lady, that questions were asked about was the process for revalidation. What happened in this case was that Lucy Letby revalidated before a fitness to practise referral was made and some questions were asked suggesting that perhaps that could have been used as an opportunity to stop her practising as a nurse, but unfortunately revalidation is not a set process or an additional process to fitness to practise referrals. There might be cases where information comes to light through revalidation which is so serious that the revalidation doesn't proceed. An example that we've given would be being informed that someone had been convicted of a very serious criminal offence that was clearly relevant to their duties as a nurse or a midwife. But, generally speaking, what's supposed to happen is that the fitness to practise process starts. That provides the law for fair process for registrants to challenge any allegations that are made against them, and if their registration falls to be revalidated while that process is going on, then that is just suspended and the revalidation and so on doesn't happen until the

conclusion of the fitness to practise process, and that means that the NMC doesn't lose the ability to pursue those fitness to practise proceedings because someone's registration has lapsed.

LADY JUSTICE THIRLWALL: And so here, where there was information, that just simply wasn't even considered on the revalidation?

MS BUTLER-COLE: No, because that's not -- if something had cropped up in the revalidation process which made people think, "This needs to be in the fitness to practise process", then it could have been pursued in that way, but the revalidation process itself is not set up to be a substitute for the fitness to practise process.

LADY JUSTICE THIRLWALL: No, but I suppose what I was trying to get to is --

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: -- if someone knew the information, which someone did know, and there was an application to revalidate, why would the information that was known -- it's not a conviction, I take your point --

MS BUTLER-COLE: No.

LADY JUSTICE THIRLWALL: -- but why would that information not be fed into the revalidation process, even if it was to say, "We should be looking at fitness to practise"?

MS BUTLER-COLE: Yes. So at the moment the information that

is asked for as part of the revalidation process, there isn't a section which says, "Is there anything else you'd like to tell us about this person?" in general terms, if there's specific information requested, for example, about convictions or the existence of other fitness to practise proceedings or something of that sort. So it's not an opportunity to just gather information about a registrant. There are specific things they have to have done to revalidate, and then there are specific things which the NMC does have to be alerted to by way of disclosure, but it's not a sort of process for just sort of information-gathering generally. When people have those concerns, they need to come through the fitness to practise process. But the NMC is carrying out a review about revalidation generally, and one of the topics that will be considered as part of that is whether anything else needs to happen in order to make sure that information that happens to come in through the revalidation process is then picked up and dealt with appropriately.

Another topic that my Lady has asked about is safeguarding. Of course, from the NMC's point of view its core objectives include the protection of the public. Safeguarding is inherent in its main functions, and so all nurses and midwives are required to be aware

of the laws about safeguarding and the relevant policies. They must act in accordance with the Code of Conduct, which, of course, reflects those safeguarding obligations, because, as I say, it's an inherent part of what the NMC does.

It's been suggested by the some of the families that the NMC should have told Alison Kelly that was a safeguarding issue, or should have itself made a safeguarding referral when the first contact was made in 2016.

I think from the NMC's point of view we can understand why that's been suggested, but what the NMC was told was that the hospital was aware that this was an issue and were about to make a decision about whether or not to refer to the police and what further steps needed to be taken. So it's difficult, I think, to see how pointing out to her that safeguarding was a relevant issue would have changed any of that. The real problem, as identified by the Inquiry, is that the police weren't contacted soon enough and that the concerns were downplayed.

So we understand, as I say, why any suggestion that anyone can think of is going to be made about what could have been done differently, but we're not sure that pointing out that safeguarding was a relevant

consideration would have made a difference at that point.

LADY JUSTICE THIRLWALL: It might have been made right at the beginning when Alison Kelly rang up, that might have been something that she should have been alerted to then, or is it not? I'm not quite sure --

MS BUTLER-COLE: So I think it's difficult to see -- so at the point where she contacts the NMC and says, "There's been an increased number of deaths and we don't have any" --

LADY JUSTICE THIRLWALL: "We've got someone on the ward who is there ..."

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: "... and we're thinking about reporting her to the police."

MS BUTLER-COLE: Yes. What I'm suggesting is that I am not sure what adding the word "safeguarding" would have added to that. It was recognised that there was a concern and that the steps the hospital were taking were to consider making a referral to the police. A safeguarding referral, I think, had anyone made it, would have ended up in the same place, which is, "Well, you need to think about whether you need to refer this to the police." Ultimately, the police are the people to investigate this and you need to get on with getting

it in front of them.

LADY JUSTICE THIRLWALL: Yes. One of the things that it appears sort of on a number of occasions suggesting that, for example, the NMC could have been more proactive and demonstrated more curiosity, and that similar language is used repeatedly in the NMC document.

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: Why don't the NMC say it should have been more proactive? Of course it could have been more proactive, but I'm not sure how that's helping the Inquiry. I mean, is the NMC position, "We should have been more proactive" or not?

MS BUTLER-COLE: So I think it is, yes. I think the NMC probably looks at it in a slightly different way, which is that that initial conversation where the impression that the recipient of the call was left with was not that there was some burning concern.

LADY JUSTICE THIRLWALL: No, and I understand the evidence and what you say about that.

MS BUTLER-COLE: Yes. But, after that, there then were gaps where the NMC didn't follow up proactively with the hospital to say, "Well, look, what are you actually doing and what is going on?" and, for example, found out about the RCPCH report only after it was publicly known about. So, yes, there is an acceptance, I think this is

in the written statements that were prepared by --

LADY JUSTICE THIRLWALL: But it's not in here?

MS BUTLER-COLE: No.

LADY JUSTICE THIRLWALL: And that's why I was asking you whether it's your document --

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: -- repeating, "It would have been better if", "It could have been", but rather than, "We should have done this; we should not have done that."

MS BUTLER-COLE: Yes. No, I haven't got the exact wording of the witness statements in my head, but I'm confident that they do say that, after that initial conversation and as things progressed, the NMC should have done more and been more proactive to try and find out what was actually going on from the hospital.

LADY JUSTICE THIRLWALL: Yes. It's particularly stark when you get to the learning and reflections section --

MS BUTLER-COLE: Yes.

LADY JUSTICE THIRLWALL: -- when I would have thought that whoever was drafting this might have looked to see what the witnesses had said. But one of the things that you say at paragraph 34, or the NMC says:

"[We have] been asked by the Inquiry to provide an acknowledgement of any failings on its part" -- the NMC's part.

MS BUTLER-COLE: Yes.
LADY JUSTICE THIRLWALL: "... the detail of the evidence ..."
And:
"As explained in paragraph 4 above, the NMC has reflected on the events at CoCH and its own processes and has identified opportunities to learn and improve ..."
Does that mean mistakes?
MS BUTLER-COLE: I can't see any reason not to say that --
LADY JUSTICE THIRLWALL: "... and some" --
MS BUTLER-COLE: -- something should have been done differently.
LADY JUSTICE THIRLWALL: I'm sorry I cut across you:
"... and some instances where in hindsight we could have done things differently."
It would have been better to say, wouldn't it, "We should have done things better" if that's the NMC position? Because it's not clear to me whether it is actually reflective and accepting --
MS BUTLER-COLE: Yes.
LADY JUSTICE THIRLWALL: -- if things were done --
MS BUTLER-COLE: No, I think my Lady is completely right. If one goes back to the written evidence, the wording is "should"; that we should have done more to satisfy

ourselves that the hospital was taking appropriate steps, for example. So I think that's absolutely right. As I say, the written submissions aren't my own drafting, but certainly the witness statements do speak in the language of "we should have done things differently." I'm fairly confident there was no intention in these written submissions to try and step back from that in any way. I think it's just a question of wording.
LADY JUSTICE THIRLWALL: Well, I'm not going to take you through any more, it's there, but you very helpfully said that it's accepted that there were mistakes made --
MS BUTLER-COLE: Yes.
LADY JUSTICE THIRLWALL: -- and things should have been done better or differently.
MS BUTLER-COLE: Absolutely. I think, as was made clear in the statements, obviously we can't say for certain what would have happened, but it must follow that if we'd done those things differently, then different things would have happened; and that, for example, includes a fitness to practise referral having been made sooner and so on. So, yes, we absolutely accept that things could have been different from the NMC's involvement.
One of the other suggestions made is to amend the NMC's Code of Conduct to just say expressly that

registrants should contact the police if they're concerned that someone is harming patients deliberately. At the moment the Code says, in Standard 16, that registrants must, and this is a quote:
"Act without delay if you believe that there is a risk to patient safety or public protection."
And Standard 17 says that:
"[You must] Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection."
If the Inquiry thinks that we need to add to that, to the Code, specific reference to circumstances in which the police should be contacted, then that again can be incorporated into the existing planned review of the Code of Conduct. It may be that, given that one of the things the Inquiry has looked at so carefully is the delineation of responsibility when there are so many organisations involved, that whatever the Inquiry says about is something that could helpfully be reflected, so that everyone is as clear as they possibly can be about whose responsibility things are, and that critical question of the circumstances in which one should go straight to the police, rather than thinking about any of the other many organisations that exist.
LADY JUSTICE THIRLWALL: But the current position is that

that's not going to be part of the standard?
MS BUTLER-COLE: So at the moment Standard 16 really just states the sort of core point which is "act without delay if you think that there's a risk."
LADY JUSTICE THIRLWALL: Yes.
MS BUTLER-COLE: The Code doesn't give sort of detailed guidance about who to contact in which situation. I think the proposal is that it be added to to say, not just act without delay, if you believe that there's a risk, but to say that if you think that there's a risk of deliberate harm, then the appropriate people to refer that to is the police.
LADY JUSTICE THIRLWALL: Thank you.
MS BUTLER-COLE: My Lady has seen in the various documents that there are a number of areas where the NMC's policies and guidance and training and so on have been strengthened since 2016. One of the areas of concern was information-sharing. One of the key developments from the NMC's point of view on that front is the emerging concerns protocol, which is a document that didn't exist at the time. In light of the recent news about NHS England, that's going to need to be reviewed and updated anyway, but in the written closing submissions it's suggested that it's further developed in relation to this possibility of deliberate criminal

activity, which isn't separated out as an issue at the moment. That will then also need to be cross-referenced to the memorandum of understanding from December 2024 to make sure that all of these various documents and protocols are consistent with each other.

Turning to the question about social media, there's existing guidance on using social media responsibly, which says that all social media and networking platforms must be used appropriately, and make clear that it's unacceptable to discuss matters relating to patients outside clinical settings.

The NMC is going to update the website pages on social media in the next few months to make that even clearer, to identify the types of social media that are covered, and there's also going to be a wider review of that guidance anyway as part of the planned review of the Code of Conduct. So if the Inquiry has any recommendations about the social media issue, that's something that again will be able to fed into that review process.

LADY JUSTICE THIRLWALL: Thank you.

MS BUTLER-COLE: More generally, in light of that existing review of the Code of Conduct, I would like to make it very clear that whatever the Inquiry says on any topic will, of course, be very carefully considered by the NMC

and will be fed into those existing reviews in order that any changes that need to be made can be made. If there's anything which falls outside the Code of Conduct, then, of course, that's something the NMC will look at separately as well.

My Lady, if there's nothing else that I can assist with, I was going to conclude my submissions by adding my thanks to the Inquiry Team but actually, perhaps more importantly, thanking the Families for participating in this process, which I think as lawyers we know can only be a stressful and difficult process, no matter the hope that the Families have of having access to all the information and the understanding that they would like.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Butler-Cole.

MS BUTLER-COLE: Thank you.

MS SCOLDING: My Lady, I am up next but, as it's nearly 1 o'clock, I don't know whether or not it would be more sensible to start fresh after lunch.

LADY JUSTICE THIRLWALL: Yes. There used to be a clock over there.

MS SCOLDING: It's 12.53, my Lady.

LADY JUSTICE THIRLWALL: Yes, thank you. We won't start now. We'll start again at 2 o'clock, please.

(12.53 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Ms Scolding.

Closing submissions by MS SCOLDING

MS SCOLDING: My Lady, I appear on behalf of the Royal College of Paediatrics and Child Health. I shall use the abbreviation RCPCH during the course of this submission as that is what has been adopted by most individuals who have come to give evidence. I hope it isn't an abbreviation too far for you, my Lady.

You have our written submissions, which we hope address in some detail the specific issues raised by your Inquiry and which make a number of recommendations.

I start, however, my submissions by repeating our deepest sympathies to the parents and wider family members whose children were injured, killed or harmed during 2015 and 2016. The RCPCH also apologies again that it was not sufficiently supportive to the paediatricians then working at the hospital. We all send our thanks at the beginning to the parents for the respectful and courteous way in which they have dealt with us and our witnesses at all times, and also pass on our thanks to the Inquiry and our gratitude for their behaviour towards us.

My Lady, I should also say that we stand ready for

any recommendations you may wish to make about us to both implement those in full and to work with others to promote, facilitate or aid any policy development training or other initiatives you may consider are required.

My Lady, for the avoidance of doubt, whilst we accept the analysis of Mr Beer KC and Ms Richard KC in respect of the legal powers you have for suspension, we make no substantive submissions about the applications made by the former directors or the Right Honourable David Davis MP or the firm of solicitors who have contacted you this morning.

I divide my submissions into two parts. Firstly, identifying where the RCPCH went wrong and, secondly, speaking to some but not all of the recommendations we make in our written submissions, given the time.

Turning first to the review, in summary it was singularly inapposite and wrong to try and undertake a review of a clinical service when criminal allegations had been raised about a nurse. The review should never have taken place. It did not provide the hospital with the answers it sought and was used in ways which was unhelpful to all concerned. Those who have come to give evidence on behalf of the RCPCH at this Inquiry have reflected very carefully upon the review and identified,

we would suggest, where they went wrong and accepted fully that mistakes were made.

The RCPCH has sought to learn from these mistakes, commissioning both an internal review of its Invited Review Service and completely recasting its review procedures in advance of this Inquiry, but none of that is to diminish the faults that the RCPCH acknowledges about how the review was conducted.

As my Lady has had explained to her in the evidence presented by the RCPCH, an invited review is requested by a commissioning organisation and is meant to provide an opportunity for professionals working in other similar settings to undertake a peer review of a local service, identify and address areas of concern, for example about patient safety, to provide ideas about quality improvement, and is meant to provide a proactive approach in seeking assurances as to the quality of care provided.

Invited reviews are not a regulatory or criminal investigation. Because the hospital, we suggest, via Mr Harvey, who was the then medical director, provided too few details of the context and background to those organising the review and because the review team did not dig for more details as to why a nurse had been taken off duty, a valuable chance was missed to avoid

the review going ahead. However, the RCPCH's view is that the information given by Mr Harvey, albeit limited, was sufficient to put Ms Eardley and others on notice that this was not usual and further steps should have been taken.

We have identified that the process of undertaking invited reviews was a relatively new one to the RCPCH and there was no standard operating procedures guidelines as now exists, but we further say that the review was organised too quickly, without adequate due diligence and without appropriate clinical oversight.

Furthermore, the Terms of Reference also set the RCPCH up to fail. The fourth term of reference, which was added as a result of discussions with Mr Harvey, was to identify any common factors or failing that might in part or in whole explain the apparent increase in mortality in 2015 and 2016. Ms Eardley mistakenly took this to mean the factors other than Letby. However, Mr Harvey clearly considered it was to include examination of Letby. This miscommunication was a significant error both on the part of the Countess of Chester Hospital and the RCPCH.

I've already said that the review should not have been taken on and/or should have been aborted on the first morning. All the other issues which arise and all

the other failings flow from these basic errors. The rationale given by the reviewers both at the time and subsequently not to abort the review tend to focus upon that it was important to get the background or to discount other factors. Whilst this may well have been laudable, it would not in fact have solved the hospital's problem.

The view of those who were interviewed in 2020 as part of the internal RCPCH review was that they felt they should not walk away from their professional responsibilities. Whilst that is plainly a legitimate concern, if someone had stood back, as the Inquiry is now able to do in the cold, hard light of day, they would have seen that this should not have been the response given and that on the first morning it should have been said that the review could not continue. Furthermore, Letby should not have been interviewed.

The RCPCH submit that the evidence of Ms McLaughlan and Ms Mancini, both of whom gave oral evidence to you, was flawed in its logic as to why that interview went ahead. They had heard information from other nurses, they said, that sought to indicate that Letby was being made a scapegoat, and there was no current criminal investigation or regulatory process put in train, so they sought to speak with the person who

had been present and working on the unit during the last year.

The fact that the content of the conversation turned out to be fairly anodyne is beside the point. Given what had been said by the paediatricians on the first morning of the review, there should not have been such an interview and that was a serious mistake.

The RCPCH submits that the report written and given to the Countess of Chester was not without some value as a general overview of the unit. It identified deficiencies in staffing, both of doctors and nurses, the lack of a rigorous review of all the deaths and the absence of systemic reviews on a number of occasions. It did also identify that there should be a human resources process to account retrospectively for Letby's removal from the unit. Ms Mancini and Ms McLaughlan in the evidence they gave to you were of the view that the way the report was written should have led to Letby being immediately suspended and the subject of at the very least disciplinary proceedings, if not police involvement.

The report did also identify the need for a thorough Casenote Review. However, and despite there being some valuable learning which came from the review, it did have several flaws.

Firstly, it failed to set out clearly and in detail the concerns of the consultants and what they had told the reviewers. They were not correctly described, with the reviewers adopting a view of the nursing staff in fact that it was simply a gut instinct, rather than identifying clearly and extensively the accumulation of circumstantial evidence which Dr Jayaram, Dr Brearey and the other consultants had outlined in the information they had provided the reviewers, which could not be ignored.

This error was then compounded by Mr Harvey not giving the consultants the unredacted copy of the report prior to its publication. Mr Harvey's explanation of the need to keep matters confidential does not, in our respectful submission, stand up.

These were circumstances where the consultants were the individuals who had provided and stated the concerns in the first place, and were running the unit that was subject of the concerns. The issue of confidentiality, in our respectful submission, simply should never have arisen.

The review was also not clear that the police should have been contacted. The recommendation in respect of a human resource-type investigation was opaque when clarity should have been identified.

There should also have not been two versions of the final report --

LADY JUSTICE THIRLWALL: Can I just ask what would have been better than being opaque, what should they have said about the --

MS SCOLDING: Well, they should have said, "You should have undertaken" -- that they should have either have said if their view was there should been a disciplinary investigation and Letby should have been suspended that should have been the recommendation made, even if it was couched in various short of qualificatory language, you know, "If the Countess of Chester Hospital considers so", or they should have said, "Contact the LADO or the police", if that was the position. The unhelpfulness was the fact that it was couched, in our respectful submission, in too opaque a way so it was read in a number of different ways by a number of different people.

LADY JUSTICE THIRLWALL: I seem to recall that Ms Mancini had a different view about what it meant from others.

MS SCOLDING: Yes, Ms Mancini had a different view from Ms McLaughlan and others --

LADY JUSTICE THIRLWALL: Yes.

MS SCOLDING: -- in terms of even what the recommendation meant.

LADY JUSTICE THIRLWALL: Yes.

MS SCOLDING: So I think kind of looking at that evidence in the round and trying to be as clear with you as possible, my Lady, I think they either should have said, "Do this" or, "Do that."

Furthermore, the fact that there were two versions of the final report should have put everyone on notice that something was going seriously wrong. Whilst there are obviously reasons why some information may need to be kept confidential or private, these reviews are usually published and are usually seen as public documents, and that should have been reflected and considered.

Furthermore, the worries of the RCPCH's quality assurance reviewers should have been conveyed both within the report and to the hospital. You heard from both those individuals, both of whom made reference to concerns about criminal behaviour, one of whom had had some dealings with the Beverley Allitt case some 30 years previously. This should have been set out in the review and communicated clearly to the hospital.

Furthermore, the RCPCH invited review board should have been engaged by the review team and been sighted on the somewhat extraordinary nature of the review and asked to provide guidance. We can't know what would

have happened had there been more focus on the review at the time of its publication, but it may have led to someone pointing out that the police should be called.

There should have been more follow-up. Ms Eardley and others stressed it was the responsibility of the Countess of Chester Hospital to contact regulatory bodies, the police or others. Ms Eardley was also contacted by Drs Brearey and Jayaram for copies of the unredacted report in early 2017, and Ms Eardley did ask the hospital to share the unredacted version with these professionals.

She also asked to see the report of Dr Hawdon but did not send this to the other reviewers. There should have been formal and regular follow-up points at three and six months to check if and how the recommendations contained in the report had been implemented.

LADY JUSTICE THIRLWALL: I think Ms Eardley and Ms Mancini accepted that the trust should have been advised to contact the police.

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: And I think Ms McLaughlan began by saying something about an HR investigation --

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: -- but I think she in the end accepted there wasn't any good reason not to contact the

police.
MS SCOLDING: Yes.
LADY JUSTICE THIRLWALL: And Dr Shortland thought the police should have been called. So they all felt that --
MS SCOLDING: Exactly --
LADY JUSTICE THIRLWALL: -- at the time.
MS SCOLDING: -- they all thought that at the time.
LADY JUSTICE THIRLWALL: Yes.
MS SCOLDING: So the question really for my Lady and for us as an organisation is: why didn't anybody say that if that was the thought process at the time? And that, I would submit, was a significant error on the part of the review team.

Furthermore, the way that the report was written and the nature of the report, therefore, meant it was then used, we suggest, incorrectly, by the senior executive team at the Countess of Chester, as it then was, and the report was not fairly represented in the very many meetings that the Inquiry has seen and discussed.

The suggestion being that the report exculpated Letby and/or dismissed the concerns raised by the paediatrician, we would suggest is simply wrong and was not a reasonable conclusion open to them, even given the somewhat opaque nature of some of the

recommendations.

The failure to provide the unredacted report to the paediatricians, furthermore, is inexplicable. What the RCPCH says that there is no way that the report could be read to say what the board minutes reflect, which is that the allegations against Letby were unsubstantiated and that there were not any immediate concerns.

Whilst we understand that Mr Harvey attempted to identify that what was meant by that were CQC immediate concerns, we would suggest that it's for your Ladyship to determine whether or not that is or isn't a credible explanation in all the circumstances.

Mr Harvey, furthermore, should have reported the need for formal action in respect of Letby for misconduct to the various internal committees of the hospital and referred matters to the relevant professional bodies, sending the report, we suggest, to NHS England, the CQC and the local neonatal network in its unredacted form and promptly upon its receipt.

Mr Harvey did not tell the relevant regulatory bodies of the RCPCH's view that there should be a misconduct investigation in respect of Letby.

My Lady, the RCPCH evidence that you have heard, both in written and oral form, sets out the changes made

after reflecting upon the CoCH review. It commissioned an independent review in 2020 which identified a number of criticisms, which I have reflected today, and which are reflected in the written submissions that we have made.

Following on from this, the RCPCH has remodelled its invited review service. It has identified and overhauled all the processes, and full details of this are set out in the written witness evidence. I'm not going to take you through that but, in summary, there is a much higher degree of due diligence before a review over a much longer period of time, with much greater input from clinicians on the terms of the review and its nature. There are revised handbooks in place. There are more detailed guidance and training to reviewers, and much more oversight from the RCPCH registrar, who is a clinician and a trustee on the board of trustees.

There is also something called the invited review programme oversight group -- I'm not going to give you the acronym for it -- which provides operational day-to-day management of the service, comprising both staff and clinicians, including both the clinical lead and the deputy clinical lead for the programme, and the assistant registrar, who is a clinician, and the registrar, who I've identified is also a clinically

qualified individual.

Furthermore, as Mr Beer noted earlier in his oral submissions, the invited review service has established formal agreements with all four nations' relevant regulatory inspectorate or bodies involved in patient safety and quality improvement, which set out how and when the RCPCH informs each about the invited reviews it has undertaken. As far as we're aware, the Royal College is the only medical Royal College that has these agreements in place.

The contract, furthermore, between the Royal College and the organisation commissioning the review includes a specific clause that the RCPCH reserves the right to contact the relevant regulator and has on at least one occasion referred an organisation to the relevant regulatory body following an invited review.

Furthermore, in contrast to what happened in 2016, there is a dedicated process for follow-up after a review has concluded and a report has been shared with the service --
LADY JUSTICE THIRLWALL: And how is that different from what *(unclear)* the last time?
MS SCOLDING: Well, there is a formal requirement for follow-up and a requirement for the organisation to

identify what steps it's taken and when. So it's gone from, you know, somebody phoning someone and saying, "What have you've done?" to being, as part and parcel of the contractual arrangements, "We will at three months write you a formal letter and say what you have done, and the expectation is you will write back and say 'We have done this, this and this', and if you haven't done this, this and this the programme review board will look at it and if necessary refer you to the relevant regulatory bodies."

Now, obviously that's all dependent upon the actual people on the ground then enforcing that but I think, my Lady, what I hope has been clear from the evidence that's been provided is the Royal College has taken the opportunity to really ensure that those kinds of follow-up processes are regulatory and involve clear analysis, not just from the person who administers the review process but also from all the clinicians who are part of the review.

LADY JUSTICE THIRLWALL: Yes. You make the point, well, that it all depends on the people who are conducting the review. Obviously, the review team would need to comply with the new guidance, but the fact is there was guidance and they didn't comply with it.

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: It wasn't an absence of guidance that led them into comprehensive error from what you've described.

MS SCOLDING: Well, I think there were some areas in which the guidance was not as clear as it could have been, and I think we've accepted that, particularly in terms of what happened if and when there were allegations of malfeasance on behalf of particular individuals, and there wasn't any escalation guidance. I think the reality is now, my Lady, that there is a far greater thoroughness to what happens before, during and after, with significantly greater oversight by the creation of the review programme oversight board, who will look at every single review and say, "Right, what's happened? What have you done? What haven't you done?" And so to that extent I think it's most unfortunate but I think the Royal College has sought, as far as it is able, to learn lessons to try and ensure that the problems which took place in 2016 are rectified as far as that's ever possible.

LADY JUSTICE THIRLWALL: No, I understand that and I take that point. What I'm just trying to get to at the moment is whether or not it's accepted or submitted that the guidance that was available at the time was insufficient or simply wasn't applied effectively.

MS SCOLDING: Well, I think both. I think, firstly, it was insufficient, inasmuch as -- and I think we say this in more detail in our written submissions but also in our oral and written opening submissions, and in the evidence that we've given. I think it was insufficient in terms of what to do when things start going wrong or what to do if there is a potential criminal allegation. They were defective in that respect --

LADY JUSTICE THIRLWALL: Just pausing on the first one, it's accepted, isn't it, that on that first morning they should have aborted?

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: So that, I think you're suggesting, would have been the right thing to do --

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: -- in the light of the guidance that was available at the time.

MS SCOLDING: Well, the guidance available at the time. If I remember rightly -- I can't necessarily remember the exact paragraph, how it's exactly --

LADY JUSTICE THIRLWALL: No --

MS SCOLDING: -- phrased in the paragraph but I think it was something like, "If there are criminal allegations, you can't deal with the issue which is the subject of the criminal allegation but you can deal with everything

else", and I think, if I remember rightly from Ms Eardley's evidence, I think what she said is she considered that it should continue to go ahead so they could deal with everything else, so that they could look at the sort of conduct --

LADY JUSTICE THIRLWALL: Yes.

MS SCOLDING: -- what could be called a normal service review.

So I think the guidance wasn't sufficient but I also think -- I mean, in some ways, my Lady, irrespective of what the guidance says, if somebody sits there and says to you, "We think that somebody is murdering babies", it would usually give you pause for thought at the very least --

LADY JUSTICE THIRLWALL: Yes, all right. So --

MS SCOLDING: -- which is in effect what's being said.

My Lady, if there's anything else I can assist you with as far as those issues are concerned?

LADY JUSTICE THIRLWALL: Not in respect of the guidance, no, thank you.

MS SCOLDING: Thank you. I now turn to some submissions about some of our recommendations.

Firstly, we make a series of recommendations to improve knowledge and understanding amongst the child health workforce of the processes set out in "Working

together to safeguard children", including referrals to the LADO. What's absolutely clear in the context of this case was that working together was not followed for lengthy periods of time and even paediatric consultants did not seem to be aware of the role of the LADO and what it did. It's notable that none of the reviewers, despite their considerable expertise in safeguarding in the context of keeping children safe from family members and others in the community, appear to have known what to do when there were concerns about staff. And the RCPCH has sought within its written submissions to try and understand why that happened.

Firstly, obviously you've had expert evidence from Professor Dixon-Woods, Sir Robert Francis and others, which in effect says that there is a -- what I think Professor Dixon-Woods identified that there is a credibility gap.

Particularly in respect of neonatal care the focus upon saving the tiniest and most precious of lives, we would suggest, makes people consider that those caring for them are benevolent in their intentions. This is not the only case where allegations are not believed against healthcare professionals. It seems, at least in 2016, the views of the healthcare staff was that, "It could not happen here", rather than, "It could happen

here." That is essentially, my Lady, a cultural issue, and, like all cultural issues, requires concerted changes of actions, beliefs and consequences.

The Local Authority Designated Officer, or LADO, has been in existence since 2004, but yet nobody knew or was aware of either the terminology or of the role. This is obviously somewhat of a surprise to those who may have undertaken work in respect of social care or education when the role is well known and understood.

Dr Kingdon, at least in part in her evidence, sought to provide an explanation for such, which is that even paediatricians who -- the relevant training necessary for paediatricians who work face-to-face with children does not mention or refer to the LADO at all. The LADO role is only currently referred to and mentioned for those who undertake the named doctor or designated doctor role.

Now, obviously in this case you heard evidence from those particular individuals from the Countess of Chester Hospital who were not involved at all. The Inquiry is, therefore, asked to recommend that all safeguarding training sessions run for those who work with children in paediatric services or child health, and what are known as the intercollegiate competencies framework, which are the general framework for

safeguarding, should have knowledge and understanding of the escalation process outlined in "Working together to safeguard children", including the role of the LADO clearly set out.

That should be routinely included in training for paediatricians, but also for nurses, clinical and nursing directors and trust board members, as the Royal College considers that if Mr Harvey and Ms Kelly were more familiar with this organisation and this body, they may have wished to have consulted them, given the issues which arose with Letby.

The Royal College is proactively taking steps in advance of this Inquiry's recommendation to address these gaps at least to some extent.

First, it has, along with a number of other Royal Colleges, a role in the development of what's known as the intercollegiate competency framework, which is designed for all healthcare staff from the cleaner on the ward, from the receptionist, through to experts. It has raised with the other Royal Colleges the need for that document to reflect the role of the LADO and has recommended such to NHS England and the Department of Health.

The Royal College also has a specific safeguarding competency framework for paediatricians, which does not

at the moment refer to the LADO. It is being revised so that it does so, and the Inquiry will be provided with those updated materials when they have been produced.

LADY JUSTICE THIRLWALL: When was that work begun?

MS SCOLDING: That work, as I understand it, was begun within the past six months. So as a direct result of this Inquiry, there's been a recognition that it needs to change.

The Royal College is also consulting with the General Medical Council, which ultimately has oversight of all the relevant specialty training curricula, to explore if the role of the LADO should be included in the general paediatric curriculum, leaving aside what is set out within any safeguarding training.

We would suggest that this at least is a start but we welcome NHS England's commitment to produce a kind of straightforward document. We would suggest that that straightforward document could replicate and look like those documents which are available in a number of other organisations which care for children so that on every ward and areas where staff works the identification name and information about the LADO is clearly and freely available.

Turning to the issue in respect of sudden and unexpected deaths, Dr Kingdon's evidence to this Inquiry

was that cases where the death was unexpected it would not usually be the case that her unit, which I remind my Lady is a Level 3 unit, so deals largely with the most premature of babies that they wouldn't --

LADY JUSTICE THIRLWALL: With a very high mortality.

MS SCOLDING: They scored a very high mortality rate, yes. I mean, Dr Kingdon is in charge of the unit at St Thomas' Hospital, which I think deals very much with the most critically unwell of babies and the most unwell of preterm babies as well, that they wouldn't necessarily use the SUDIC approach and that there may need to be a rethink of how those guidelines are used in neonatal settings.

LADY JUSTICE THIRLWALL: I think she was pretty clear that they didn't --

MS SCOLDING: No, she's pretty clear that they didn't.

LADY JUSTICE THIRLWALL: And she didn't think it I was applicable --

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: That was --

MS SCOLDING: And obviously that runs into some of the other evidence that my Lady has heard about the necessity for that.

One of the issues is there is often clinical uncertainty as to the precise reason that this has

happened, and what Dr Kingdon said it would usually be the coronial process or now the medical examiner process alongside that which are used instead of it.

The Royal College would suggest that they wouldn't wish that the SUDIC process is used when it is not required, that's adding to the burden of work unnecessarily, but there should be some kind of collaborative way of the relevant professionals identifying which system is best so that the systems work together and set clear triggers for the various kinds of investigation.

We set out in some detail in our written submissions the position and the guidance in respect of child death review panels, but what we would identify is that there is no one-size-fits-all in terms of we would suggest that implementing the SUDIC Guidelines in all cases where babies die may well not be necessary and may well lead to an unnecessary burden of neonatal units, given the extent of and complexity of the information which then needs to be provided.

However, obviously this case is a salutary lesson in what happens when you don't undertake those processes. So our view would be that there needs to be some sort of collective process in which the coroner, the specialist neonatal unit, the relevant child death

review individuals, both within the hospital and within the ICB, come together to discuss those cases where there is a lack of clarity about what should happen.

What we do suggest, however, my Lady, is that in all cases where deaths are unexpected or unidentified following further medical investigations that such -- the relevant Child Death Overview Panel procedures should apply and should be the form of careful oversight and scrutiny which --

LADY JUSTICE THIRLWALL: Sorry, just picking up on a related theme. You mentioned earlier about people in the Countess not being able to imagine --

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: -- that someone within their number could be responsible and, of course, Dr Kingdon --

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: -- said in terms when I asked her, "What about foul play?" She said, "Well, we don't really consider that." And I suppose in a situation which you've described in a little bit more detail orally than in your submissions but which we had in evidence, there isn't a situation, is there, or a clinical setting in which one would say, "You don't have to be alert to that" --

MS SCOLDING: No.

LADY JUSTICE THIRLWALL: -- to the possibility of deliberate harm?

MS SCOLDING: No, I think the reality is it requires a change of culture from "This could never happen", to "It could happen here". And I think, my Lady, to strike a note of optimism, one can see in other settings where the work has been ongoing -- I'm thinking in particular schools and social care -- where you've had that work ongoing over the past sort of 20 to 30 years. There has been, I would respectfully submit, a change in culture because of the constant reinforcement of the very simple basic, "It could happen here", and I think that needs to happen within hospital settings, but I think, coupled with a raising awareness of the LADO -- because, obviously, if nobody has provided any information in any of the training documents about it, how on earth are they going to know, my Lady? And so I think that will make a change alongside there being this greater scrutiny and oversight where there are concerns.

I mean, you know, one can never say that that would completely extinguish any risk of this happening again, but, my Lady, I think those things together, we would suggest, may significantly reduce the risk from what could be perceived and seen in 2015/2016.

We also agree with the evidence of Dr Garstang

that the SUDIC Guidelines issued in November 2016 are woefully out of date. We have agreed to update these guidelines, but, as we identified in our opening submissions, require funding to be able to carry out this work.

Sir Stephen Powis in his evidence to this Inquiry committed, as we understand it, to update the relevant documents and materials in respect of SUDIC, and we're very grateful to Mr Beer for his confirming that commitment today. What we would identify is that there has been no email or letter from the NHS England saying, "Here's the money and this is the date upon which the money should arrive."

So we would be most grateful if it is NHS England's view that the RCPCH, which I think was the view of Dr Garstang, should be the principal individuals to update those guidelines that that is shortly forthcoming, and we're very happy to work with NHS England to take such steps.

We're also more than happy to work with NHS England to take steps to identify the document that they suggest should be produced which simply sets out what should be done where there are concerns about deliberate harm, and we're happy to work with NHS England or any other body in order to provide and do

so.

Turning to some other recommendations, as we have identified in our closing written submissions and in the evidence that we've provided and as you've identified today, my Lady, leadership roles within hospitals do not automatically come with leadership training and that training often has to be paid for by certainly those who come from our organisation at their own expense. As my Lady has identified in her discussion with Mr Sheldon earlier, the RCPCH would suggest that those who move from clinical to managerial roles need to receive adequate training and skills in that particular skill set.

Whilst all clinical training for doctors includes an element of leadership, that is clinical leadership, not managerial and organisational leadership.

Furthermore, whilst time for administrative work is allocated to clinicians if they have clinical roles but also have to undertake some additional work, one can see, and the example identified in this case, is unfortunately more often than not what happens, which is that work takes place outside of clinical time and that there is not always the suitably skilled and experienced administrative support which is necessary for clinicians to be able to undertake their role properly.

I raise now briefly three further submissions in respect of recommendations.

Firstly, in respect of the co-ordination of data, there seems to be no disagreement that it is a good idea to have different sets of data, and we've set out in some detail in our written submissions about that, and there seems to be no disagreement that there is a real problem with the NNAP, the National Neonatal Audit Programme, the fact that it now has to been inputted clerically by someone who has the time.

We acknowledge that it can sometimes be difficult to find fixes for those particular computer problems, especially where there is no consistent or overarching, you know, one computer, but we would suggest it's not beyond the wit of the very skilled individuals at NHS Digital who managed to work and identify, certainly if one sees during the course of the COVID Inquiry, a number of ways in which to integrate data together that there needs to be such a patch, and we would ask that there is a recommendation put in place that that takes place within three months of the Inquiry report being published, simply because this is something which has been common knowledge for at least a year.

We would also suggest and agree with the recommendations made by Professor Knight in her evidence

about the need for adequate training for individuals in order to be able to analyse the data at the a hospital level.

You heard evidence, my Lady, from Dr Fletcher, the National Medical Examiner, and he was asked about whether or not there needed to be specialist neonatal and/or paediatric or those with that relevant background who undertook the work. He promised to -- and we are happy to hear from NHS England today that guidance has been issued and good practice documents have been issued. That is all laudable. However, the RCPCH still considers that on a regional basis there should be some form of medical examiners who are paediatric and/or neonatal specialists.

We respectfully disagree with Dr Fletcher's view that there's nothing inherently different to the paediatric specialties than there are to other adult specialties. The sheer scale, size and form of paediatric medicine is fundamentally different to and requires different specialist skills and knowledge from other forms of adult medicine, and one would suggest that Mr Fletcher's comparison was not necessarily apt in that context.

My Lady, you've heard what Mr Beer KC from NHS England has to say about our submissions in respect

of child health services, both funding and workforce. As Mandy Rice-Davis might say, "He would say that, wouldn't he?"

My Lady, in order to ensure that there is an adequate system and that there are adequate staff in order to provide good quality of care, it is essential that appropriate priority is given to paediatric services within hospital and community settings.

The Royal College has identified clearly that there is a lack of focus upon children which has resulted in poorer health outcomes for children over the past ten years, and that there has been chronic underinvestment in paediatric services. There are over 50,000 children in England who are having to wait more than a year for health treatment.

Of particular relevance to this Inquiry, furthermore, the prevalence of life-limiting and life-threatening conditions in childhood has increased by 40% between 2001 and 2019. That increase in children who are extremely unwell, with a number of co-morbid chronic conditions which require specialist oversight has not been reflected in increase in staff or services to meet this demand.

This Inquiry has seen from the Countess of Chester that paediatric services are usually only a small part

of hospital provision and it is, therefore, easy for them to be given less focus in a system where resources are stretched and where paediatric care is not seen as a national priority.

NHS indicators are not focused upon children. This means in reality at board level that children are less likely to be given priority in respect of financial decision-making or to be examined as part of the oversight or scrutiny of boards. Given the expert evidence in this Inquiry, which has identified that the focus in most boards is on the financial bottom line or at the very least that weighs heavily in decision-making, a lack of such focus means that children slip down the priority list.

The Royal College has published a blueprint for transforming child health services which makes various recommendations to seek to increase their priority within the health system as it exists.

Firstly, all integrated care cards and should be assessed by looking that their performance in respect of children and young people, including the CQC inspecting and assessing the ICB against specific performance.

We have listened to what NHS England said this morning about this particular recommendation and the joint forward plan. However, we would suggest that the

priorities and operational planning guidance should focus upon and include children and young people. At the moment it does not do so.

There are --

LADY JUSTICE THIRLWALL: Can I just ask you, you refer to the CQC inspecting and assessing the ICB against specific performance --

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: -- indicators.

MS SCOLDING: For children.

LADY JUSTICE THIRLWALL: Yes, for children. What would that actually mean? We know how limited the scope of a CQC inspection is.

MS SCOLDING: Yes. Well, I don't think it's the complete answer, my Lady, but what it does mean is that if you're inspected against something by the CQC, even though it doesn't undertake, as Ms Richards identified, a sort of regulatory-type of investigation into particular issues, it means that it's on your list of things that you have to think about, things that have you to do. If you're a senior manager you will be thinking, "Right, when the CQC comes in, what statistics and information do I have to have?" And if you don't have anything about children and young people in respect of the Integrated Care Board, this will be the Integrated Care

Board rather than the hospitals --

LADY JUSTICE THIRLWALL: Yes.

MS SCOLDING: -- it in all likelihood means that if it is thought about, it is going to be very far down your list of priorities. Given that children are a quarter of our demographic, it seems a missed opportunity not to use the Integrated Care Board to try and drive improvement in child health via the CQC assessment of them by having specific targets in respect of children and young people.

We're not suggesting it should be the only target or the first target, and obviously we do recognise that it's always possible for there to be priority thickets and too much top-down management but it would seem a fairly basic and essential thing to say, "We need to look at these things", and more than just -- at the moment there is a focus quite rightly upon children and young people's mental health services, of which the waiting lists are, as we all know, significant, but other aspects of care such as, for example, neonatology are as important for the ICB to have a focus upon and to be clear about what services are being provided for children in its area.

We also consider, my Lady, that there should be a national outcomes framework for children's health,

which obviously we would suggest is self-explanatory.

Furthermore, given the difficulties with the workforce, it is somewhat disappointing that the NHS long-term workforce plan doesn't include anything specific about paediatric nurses. At present, the plan doesn't provide for any increase in children's nurses and doesn't provide, we would suggest, a coherent plan for the children's workforce.

We accept what NHS England has said that investment has been made more generally in maternity and neonatal services. However, given that in particular the chronic understaffing in neonatal care has been a long-term problem, dating back at least 15 years, it is disappointing to the Royal College that there has not been greater focus upon that in the long-term workforce plan at the moment.

We do recommend greater funding and investment in the neonatal workforce (including medical, nursing, allied health professionals, pharmacy and psychology) to achieve the required national standards to improve safety, and to train and develop the workforce to retain our valued staff. We would suggest that the evidence from this Inquiry shows unequivocally the need for such investment.

Last but by no means least, we focus upon

specialist bereavement support in neonatal care. It is patchy at the moment with many units not having specialist psychological support or trained nursing oversight as a matter of routine. The evidence of this Inquiry by those parents should be more than enough to convince you, my Lady, why such is essential and should be provided as a matter of routine.

My Lady, we set out in our written submissions issues around CCTV and other areas but I'm not going to take you to them now.

We wish to end, as we began, to express our deep sympathies to all those who lost babies and whose babies were injured and whose lives were irreparably damaged by what happened at the Countess of Chester Hospital.

Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Ms Scolding. Just before you go --

MS SCOLDING: Yes, of course.

LADY JUSTICE THIRLWALL: -- in your earlier written submissions you say that the service review was never going to answer the question of why there was an increase in unexplained and unexpected deaths.

MS SCOLDING: Yes.

LADY JUSTICE THIRLWALL: And really just to sort of close the loop, it's your submission that, of course, it

didn't do that.

MS SCOLDING: No, it didn't.

LADY JUSTICE THIRLWALL: No, no. Thank you.

MS SCOLDING: Thank you very much.

LADY JUSTICE THIRLWALL: Mr Kennedy. Mr Kennedy, take your time. If there comes a point when a break would be convenient, by all means take one. If you want to continue --

MR KENNEDY: My Lady I'm very grateful.

LADY JUSTICE THIRLWALL: I'm conscious of the shorthand writer who will probably need a break about quarter past 3.

Closing submissions by MR KENNEDY

MR KENNEDY: Can I at least make a start.

My Lady, as you know, I appear on behalf of the Countess of Chester Hospital NHS Foundation Trust. My Lady, can I start, as we started our opening submissions to you, and remind everybody that throughout this process the Countess' thoughts have been with the parents of the babies who died and who were harmed.

The evidence which they have heard will have been distressing. We commend them for their dignified manner in which they gave their evidence and in which they have listened to that distressing evidence. Throughout we have had in mind the profound suffering of those

families. My Lady, we've set out our position in some detail in writing.

LADY JUSTICE THIRLWALL: Yes, thank you.

MR KENNEDY: It's not my intention to revisit that orally today. What I propose to do is just to identify one or two themes, address in broad terms the concessions that are made by the Countess and then say a word or two about changes.

I don't anticipate I will take the full hour which I asked for. So that may be a comfort to the shorthand writer.

My Lady, the Countess has worked with the Inquiry really since the announcement was first made by the Secretary of State now almost two years ago, in 2023.

We have provided the Inquiry with a large number of documents and very many witness statements. That said, I recognise that the volume of disclosure has meant that at times the disclosure has not been as efficient and as complete as we would have liked and the Inquiry would have wished.

We are grateful to the Inquiry's legal team for their support and encouragement to complete the disclosure exercise, but I recognise and apologise for the fact that at times the disclosure has been incomplete and tardy, but we hope ultimately that the

Trust's involvement will have assisted the Inquiry in its tasks.

My Lady, can I just deal at the outset briefly with the question of postponement just to set out what our position is on that --

LADY JUSTICE THIRLWALL: Okay.

MR KENNEDY: -- insofar as it's not already clear from what we've said in writing.

The Trust opposes a postponement of the Inquiry's work. We've set out why we believe neither fairness nor cost considerations should cause you to pause your work, and I don't propose to repeat that now.

We note that a similar letter was sent to the Secretary of State inviting him to exercise his powers under section 13 of the Inquiries Act. Can I indicate that we agree with the position taken by NHS England and by Ms Richards KC on behalf of the CQC that suspending the Inquiry is primarily a matter for the minister, having consulted with you as the Chair, and it may be, as NHS England have suggested in their written submissions, that it is helpful for you at least to canvass the views of the Core Participants on this issue.

As we indicated in paragraph 370 of our written closing, we do not believe that a possibility of

a referral by the Criminal Cases Review Commission to the Court of Appeal warrants a pause in proceedings. Letby's convictions stand. They have been tested in two unsuccessful appeals. A postponement, which would necessarily be of indeterminate length, is not warranted and it would serve to delay the implementations of recommendations, which unhappily the evidence in this Inquiry have demonstrated are desperately needed.

Can I just deal briefly with the point that we understand to be made on behalf of the former executives, that is that they were unfairly criticised for a failure to accept Letby's criminality. It seems to us that there are three responses to that.

First, we are not clear that in fact that was the basis upon which they were questioned.

Second, if it was the basis upon which they were questioned, the same basis for questioning was put to other witnesses who gave evidence before you. Without going into unnecessary detail, you will recall, for instance, the questions asked of some of the nurse managers about what they said during the grievance process.

In any event, the focus of your Inquiry has not been on whether Letby's criminality was established or not, but it has been on the response or lack of it to

the increasing number of deaths on the neonatal unit and their potential link to Letby.

Letby's conviction is not, we would suggest, necessarily relevant to a consideration of the adequacy of the actions taken by nurses, doctors, managers, executives or indeed the board. And we would suggest that the proposition advanced that it is, is to fall into the trap that we say and others have said the executives fell into between 2015 and 2017. That is, firstly, to have asked the wrong question when commissioning internal and external reviews.

Secondly, to misinterpret the outcome of those reviews as tending to be exculpatory.

And, thirdly, to have required proof at whatever standard of Letby's criminality.

So, my Lady, our position is that we would invite you insofar as you are going to set out your views to the minister to take into account what we have said here and what we've said on paper.

My Lady, in our written and oral submissions at the opening of your Inquiry, we made clear a number of concessions of failures on the part of the Trust. Those related primarily to questions of communication because, at that stage, it seemed to us, not obviously having heard the evidence, to be unarguably the case. We stand

by those concessions. They are, we suggest, reinforced and amplified by the very moving oral evidence that you heard from the Families about the communication and lack of it. I don't propose to go back over that, but we accept that, by virtue of those communication failings, the Trust failed in its duty of candour.

In our written closing, we have made further concessions concerning the adequacy and the speed of response to concerns about Letby. We have also accepted that there were failures in the action taken once those concerns were taken seriously. I don't try and give you an exhaustive list but just a summary.

The grievance process undoubtedly delayed bringing Letby to the attention of the police.

The involvement of Letby's family tended to confound.

There are undoubtedly concerns, as we've set out in our written submissions, about the timings of the involvement of the police and, as we've endeavoured to trace, how there was a movement from almost universal agreement that the police needed to be called at the end of June 2016 to a position later in 2016 and into 2017 when the evidence points, primarily through the desire to return Letby to the unit, to an intention not to call the police.

Finally, in my abbreviated list, the information that was provided by the Trust, whether through the former executives or otherwise, to regulators, commissioners and to NHS England, which, as others have set out, was incomplete at best.

In our written submissions we have accepted that Letby should have been removed from the neonatal unit many months before July 2016. I will address that briefly, if I may, in a moment, but can I, having acknowledged that and other failings on the part of the Trust, make it clear that the Trust apologises without reservation for the failings we identified in our opening note and for those that we now identify, given the evidence that you have received.

The babies and their families deserved better. They were let down by systemic and individual failings, which had the gravest imaginable consequences. The Families trusted their precious children to the care of the Trust and its employees. They were let down. In their grief, the Families were entitled to expect to receive support from the bereavement services and, so far as was possible, answers to questions that they had about their child's death or injury. Many families have reported to you that the support that they received was inadequate and for that, too, the Trust apologises.

My Lady, in our opening submissions we posed the question: was the Trust's response adequate? And answered it -- this was in relation to identifying Letby as a cause for concern -- by suggesting that up to the time of the generation of the second thematic review or the final thematic review in March 2016, the Trust's response was adequate.

From March 2016, we accepted that there were a number of failings in terms of the immediate response to the concerns about the increase in mortality and the association with Letby and, secondly, to the investigation of the paediatricians' concerns in the periods after the deaths of Children O and P on 23 and 24 June 2016.

In our written submissions at the conclusion of your Inquiry, we accept we must bring that time frame forwards. That is because of the evidence that you have heard.

We reflect in making that concession the evidence of Drs Brearey and Jayaram, in particular, but also the evidence of Drs Newby and Gibbs, which suggests that concerns amongst the paediatricians had developed to a point that action was required following the death of Child I on 23 October 2015.

As we've indicated in our written submissions, we

accept that the correct course of action at the end of October 2015 was for Letby to be excluded from the neonatal unit.

We recognise the significance of this concession to the parents of children who were harmed or killed by Letby after the beginning of November 2016, and I can only say that the Trust is profoundly sorry for the failure to intervene sooner.

My Lady, can I then deal with two matters about which you've received a lot of evidence and which are commented on by others in their closing. The first is the question of SUDIC and the second is the question of incident reporting.

The consistent evidence that you've received in relation to SUDIC is that it was not normal practice in 2016, whether at the Countess of Chester or elsewhere, for paediatricians to commence a SUDIC process following the in-hospital death of a neonate who had not been home. Whilst that is an objectively unsatisfactory situation, that appears to be the effect of the evidence that you have received, and we would suggest that so far as those who failed to act are concerned, it is difficult to criticise their actions when they appear to have been consistent with the normal practice of the profession. That practice appears to have been

consistent with a reading of the SUDIC guidance in force at the time when that guidance is read in its entirety.

We acknowledged in our written closing the evidence of Dr Garstang in that respect. Her views obviously differ. It may be that they are shaped by her role not as a hospital doctor but as a community paediatrician.

Whether the SUDIC process should be used in all circumstances where a neonate dies in hospital is, we suggest, a separate question. It requires a consideration of what the intended purpose of SUDIC is; that is whether it is to investigate all unexpected deaths or only those which give rise to some particular concern. We note that the Pan Cheshire guidelines in April 2023 are still qualified, so they read "if deemed reasonable, appropriate and proportionate".

On the face of it, that would appear to envisage that some unexpected deaths may fall outside the SUDIC process. Whether that is correct and the intended position is for other Core Participants to comment on, those who will be better placed to consider that matter. What we suggest on behalf of the Trust is that there is a need for consistency and clarity.

Any guidance should be unambiguous as to the intention of the underlying process and it is, as we

explored with Sir Robert Francis KC, unsatisfactory for there to be a multiplicity of guidance which speaks with, albeit subtly, different tones and conclusions. So we suggest and we acknowledge, as my learned friend Ms Scolding KC has acknowledged, that it is a task itself and funding is required but we suggest that a single authoritative and clear source of guidance is likely to be of greater benefit for practitioners on the ground.

My Lady, just briefly in terms of incident reporting, several Core Participants have invited the Inquiry to conclude that the reporting culture on the neonatal unit at the Countess was poor or that there was inconsistent or incomplete use of data reporting. We suggest that that is a conclusion that the Inquiry should approach with a little caution.

First, we note that all deaths were in fact reported on the Datix system. The criticisms of the reporting culture appear to be predicated on the basis that in addition to the reporting of deaths, unexpected collapses should have been reported as well. The difficulty with that proposition is that it does not appear to find support in the prevailing guidance.

Now, it may be that the prevailing guidance should have been rewritten, but as my learned friend Mr Skelton

KC identifies on behalf of Families Group 1, the guidance appears to be and continues to be predicated upon the requirement for an investment or circumstance to trigger the report.

We suggest in reality that that is a logically sustainable position. Otherwise, as Debbie Peacock told you, the danger is that Datix reporting becomes an industry in itself. Put another way, put colloquially, there is a danger that you do not see the wood for the trees.

The challenge, therefore, is how and where to set the threshold.

My Lady, secondly, the evidence that you received was that the practice of not reporting collapses was consistent with the practice in other units. Now, I accept that the evidence you received in relation to that issue was not as extensive as the evidence you received about SUDIC, but you'll recall Dr McGuigan's evidence about the unit that he came from, his experiences in Crewe that he came from before the Countess of Chester.

So, my Lady, his evidence was that if there was an event -- and he gave the example of a drug error -- then that would trigger a Datix report but if there wasn't, a Datix report would not be completed simply for

an unexpected collapse.

We suggest that that position is, as I said, logically sustainable but also consistent with the purpose of incident reporting, that being to identify acts and omissions which are capable of causing harm so as to facilitate learning for avoidance in the future, rather than being simply a record of an unexpected collapse in and of itself.

Linked, and thirdly, there has been some criticism, understandably, of the reference to deaths being reported as no harm incidents, and it is easy to understand why that will have been distressing for others. An understanding of the Datix process leads to the conclusion that identifying a death as harm or no harm is informed by the clinician's understanding of the circumstances of the death. In other words, criticism of Datix as identifying a death as being a no harm incident is a criticism of the paediatricians arguably for not identifying that the deaths were the consequence of Letby's actions. We note that by the time it came to the cases of Child O and Child P, the level of harm recorded on the Datix was "death".

So there is caution required, we suggest, of not judging the quality of the recording by what was later revealed about Letby's actions.

We also observe that insofar as concerns were raised about the reporting culture on the unit, they appear to have arisen after the end of June 2016. There is reference to them in the Kelly-Millward paper that was prepared as part of the Silver Command exercise.

What there hasn't been is a deal of evidence suggesting that there were concerns about the reporting structure prior to June of 2016, or that there were efforts -- sorry, that there were paediatricians who were obstructing efforts to improve it. I'm conscious in saying that of the evidence of Ruth Millward and the difficulties that she reported eliciting information from Dr Brearey. But that was not a question of reporting. That was simply -- sorry, that was a question of obtaining answers to queries that she was raising about deaths which had been reported or Datixs which had been completed.

In fact, the evidence that you received on the quality of reporting was from Dr Subhedar who recorded -- and you'll recall was the chair of the clinical effectiveness group -- was that he regarded the reporting culture on the neonatal unit as being good.

Finally, I would just remind you, if I may, of the evidence that Ruth Millward gave in relation to the reporting culture. What she told you -- and this was

page 161 at line 6 of her evidence, so week 8, Day 1 -- was that the paediatricians were very transparent about gaps in care that had happened and they were very clear where there was elements of suboptimal care and what they planned to do to remedy that in the future.

And so, as I say, we just invite you to approach the suggestion of a poor incident reporting culture with a little circumspection for those reasons.

My Lady, I was going to move on to a new topic. I'm wondering whether the --

LADY JUSTICE THIRLWALL: This would be a convenient moment.

MR KENNEDY: That would be a convenient moment.

LADY JUSTICE THIRLWALL: So we'll start again at -- let's say 20 to. 20 to four.

(3.19 pm)

(A short break)

(3.40 pm)

MR KENNEDY: My Lady, just to indicate how I plan to take matters forward. I've got just some short matters arising from the closing submissions of two of the other Core Participants and then I have some brief comments on culture and changes that have been made at the Trust.

LADY JUSTICE THIRLWALL: Just pause a minute. There's a couple of people coming in.

MR KENNEDY: Yes, of course.

(Pause).

LADY JUSTICE THIRLWALL: Please go ahead.

MR KENNEDY: Thank you.

My Lady, with a little diffidence, we invite you to approach some of what has been said on behalf of the former executives with a degree of caution.

I'm focusing on paragraph 69 and 70, which, if you are working from the same bundle as I am, is page 331 in the bundle.

It's maybe memorable to my Lady because it is where it is inferred, implied or perhaps suggested that there was a reluctance to identify shortcomings amongst the paediatricians because of a desire not to lose level 2 status of the neonatal unit, and I take issue with what is said in those two paragraphs. And I'll just say briefly. It will, I anticipate, be readily apparent.

Firstly, it is, we suggest, not correct to say that after the end of June 2016 the neonatal unit required micromanagement to ensure an adequate standard of care. Certainly it is right, it was the subject of closer scrutiny and regular reporting to the board. You'll recall there were arrangements for regular updates on the neonatal unit. But we suggest that that was not necessary to ensure an adequate standard of

care, as has been implied. It was necessary because of what had happened up to that point and, as we see it, therefore, the delay in identifying the actions of Letby.

Secondly, in paragraph 69, it is suggested that a culture of coping had developed. Again, that is the perspective of the former executives. They purport to rely upon the evidence of Dr Neame and, insofar as it's relevant, she -- and you may remember -- told you that she detected a difference between her time at the Countess in 2012 and 2013 from 2015, in that later period she felt she was caring for babies who seemed more unwell or sicker.

But in terms of staffing pressures which may underpin the culture of coping proposition, she told you that the unit was typical of other units where she had worked and did not feel unusual.

The third point arising from these two paragraphs is, as I highlighted earlier, the suggestion that there was a reluctance to identify shortcomings in care because that might result in a loss of level 2 status. We suggest as a proposition that is without foundation.

We've addressed the prevailing approach to reporting collapses. The proposition that is advanced ignores, in our submission, the fact that all of the

deaths were reported on Datix, they were all considered by the local network and they were all the subject of internal reviews, accepting that others have commented on the adequacy or otherwise of those reviews.

And so, as I say, we suggest that the proposition there was a reluctance to identify shortcomings is not supported by the evidence.

It is similarly wrong, as is done in paragraph 70, to accuse the paediatricians of marking or seeking to mark their own homework. It's wrong for one simple reason, that Dr Brearey chose to involve the head of the local network in the thematic review exercise, and we note, with some irony, that elsewhere Dr Subhedar is described in those submissions as being external, independent and specialist.

We also identify in the submissions made by the former execs the following, and we just flag this as a matter of concern, in paragraph 36 they describe how Dr Jayaram caught Letby in the act of murdering Child K. That may be a shorthand, that may be an abbreviation but it's important to understand publicly the evidence that Dr Jayaram gave to you.

You'll recall -- and this was page 38, line 4 of his evidence -- that his evidence was that he did not walk in and see something happening. Rather, when he

went in he found an endotracheal tube to have been dislodged and Letby not responding to this.

It may be, as I say, that the description of catching Letby in the act of murder is a shorthand but it's important that the evidence is properly understood.

My Lady, if it would assist, we can give you the references to the transcripts in the criminal trial, but it may be sufficient for your purposes just to revisit what Dr Jayaram told you.

Just following on from that passage, and we've dealt with this in writing, the former execs seek to stress the significance of the disclosure of this information or indeed the late disclosure of this information, as they would put it, to Ms Hodkinson. As I say, we deal with that at section D5 of our written closing.

The short point that we make is that the response of the former execs to the disclosure made on 15 March 2017 is not consistent with the position that they now seek to advance, namely that it was a disclosure that would have materially influenced their thinking and materially altered the way they managed Letby.

Two further very short points. One is simply a correction, and it may be it's been picked up by

Family Group 1 already. In paragraph 82, they refer to, as I put it, the wrong Griffiths. So they refer to Yvonne Griffiths failing in her obligations as a designated officer under Speak Out Safely. That was Hayley Griffiths, now Hayley Cooper.

And just while I'm on Yvonne Griffiths, it's worth just observing that the criticism is made of her at the beginning of Family Group 1's submissions for a startling lack of curiosity. It's worth perhaps observing that of those listed, and they range from her through Eirian Powell, Ann Murphy, Karen Rees and Sian Williams, she was, as we understand it, the most junior. That doesn't take away from the validity of the observation.

Finally, in terms of corrections, and I've picked up ones which are relevant at least to the Countess, Ruth Millward is often described as a senior manager. Obviously it will be a matter for you how you approach that purported designation, but you'll recall I think when she was answering Mr de la Poer's questions that she was keen to explain that she wasn't a senior manager, or certainly she didn't regard herself as a senior manager. She told you she was a band 8A, and you may recall that in terms of hierarchy, although she was head of risk and patient safety, she reported to

Sian Williams who in turn reported to Alison Kelly.

We mentioned in our closing submissions -- I move on.

We mentioned in our closing submissions the criticisms of Ms de Beger and Dr Bowles. I just perhaps ought to make it clear, I'm not suggesting that they are deserving of no adverse observation. They themselves accepted that there were criticisms of some of their conduct. The issue that we just identify is how far the criticisms should go.

In summary, one must understand Ms de Beger's peculiar position so far as Letby was concerned. Letby's welfare was her prime responsibility. Whether that went too far in terms of the number of messages that were passed may be a matter you will need to consider but the backdrop is that she was her prime responsibility.

And just briefly in terms of Dr Bowles, the criticism of her for not keeping her diary was one that we suggest may be a little strong.

So if I can just turn, then, to my final observations on culture and changes.

The expression "tribalism" has been used to describe the culture within the neonatal unit. Again, we would urge a little bit of caution in relation to the

use of that sort of emotive term. The evidence that you have received, whether orally or through statements or through the questionnaires that were sent out, was to the effect that generally the culture within the neonatal unit was satisfactory, doctors and nurses and managers worked well and there was mutual respect.

Perhaps understandably, those relationships were put under strain, and when they were put under strain divisions or fractures occurred. Those divisions were unhappily exacerbated by events, including the grievance process, and that was laid bare in the evidence you received. But it would be wrong, we would suggest, for the impression to be left that, aside from what happened with Letby, that the culture in the unit was a cause for concern.

Turning, if I may, just briefly to the culture within the wider organisation. Much has been written and said about that, and much of that will be of concern to the Inquiry. We have addressed a lot of that in our closing submissions and in our written closing submissions, and I'm not going to repeat it here.

What is, in our submission, unarguable is that the cultural tone of an organisation is set by those with leadership responsibilities and has an important impact on relationships with staff further down the

organisational hierarchy. It is axiomatic, we suggest, that an open and transparent culture fosters open and transparent reporting of concerns. An open and transparent culture fosters open and transparent investigation of those concerns.

It will be for you, my Lady, to determine whether in the period 2015 to 2017 the culture set by those with managerial responsibilities and those at the top of the organisation adversely impacted the actions taken to identify Letby and to bring about an appropriately forensic investigation of her conduct.

My Lady, you've received some evidence that cultural problems at the Trust persisted after the departure of the medical director and the chief executive, so after the departure of Mr Harvey and Mr Chambers. I don't seek to hide from that by suggesting that that is outwith the scope of your Inquiry, but I do recognise and invite you to recognise that the evidence about the culture after 2018 has necessarily been limited.

Conscious of the impact that the evidence that has been given to your Inquiry and the conclusions that some may have reached from hearing that evidence and the impact that that may have on public confidence, can I just briefly address some changes that the Trust has

made.

We have set them out in detail in our written closing, but, if I may, I will just highlight four aspects.

The first is not perhaps as clearly set out in my written closing as it might have been. It is this, that the trust has a new executive and non-executive team. Most recently and for reasons which will perhaps be obvious, the Trust appointed a new interim chair of the board. That is Neil Large. He brings extensive experience of board level positions in the NHS. Prior to joining the Trust, he was the chair of the Liverpool Heart and Chest NHS Foundation Trust for more than a dozen years.

It is of note that there he worked alongside the Countess' current chief executive, Jane Tomkinson. They worked together for ten years at the Liverpool Heart and Chest. That hospital is a hospital that has consistently been rated as a top performing trust in the national NHS survey and has, perhaps importantly for our purposes, been in the top five of the National Guardian's Office Freedom to Speak Up survey.

For those checking the Trust's website, they will see that the executive team has extensive experience of working within the NHS but that all of them have been

appointed since 2022. So that's why I say a new exec and non-exec team.

There is greater clinical expertise within the non-executive team. We flag that in our opening as a deficiency amongst the non-executive directors, so that one non-exec was in full-time medical practice until September of 2021, and another has a background in nursing. All have extensive board level experience, whether in the private sector or, as many do, bringing to bear extensive NHS board level expertise.

Second, in terms of changes, I would just flag the evidence that you've received about the culture of the organisation as set out by Jane Tomkinson. We agree with the written submissions of the Department that good culture and good leadership are manifestly connected. We note the passage that the Department cites from the evidence of Mr Vineall at paragraph 75 of their written closing and his assessment of Jane Tomkinson's recognition of the importance of good culture.

We are confident that there has been a change of culture within the Trust. That is not to say that the Trust is complacent. It is a continuing process and it will be the case that mistakes will continue to be made, we do not hide from that, but the test is and will be how the Trust responds when mistakes occur.

Third, there have, we suggest -- we invite you to conclude -- been significant governance changes. As you are aware, the Trust has commissioned a number of reviews into its governance structures and processes, and they have at times been uncomfortable reading.

The current leadership group continues to drive forward changes in governance and we just flag again for, my Lady, you and perhaps wider public consumption the following five points.

Firstly, the establishment of the operational management board in January 2023 with the specific task of overseeing implementation of operational strategies and objectives and with the requirement of reporting to the board of directors.

QSPEC, described by Professor Smith, I think, or Dr Smith, as being unwieldy in terms of numbers has been replaced by the quality and safety committee with a streamlined membership.

Third, there is a new route for reporting perinatal quality so that the women and children's governance committee reports direct to the board of directors through the director of midwifery.

Fourth, there is a renewed focus on safety and Freedom to Speak Up, with safety and Freedom to Speak Up champions and a Freedom to Speak Up guardian who reports

directly to the Trust board.

And, finally, the introduction of a weekly learning bulletin that is shared with all doctors, nurses and trainees across the Trust.

Finally, in terms of changes, the Trust has appointed, as you will have seen in our closing submissions and as set out in Jane Tomkinson's written evidence, the Trust has appointed a child death review lead. That was a post that did not exist in 2015/2016. The Trust requires that all sudden and unexpected deaths of babies are managed in accordance with the Pan Cheshire SUDIC Guidelines and its own child death guideline, which Dr Davis has updated, and you'll recall you received a draft of that in one of Dr Brearey's supplemental statements.

As I said earlier, the objective must be, as we explored with Sir Robert Francis, uniform national processes and guidance.

There's undoubtedly been progress. Others are far better placed to speak to that progress than me. We just identify two matters, and in part this is in common with NHS England. So we referred in our written closing to the Cascade system, which is intended to address, at least in part, the need for duplicate reporting, so that a death reported to MBRRACE is transmitted on to the

CDOP process.

And, secondly, the proposal in the closing submissions of NHS England for the consolidation of child death review and SUDIC. As I said to you, and I've said now on a couple of occasions, the Trust would support in terms of SUDIC, safeguarding or otherwise, any recommendations that ensure simplified, streamlined and structured reporting of neonatal deaths.

My Lady, the Trust clearly wishes that these changes had not been necessary. That it has made these changes may provide little comfort to the families of Letby's victims, but we hope it will provide reassurance to those who now use the Countess of Chester Hospital and those who will do so in the future.

So far as the Families are concerned, we hope that they will understand that the Trust has learned from the events that you have inquired into and I make it clear that the Trust is determined to continue learning and implement the changes that are necessary.

My Lady, that is what I have to say orally.

I just finish, I think, as others have finished, by paying tribute to the Families for the dignified way that they have conducted themselves in these proceedings and to reiterate the apology that I have made on a number of occasions in the course of my oral closing.

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

MR KENNEDY: Thank you.

LADY JUSTICE THIRLWALL: So we'll rise now and start again tomorrow morning at 10 o'clock with submissions from Ms Blackwell.

(4.08 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 18 March 2025)

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