

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.

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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

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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 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

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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.

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

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

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

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

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

5 **MR SHELDON:** Of course, my Lady.

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

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

22 **LADY JUSTICE THIRLWALL:** Of course, yes.

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

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

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

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

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

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

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

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

8 **LADY JUSTICE THIRLWALL:** Yes, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **MR SHELDON:** But the Patient Safety Incident Response  
2 Framework, which provides a new approach for responding  
3 to patient safety incidents and is anchored in the  
4 principles of openness, fair accountability, learning  
5 and continuous improvement, became a contractual  
6 obligation for all providers of NHS services from  
7 1 April last year. The feedback on the framework  
8 received to date has been positive, and you may recall  
9 the evidence of Professor Dixon-Woods to the effect that  
10 so far it represents an improvement on previous  
11 processes in this important area.

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

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

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1 more than once?

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

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

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

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

18 **MR SHELDON:** Of course, my Lady.

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

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

8 **MR SHELDON:** Of course, my Lady.

9 **LADY JUSTICE THIRLWALL:** -- that would be helpful.

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

13 **LADY JUSTICE THIRLWALL:** Whistleblowing.

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

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

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

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

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

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1 light of the events at the Countess of Chester Hospital,  
2 and required to adopt the policy by January 2024.  
3 Martha's Rule, which is being currently rolled out in  
4 143 hospital sites, gives patients and their families  
5 the ability to initiate a rapid review of their case  
6 24 hours a day from someone outside their immediate care  
7 team. And there is also the formal NHS complaints  
8 system which provides a process for complaints to be  
9 addressed and investigated at a local level.

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

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

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

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

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

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

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

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

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

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

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

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1 and powerfully to you in her evidence:

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

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

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

11 He described encountering:

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

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

18 There are a number of other respects in which the  
19 Department and NHS England are working to build strong  
20 leadership as a means of improving culture and they are  
21 set out in paragraph 64 of our written submissions.

22 I won't take up time now listing them. The point for  
23 present purposes is that we recognise this will be  
24 an area of particular concern to you in the Inquiry.

25 It's an area where a significant amount of work is

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

3 As Mr Vineall put it to you during his evidence:

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

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

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

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

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

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

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

18 The consultation on manager regulation closed on  
19 18 February this year and it received strong engagement  
20 across the sector and the wider public. We received  
21 just under 5,000 responses in total, and the Department  
22 is already considering all of those responses before  
23 setting out the next steps for implementation.

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

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

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

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

22 **MR SHELDON:** Yes, my Lady.

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

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

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

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

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

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

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

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

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

20 **MR SHELDON:** Understood, my Lady.

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

22 **MR SHELDON:** Thank you.

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

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

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

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

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

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1 from staff on the ground, such as Dr McCormack, who  
2 commended medical examiners for offering:  
3 "... a dedicated and confidential forum for  
4 discussing concerns and expertise on matters such as the  
5 coronial process, and [assisting] by educating and  
6 reminding staff of cases such as Allitt and Stepping  
7 Hill."

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

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

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

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

25

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

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

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

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

25 The tragic events at the Countess of Chester

27

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

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

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

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

26

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

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

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

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

28

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

8 My Lady, thank you very much.

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

12 **MR SHELDON:** Thank you, my Lady.

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

14 Mr Beer.

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

20 Mr Beer.

21 **Closing submissions by MR BEER**

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

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

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

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

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

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

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

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

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

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

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

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

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1 **MR BEER:** Yes.

2 **LADY JUSTICE THIRLWALL:** -- but it's one thing to say at  
3 some point in the future the organisation will cease to  
4 exist but the impression one has from reporting, and  
5 I don't know whether this is an accurate impression, is  
6 that there will be reductions in the number of people  
7 working for NHS England before the organisation ceases  
8 to exist, and so that's the reason for my question  
9 earlier as to who actually is going to be responsible  
10 for whichever recommendation, and I appreciate it may be  
11 that NHS England's input may be less than that of the  
12 Department but it is something which is of concern.

13 **MR BEER:** Yes, as to that, I would say three things.

14 Firstly, we may not be the best person to ask now  
15 in terms of the relationship as it now exists.

16 And, secondly, in any event, we're very early in  
17 the process.

18 **LADY JUSTICE THIRLWALL:** Yes.

19 **MR BEER:** This happened on Thursday, and we're now on  
20 Monday.

21 And the third thing is you may not get an answer  
22 in time for the writing of your report to know where  
23 each relevant function may sit as between NHS England,  
24 the Department or some other body, in which case you may  
25 wish to include in your recommendations a recommendation

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1 abolition of NHS England does not change the evidence or  
2 the reflections that it has given, nor diminish the  
3 value of its participation to date. If anything, it's  
4 all the more important that NHS England formally records  
5 the learning that it has derived from the events at the  
6 Countess of Chester and from its participation as  
7 a Core Participants in this Inquiry.

8 Professor Sir Stephen Powis, from whom the Inquiry  
9 heard, Duncan Burton, the chief nursing officer for  
10 England, which is a joint Department of Health and  
11 Social Care and NHS role, who has given three witness  
12 statements to the Inquiry, and Sarah-Jane Marsh, the  
13 deputy chief operating officer, still remain directly  
14 and actively involved with NHS England's response to  
15 this Inquiry.

16 The Inquiry will understand that alongside very  
17 experienced NHS managers, NHS England employs  
18 professors, senior doctors and other clinicians who  
19 contribute valuable practical knowledge from the NHS  
20 front line into policy roles and who will provide  
21 corporate memory in the course of the transition.

22 **LADY JUSTICE THIRLWALL:** Just before you move into --

23 **MR BEER:** Yes.

24 **LADY JUSTICE THIRLWALL:** -- perhaps to develop some of that  
25 in relation to transition, I wonder if I could just ask

35

1 about an implementation board or *in extremis* not close  
2 your Inquiry and yourself act as such a body by not  
3 closing the Inquiry under section 14.

4 **LADY JUSTICE THIRLWALL:** Yes, I understand.

5 **MR BEER:** They're not things I positively urge upon you but  
6 are matters for you to consider.

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

8 **MR BEER:** The speed of the transition of powers and  
9 functions or the order in which powers and functions is  
10 to occur is presently unclear. Other functions are  
11 discharged by NHS England pursuant to its general  
12 powers, so not specific statutory powers, and again  
13 these will have to be transferred to the Secretary of  
14 State or to others. Again, by reason of the timing of  
15 the Prime Minister's announcement, there's presently no  
16 timetable or order in which such functions are to be  
17 transferred, save for the mention of a long-stop period  
18 of two years.

19 The Inquiry should be supported, we submit, in the  
20 preparation of its report, so over the coming months it  
21 does not need to check which body or person presently  
22 has the legal, functional or operational responsibility  
23 for the discharge of a function and, therefore, which  
24 body or person to whom a recommendation is directed.

25 The third point I would make on this is that the

34

1 you about the change in view from NHS England about  
2 CCTV --

3 **MR BEER:** Yes.

4 **LADY JUSTICE THIRLWALL:** -- because when

5 Professor Sir Stephen Powis gave evidence -- it's your  
6 paragraph 46 --

7 **MR BEER:** It is.

8 **LADY JUSTICE THIRLWALL:** -- he indicated NHS England's  
9 intention to explore the issue of CCTV through the  
10 commissioning of pilots.

11 **MR BEER:** Yes.

12 **LADY JUSTICE THIRLWALL:** When we get to paragraph 47, we see  
13 a decision has been taken not to do that, and, given  
14 that this is a suggestion that was made very early in  
15 this process by and on behalf of the parents, I think it  
16 would be useful to have a bit more of an explanation  
17 than appears in the written document as to why that  
18 decision has been taken.

19 **MR BEER:** Yes. I think Sir Stephen's view was that it was  
20 necessary to conduct some pilots to find out the answers  
21 to some fundamental questions on the benefits and any  
22 disadvantages of using cot cameras or cot monitors, and  
23 he suggested that this could be taken forward through  
24 the work of the chief nursing officer or the national  
25 medical director for neonatal care.

36

1 **LADY JUSTICE THIRLWALL:** Yes.

2 **MR BEER:** In fact, both of those people have undertaken

3 a review of what transpires to be existing pilot studies

4 on those issues --

5 **LADY JUSTICE THIRLWALL:** Ah.

6 **MR BEER:** -- and in particular you may remember in the

7 written submissions there's a cross reference to work

8 done in particular by the neonatal unit at University

9 College London, which is in fact published quite

10 extensively on this issue and overall, and this is my

11 summary --

12 **LADY JUSTICE THIRLWALL:** Yes, that would be helpful.

13 **MR BEER:** -- what that shows is, firstly, there wasn't

14 an identifiable gain in patient safety terms by having

15 cot cams.

16 **LADY JUSTICE THIRLWALL:** How was that assessed?

17 **MR BEER:** Well, there was no change to the outcomes for

18 babies. There was, secondly, however, a positive

19 reception from the families concerned. So they --

20 **LADY JUSTICE THIRLWALL:** Sorry, just so I can understand --

21 **MR BEER:** Yes.

22 **LADY JUSTICE THIRLWALL:** -- the families felt it was a good

23 thing?

24 **MR BEER:** Yes, the families felt that it was a good thing.

25 They felt reassured --

37

1 **MR BEER:** No, I imagine there would be a marginal --

2 **LADY JUSTICE THIRLWALL:** Minimal, yes.

3 **MR BEER:** -- point on that, but that's probably by the by.

4 **LADY JUSTICE THIRLWALL:** So it's the parents would see

5 something on the camera that was of concern to them --

6 **MR BEER:** Yes.

7 **LADY JUSTICE THIRLWALL:** -- and they would get in touch, and

8 I suppose if a parent was standing next to the cot and

9 saw something which was of concern, presumably they'd do

10 the same thing?

11 **MR BEER:** Yes. But by way of discussion and there could be

12 dialogue with the clinical indicators in front of each

13 them as they speak, so that there could be a discussion

14 and if necessary bringing in of other staff. I'm simply

15 at the moment reflecting in my understanding the outcome

16 of the research that has taken place.

17 **LADY JUSTICE THIRLWALL:** No, no, that's very helpful. Yes,

18 it just seemed to me those were questions that anyone

19 who was interested in this would want to know the

20 answers to. And where are the detailed answers found?

21 Is this in the work from UCH or --

22 **MR BEER:** UCL.

23 **LADY JUSTICE THIRLWALL:** UCL.

24 **MR BEER:** Yes. Yes, we can give you the citations of the

25 academic papers --

39

1 **LADY JUSTICE THIRLWALL:** Yes.

2 **MR BEER:** -- it gave them a feeling of greater safety.

3 **LADY JUSTICE THIRLWALL:** A justified feeling --

4 **MR BEER:** Sorry?

5 **LADY JUSTICE THIRLWALL:** Presumably a justified feeling of

6 greater safety --

7 **MR BEER:** Yes.

8 **LADY JUSTICE THIRLWALL:** -- and reassurance? Yes.

9 **MR BEER:** Yes. But, thirdly, it led to increased workload,

10 in particular because parents believed that they could

11 see issues on the cot cams that required attending to,

12 ie some clinical response.

13 And, fourthly -- and again this is my summary --

14 the necessary training, supervision and resource demands

15 that the introduction of cot cams led to were

16 significant.

17 **LADY JUSTICE THIRLWALL:** Because -- what would the training

18 be for?

19 **MR BEER:** The training was in relation to when to respond to

20 an issue. So quite often it was said that parents

21 called in and said that they had seen something that

22 required attending to, whether that was to be responded

23 to or not.

24 **LADY JUSTICE THIRLWALL:** Oh, I see, not training but in the

25 use of the cot cams (*unclear*) point.

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1 **LADY JUSTICE THIRLWALL:** Well, perhaps --

2 **MR BEER:** -- it's not restricted to UCL.

3 **LADY JUSTICE THIRLWALL:** Yes, I can see Mr Suter saying

4 we've got them. So that's something we can have a look

5 at, because I think it's an interesting question and if

6 there are issues, I'd like to know what they are --

7 **MR BEER:** Yes.

8 **LADY JUSTICE THIRLWALL:** -- before making my

9 recommendations. Thank you.

10 Sorry, Mr Beer, I took you off course.

11 **MR BEER:** No, no, of course.

12 Going back to where I was, I was submitting that

13 NHS employs senior professors, doctors and clinicians

14 who contribute valuable practical knowledge from the

15 front line into policy roles and that in the light of

16 the announcement to the abolition of NHS England, it's

17 important, we submit, that there should be a backstop in

18 the form of the Secretary of State to provide assurance

19 to the Inquiry that recommendations will not fall into

20 a vacuum, because the Inquiry should not be left in

21 a position after today, whilst it is writing its report,

22 of needing regular updates on which functions have or

23 have not been transferred.

24 The second overall consequence of the decision

25 that NHS England will be abolished is the effect that it

40

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

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

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

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

25 We're strongly supportive of the proposals to  
41

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

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

16 So, firstly, reporting concerns. And so, firstly,  
17 on the proposal by Family Group 1 that the Department  
18 and/or NHS England should publish a single short  
19 document that clearly and unambiguously sets out the  
20 steps that must be taken immediately when information  
21 arises that indicates that a healthcare professional has  
22 or may have deliberately harmed a patient. We agree  
23 that this has merit. As we explain in paragraph 189 of  
24 our closing submissions, our view is that this would be  
25 best taken forward as part of the review of the Child  
43

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

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

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

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

25 We have considered carefully and reflected on the  
42

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

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

19 We understand why these recommendations have been  
20 proposed. However, NHS England does not consider that  
21 such a recommendation is necessary because, firstly,  
22 providers are required to notify the CQC of all service  
23 user deaths in any event, as well as injuries to all  
24 service users: see Regulations 16 and 18 of the CQC  
25 (Registration) Regulations 2009.  
44

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

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

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

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

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

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

45

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

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

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

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

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

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

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

25 **LADY JUSTICE THIRLWALL:** And when you refer to the

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1 **MR BEER:** Yes, it's --

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

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

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

15 The Families make two additional proposals around  
16 insulin.

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

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

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

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

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

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

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

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

18 **LADY JUSTICE THIRLWALL:** Is there a timescale for it?

19 **MR BEER:** Sorry?

20 **LADY JUSTICE THIRLWALL:** Is there even a timescale for it

21 (a) which challenge and when is it going to be met?

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

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1 information-sharing between healthcare regulatory  
2 bodies.

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

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

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

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

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

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

20 **LADY JUSTICE THIRLWALL:** Yes.

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

22 **LADY JUSTICE THIRLWALL:** No, I --

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

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

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

7 **MR BEER:** Yes.

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **MR BEER:** Yes. In short, yes.

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

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

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

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

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

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

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

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

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

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

18 **MR BEER:** Dr Longdon or Dr Kingdon?

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

20 **MR BEER:** You had me there because --

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

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

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

25 **MR BEER:** Dr Kingdon from the Royal College.

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

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

11 Secondly, ICB performance assessment. ICB is  
 12 already subject to statutory duties under the NHS Act  
 13 2006 in relation to children and young people. This  
 14 includes requirements to cover this group's particular  
 15 needs in their joint forward plan, so a statutory  
 16 requirement. We've published guidance on this for ICBs,  
 17 and our annual assessment of ICBs is underpinned by four  
 18 main questions, one of which is how far the ICB has  
 19 achieved its local ambitions articulated in its joint  
 20 forward plan.

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

25 Fourthly, the development of a national outcomes

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

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

9 **LADY JUSTICE THIRLWALL:** Yes.

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

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

19 **MR BEER:** Yes, thank you.

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

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

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

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

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

25 And then, finally, in relation to social media,  
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1 a section 13 issue for the Secretary of State. Your  
2 views as a consultee are important and this is a good  
3 opportunity to inform those views by taking submissions  
4 from Core Participants. As to the substance, we take  
5 a neutral position.

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

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

10 (11.25 am)

11 (A short break)

12 (11.46 am)

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

16 **Closing submissions by MS RICHARDS**

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

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

24 And the written closing submissions on behalf of  
25 Family Groups 2 and 3 record, entirely understandably,  
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1 we're pleased to note that the NMC has formally  
2 committed to further work to strengthen its professional  
3 regulatory guidance about social media, an issue of  
4 importance both to the Families and to NHS England. The  
5 NMC's position reflects our view that leadership on this  
6 important issue needs to come from the professional  
7 regulators.

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

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

19 Thank you.

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

25 **MR BEER:** No, I don't think so, my Lady. In summary, it's  
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1 dismay regarding gaps in the Care Quality Commission's  
2 disclosure.

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

14 Although the Care Quality Commission as  
15 an organisation has no reason to think that the  
16 documents which have not been found would have contained  
17 information relating directly to the neonatal unit, some  
18 of them may well have included information relevant to  
19 the broader culture of the hospital, and in particular  
20 your Ladyship knows that the record of the focus group  
21 meeting with hospital consultants on 17 February is one  
22 of the documents that has not been found and, as such,  
23 the Inquiry had only such limited information as  
24 Julie Hughes of the CQC was able to provide through her  
25 diary and oral evidence regarding the nature and extent  
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1 of the concerns raised during that meeting.  
 2 Ann Ford and Chris Dzikiti of the CQC have already  
 3 apologised in their evidence for this deficiency in  
 4 disclosure, but I repeat that apology today on behalf of  
 5 the CQC and directly to the Families. We are sorry and  
 6 we understand that any gap in documentation impairs the  
 7 Families' ability to, in Mother A and B's words, "find  
 8 out what happened".  
 9 My Lady, conscious of the need to learn from this,  
 10 the CQC has recently engaged an information management  
 11 expert organisation called Metataxis to conduct  
 12 a detailed review of its information and records  
 13 management practices and more generally to evaluate the  
 14 level of compliance with information governance and to  
 15 make recommendations for improvement. This required  
 16 an assessment of current information governance  
 17 structures and ownership within CQC, the quality of  
 18 records management practice, digital and physical  
 19 storage arrangements and the provision of access to  
 20 records in response to the needs of public inquiries.  
 21 I understand, my Lady, a report has now been provided to  
 22 the CQC's executive team for them to review its content  
 23 and recommend appropriate actions and next steps.  
 24 **LADY JUSTICE THIRLWALL:** Thank you.  
 25 **MS RICHARDS:** My Lady, staying with the focus group meeting  
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1 wasn't explored at all during the inspection, and  
 2 I understand no one said anything about it, but is that  
 3 usual, just the fact that it's not mentioned? Does that  
 4 mean, therefore, that it's not even looked at, the  
 5 question of mortality?  
 6 **MS RICHARDS:** My Lady, it would not have been part of the  
 7 ordinary processes of the Care Quality Commission at  
 8 that time as part of a comprehensive inspection to  
 9 routinely ask questions about mortality data in the  
 10 absence of something that gave rise to a specific  
 11 concern. So the focus would have been on asking about  
 12 the processes that would be followed in relation to  
 13 neonatal mortality and indeed other aspects of  
 14 incidents.  
 15 **LADY JUSTICE THIRLWALL:** So just by way of an example, then,  
 16 what would be the question that would elicit the  
 17 response, "We've had so many deaths this year and we had  
 18 so many deaths last year"? Would that be a question  
 19 you'd expect to ask?  
 20 **MS RICHARDS:** So, my Lady, there are two ways in which that  
 21 information could have been elicited in terms of how  
 22 this inspection actually was conducted.  
 23 **LADY JUSTICE THIRLWALL:** Sure.  
 24 **MS RICHARDS:** The first is that there was a discussion about  
 25 the neonatal mortality meetings. So there was  
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1 with consultants in February 2016, the  
 2 Care Quality Commission has accepted in its written  
 3 submissions a number of respects in which it should have  
 4 done better or differently and, in relation to that  
 5 focus group meeting, the Care Quality Commission accepts  
 6 that as well as reporting those concerns to the medical  
 7 director, the issue should have been followed up and  
 8 escalated to the chair of the Countess of Chester  
 9 Hospital if a problem remained, and there is no evidence  
 10 to suggest that that was done.  
 11 When the Countess of Chester finally told the  
 12 Care Quality Commission about the increased neonatal  
 13 mortality, and that was on 29 and 30 June 2016, the  
 14 Care Quality Commission was reassured in terms of the  
 15 ongoing safety of the unit as to the steps and actions  
 16 that were proposed by the hospital, but CQC should have  
 17 requested sight of the thematic review and of any other  
 18 views that had been carried out, and having considered  
 19 those and having noted the dates upon which they had  
 20 been commissioned and received, CQC should in particular  
 21 have explored with the Countess of Chester Hospital why  
 22 this information had not been provided to it sooner. It  
 23 did not do so.  
 24 **LADY JUSTICE THIRLWALL:** Ms Richards, just before you move  
 25 on, but on the topic of neonatal mortality, and it  
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1 a specific discussion about the processes for  
 2 considering neonatal mortality within the hospital.  
 3 **LADY JUSTICE THIRLWALL:** Yes, that was why I was wondering  
 4 why they wouldn't have asked, "Well, you know, where's  
 5 the mortality data? What are the records?" It doesn't  
 6 look as though that was done, does it?  
 7 **MS RICHARDS:** My Lady, it's not what was done. This was  
 8 part of the CQC's comprehensive inspection process at  
 9 that time. So these were big, set piece inspections  
 10 sometimes for the first time, certainly for the first  
 11 time under the new key lines of inquiry of services  
 12 across the range of an entire hospital, and so there are  
 13 a number of obviously outcomes questions that could be  
 14 asked. The approach, however, was not specifically to  
 15 ask each of those questions unless, of course, there was  
 16 a specific reason to do so, either because of the data  
 17 or because what was being observed by the inspectors  
 18 gave rise to concerns.  
 19 So, my Lady, that's one way in which the  
 20 information could and we say should have been provided  
 21 by some of those at the Countess of Chester Hospital  
 22 during the inspection.  
 23 **LADY JUSTICE THIRLWALL:** I understand very well what's said  
 24 about what they should have done. What I'm just kind of  
 25 interested to tease out --  
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1 **MS RICHARDS:** Yes.

2 **LADY JUSTICE THIRLWALL:** -- is what perhaps the CQC should  
3 have done. But, anyway, in the course of  
4 a comprehensive inspection that sort of question about  
5 neonatal unit wouldn't have been routinely asked.

6 **MS RICHARDS:** It wouldn't have been routinely asked.

7 **LADY JUSTICE THIRLWALL:** I understand.

8 **MS RICHARDS:** My Lady, the second way in which the questions  
9 would have been asked that might have given rise to  
10 relevant answers but didn't are the open questions that  
11 you heard from a number of the witnesses would have been  
12 part and parcel of the inspection process. So at the  
13 end of a meeting, "Is there something further that you  
14 want to say? Are there any specific concerns or  
15 particular concerns that you have?"

16 **LADY JUSTICE THIRLWALL:** Yes, and I've got your evidence  
17 about that, yes.

18 **MS RICHARDS:** My Lady, I'm grateful.  
19 My Lady, I should say -- and you'll have seen this  
20 from quite a lot of the CQC's written evidence -- the  
21 CQC's approach to inspection has changed at various  
22 stages, and one of the changes post-dating the period  
23 with which your Ladyship is concerned is a shift to more  
24 risk-based inspection. So rather than the set piece  
25 comprehensive routine inspections looking across all

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1 deferential to that. It was rightly concerned not to  
2 interfere with or prejudice the police investigation but  
3 that should not have stopped it from considering whether  
4 it needed to carry out its own investigations into  
5 whether there had been regulatory breaches and should  
6 not have stopped it from taking a decision as to whether  
7 a specific enforcement action should be contemplated,  
8 and that's particularly important because, as your  
9 Ladyship knows, there are statutory limits on the CQC's  
10 ability to take enforcement action.

11 You may have picked up, it's in a footnote in our  
12 written submissions, I'm afraid I can't remember which  
13 one, that the CQC has previously approached the  
14 Department of Health and Social Care with a view to  
15 exploring whether there could be an extension of those  
16 time periods which would require statutory amendment,  
17 but that hasn't been done. It is the Commission's  
18 experience that those time limits can be problematic in  
19 complex investigations.

20 **LADY JUSTICE THIRLWALL:** Has there been a response?

21 **MS RICHARDS:** My Lady, I don't know whether there's --  
22 I'm not sure there's been a lack of formal response, but  
23 there was no change made in response to those overtures,  
24 is my understanding.

25 **LADY JUSTICE THIRLWALL:** All right, thank you.

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1 services, CQC has over the following years moved towards  
2 inspections that may be tailored to specific concerns  
3 that have been raised with it or have come to its  
4 attention, and those types of inspections, those  
5 risk-based inspections, may be more bespoke in character  
6 and may, of course, lead to more in-depth investigation  
7 because they have been specifically triggered by the  
8 raising of some form of concern.

9 **LADY JUSTICE THIRLWALL:** Yes. So at the time of the  
10 inspection with which we're concerned, it was about  
11 process but not about actually what was going on unless  
12 the hospital raised it?

13 **MS RICHARDS:** Well, my Lady, I wouldn't say it was not about  
14 what was actually going on but, my Lady, may I come back  
15 to that --

16 **LADY JUSTICE THIRLWALL:** Yes, of course, take your time.

17 **MS RICHARDS:** -- because I am going to deal with that point  
18 in a little while.  
19 So, my Lady, just still dealing with some of the  
20 deficiencies of approach which CQC has accepted.  
21 Following the June 2016 sharing of information, it was  
22 not until May 2017 that the hospital finally told the  
23 Care Quality Commission about the possibility of  
24 criminal conduct and the involvement of the police, and  
25 CQC looking at the position now accepts it was

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1 **MS RICHARDS:** It's not that they were ignored but there  
2 hasn't been a substantive change.

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

4 **MS RICHARDS:** So, my Lady, drawing those threads together,  
5 the Care Quality Commission accepts it should have shown  
6 greater professional curiosity once it was informed of  
7 the increase in deaths and having carried out further  
8 enquiries should have considered enforcement action, and  
9 it wishes to apologise to the Families for those  
10 deficiencies.

11 My Lady, turning then back to the February 2016  
12 inspection, we have, I hope, made clear in our  
13 submissions that at no point before, during and after  
14 the inspection prior to the publication of the report on  
15 29 June did anyone at the hospital, be it manager,  
16 executive, doctor or nurse, tell CQC that there were  
17 concerns regarding deaths on the neonatal unit, and  
18 there were ample opportunities to do so, really from the  
19 period of the engagement meeting on 21 July 2015  
20 onwards.

21 There was a follow-up meeting on 13 October 2015,  
22 again a routine engagement meeting, a pre-inspection  
23 engagement meeting in late November. The data packs  
24 were sent to the hospital in both draft form and final  
25 form prior to the inspection. There was the inspection

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1 itself and the meetings during that process.

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

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

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

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

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

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

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

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

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1 make brief reference to that. What we explain there is  
2 that an inspection visit by its very nature is focused,  
3 intense, it takes place over a fixed and short period.

4 To some extent, it is an inevitable snapshot in time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **MS RICHARDS:** Yes.

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

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

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

4 And, my Lady --

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

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

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

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

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

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

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

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

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

21 **LADY JUSTICE THIRLWALL:** So --

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

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

10 And, my Lady, in considering the reasonableness of  
 11 CQC's approach, I ask the Inquiry to note that CQC  
 12 regulates approximately 36,000 providers across over  
 13 55,000 locations. And if your Ladyship looks at the  
 14 figures in the statement of Lisa Annaly at  
 15 paragraph 5.3, these give the figures for 2023, CQC  
 16 received an average of 50,000 reported incidents per  
 17 week in 2023 and 56,000 reported incidents per week in  
 18 2024.

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

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

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

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

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

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

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

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

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

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

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

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

25 There may, of course, then be information that

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

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

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

20 **MS RICHARDS:** Yes, of course.

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

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

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

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

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

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

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

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

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

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

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

18 And most recently, earlier this year, there were  
 19 three cases concerning three separate infant deaths at  
 20 Nottingham University Hospitals NHS Trust. Those were  
 21 deaths that had taken place over a three-month period in  
 22 2021. That resulted in a prosecution for regulatory  
 23 breaches and the imposition of a £1.6 million fine on  
 24 that particular hospital trust.

25 So enforcement is something of which the CQC is

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

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

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

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

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

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

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

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

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

17 **LADY JUSTICE THIRLWALL:** Yes.

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

23 So, my Lady --

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

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1 Ms Richards.

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

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

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

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

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

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

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

14 **Closing submissions by MS BUTLER-COLE**

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

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

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

4 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

25 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
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1 in the other closing submissions, particularly those of  
2 the Families.

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

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

9 **LADY JUSTICE THIRLWALL:** No.

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

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

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

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

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

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

19 **MS BUTLER-COLE:** Yes.

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

24 **MS BUTLER-COLE:** Yes. Well, you'll probably recall  
25 Mr Newman's evidence. He was the person who took that  
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1 not because the hospital was sharing the information  
2 with it proactively.

3 **LADY JUSTICE THIRLWALL:** Yes, thank you.

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

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

19 **MS BUTLER-COLE:** Yes.

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

23 **MS BUTLER-COLE:** Yes.

24 **LADY JUSTICE THIRLWALL:** -- and that might be one question  
25 that you might ask. And you deal with it, I appreciate,  
95

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

4 **LADY JUSTICE THIRLWALL:** Yes.

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

16 **LADY JUSTICE THIRLWALL:** Yes.

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

21 **LADY JUSTICE THIRLWALL:** Yes.

22 **MS BUTLER-COLE:** And although the NMC did then get further  
23 information from the hospital over the coming months,  
24 usually that was because the NMC was contacting the  
25 hospital, having heard reports in the press and so on,  
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1 over a couple of paragraphs, but I think it comes to the  
2 same thing, doesn't it?

3 **MS BUTLER-COLE:** Yes.

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

7 **MS BUTLER-COLE:** Yes.

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

10 **MS BUTLER-COLE:** Yes, yes.

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

20 In light of those differences of views, the NMC  
21 has amended its guidance on Interim Orders and it now  
22 says that in a case where the allegations against  
23 a nurse or a midwife are of the most serious kind, it  
24 may be possible to obtain an Interim Order even where  
25 there's very little direct evidence available to the  
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1 NMC. That guidance was published about a year ago now.

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

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

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

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

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

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

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

16 **MS BUTLER-COLE:** Yes.

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

21 **MS BUTLER-COLE:** No.

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

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

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

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

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

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

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

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

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

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

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1 it in front of them.

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

7 **MS BUTLER-COLE:** Yes.

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

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

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

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

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1 consideration would have made a difference at that  
2 point.

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

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

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

13 **MS BUTLER-COLE:** Yes.

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

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

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1 in the written statements that were prepared by --

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

3 **MS BUTLER-COLE:** No.

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

6 **MS BUTLER-COLE:** Yes.

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

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

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

18 **MS BUTLER-COLE:** Yes.

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

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

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1 **MS BUTLER-COLE:** Yes.  
 2 **LADY JUSTICE THIRLWALL:** "... the detail of the  
 3 evidence ..."  
 4 And:  
 5 "As explained in paragraph 4 above, the NMC has  
 6 reflected on the events at CoCH and its own processes  
 7 and has identified opportunities to learn and  
 8 improve ..."  
 9 Does that mean mistakes?  
 10 **MS BUTLER-COLE:** I can't see any reason not to say that --  
 11 **LADY JUSTICE THIRLWALL:** "... and some" --  
 12 **MS BUTLER-COLE:** -- something should have been done  
 13 differently.  
 14 **LADY JUSTICE THIRLWALL:** I'm sorry I cut across you:  
 15 "... and some instances where in hindsight we  
 16 could have done things differently."  
 17 It would have been better to say, wouldn't it, "We  
 18 should have done things better" if that's the NMC  
 19 position? Because it's not clear to me whether it is  
 20 actually reflective and accepting --  
 21 **MS BUTLER-COLE:** Yes.  
 22 **LADY JUSTICE THIRLWALL:** -- if things were done --  
 23 **MS BUTLER-COLE:** No, I think my Lady is completely right.  
 24 If one goes back to the written evidence, the wording is  
 25 "should"; that we should have done more to satisfy  
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1 registrants should contact the police if they're  
 2 concerned that someone is harming patients deliberately.  
 3 At the moment the Code says, in Standard 16, that  
 4 registrants must, and this is a quote:  
 5 "Act without delay if you believe that there is  
 6 a risk to patient safety or public protection."  
 7 And Standard 17 says that:  
 8 "[You must] Raise concerns immediately if you  
 9 believe a person is vulnerable or at risk and needs  
 10 extra support and protection."  
 11 If the Inquiry thinks that we need to add to that,  
 12 to the Code, specific reference to circumstances in  
 13 which the police should be contacted, then that again  
 14 can be incorporated into the existing planned review of  
 15 the Code of Conduct. It may be that, given that one of  
 16 the things the Inquiry has looked at so carefully is the  
 17 delineation of responsibility when there are so many  
 18 organisations involved, that whatever the Inquiry says  
 19 about is something that could helpfully be reflected, so  
 20 that everyone is as clear as they possibly can be about  
 21 whose responsibility things are, and that critical  
 22 question of the circumstances in which one should go  
 23 straight to the police, rather than thinking about any  
 24 of the other many organisations that exist.  
 25 **LADY JUSTICE THIRLWALL:** But the current position is that  
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1 ourselves that the hospital was taking appropriate  
 2 steps, for example. So I think that's absolutely right.  
 3 As I say, the written submissions aren't my own  
 4 drafting, but certainly the witness statements do speak  
 5 in the language of "we should have done things  
 6 differently." I'm fairly confident there was no  
 7 intention in these written submissions to try and step  
 8 back from that in any way. I think it's just a question  
 9 of wording.  
 10 **LADY JUSTICE THIRLWALL:** Well, I'm not going to take you  
 11 through any more, it's there, but you very helpfully  
 12 said that it's accepted that there were mistakes made --  
 13 **MS BUTLER-COLE:** Yes.  
 14 **LADY JUSTICE THIRLWALL:** -- and things should have been done  
 15 better or differently.  
 16 **MS BUTLER-COLE:** Absolutely. I think, as was made clear in  
 17 the statements, obviously we can't say for certain what  
 18 would have happened, but it must follow that if we'd  
 19 done those things differently, then different things  
 20 would have happened; and that, for example, includes  
 21 a fitness to practise referral having been made sooner  
 22 and so on. So, yes, we absolutely accept that things  
 23 could have been different from the NMC's involvement.  
 24 One of the other suggestions made is to amend the  
 25 NMC's Code of Conduct to just say expressly that  
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1 that's not going to be part of the standard?  
 2 **MS BUTLER-COLE:** So at the moment Standard 16 really just  
 3 states the sort of core point which is "act without  
 4 delay if you think that there's a risk."  
 5 **LADY JUSTICE THIRLWALL:** Yes.  
 6 **MS BUTLER-COLE:** The Code doesn't give sort of detailed  
 7 guidance about who to contact in which situation.  
 8 I think the proposal is that it be added to to say, not  
 9 just act without delay, if you believe that there's  
 10 a risk, but to say that if you think that there's a risk  
 11 of deliberate harm, then the appropriate people to refer  
 12 that to is the police.  
 13 **LADY JUSTICE THIRLWALL:** Thank you.  
 14 **MS BUTLER-COLE:** My Lady has seen in the various documents  
 15 that there are a number of areas where the NMC's  
 16 policies and guidance and training and so on have been  
 17 strengthened since 2016. One of the areas of concern  
 18 was information-sharing. One of the key developments  
 19 from the NMC's point of view on that front is the  
 20 emerging concerns protocol, which is a document that  
 21 didn't exist at the time. In light of the recent news  
 22 about NHS England, that's going to need to be reviewed  
 23 and updated anyway, but in the written closing  
 24 submissions it's suggested that it's further developed  
 25 in relation to this possibility of deliberate criminal  
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1 activity, which isn't separated out as an issue at the  
2 moment. That will then also need to be cross-referenced  
3 to the memorandum of understanding from December 2024 to  
4 make sure that all of these various documents and  
5 protocols are consistent with each other.

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

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

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

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

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1 (The luncheon adjournment)  
2 (2.00 pm)

3 **LADY JUSTICE THIRLWALL:** Ms Scolding.

4 **Closing submissions by MS SCOLDING**

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

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

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

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

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

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

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

16 **MS BUTLER-COLE:** Thank you.

17 **MS SCOLDING:** My Lady, I am up next but, as it's nearly  
18 1 o'clock, I don't know whether or not it would be more  
19 sensible to start fresh after lunch.

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

22 **MS SCOLDING:** It's 12.53, my Lady.

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

25 (12.53 pm)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **LADY JUSTICE THIRLWALL:** Yes.

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

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

14 Furthermore, the worries of the RCPCH's quality  
15 assurance reviewers should have been conveyed both  
16 within the report and to the hospital. You heard from  
17 both those individuals, both of whom made reference to  
18 concerns about criminal behaviour, one of whom had had  
19 some dealings with the Beverley Allitt case some  
20 30 years previously. This should have been set out in  
21 the review and communicated clearly to the hospital.

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

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

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

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

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

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

23 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

20 **MS SCOLDING:** Yes.

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

23 **MS SCOLDING:** Yes.

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

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1 police.

2 **MS SCOLDING:** Yes.

3 **LADY JUSTICE THIRLWALL:** And Dr Shortland thought the police

4 should have been called. So they all felt that --

5 **MS SCOLDING:** Exactly --

6 **LADY JUSTICE THIRLWALL:** -- at the time.

7 **MS SCOLDING:** -- they all thought that at the time.

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **MS SCOLDING:** So the question really for my Lady and for us

10 as an organisation is: why didn't anybody say that if

11 that was the thought process at the time? And that,

12 I would submit, was a significant error on the part of

13 the review team.

14 Furthermore, the way that the report was written

15 and the nature of the report, therefore, meant it was

16 then used, we suggest, incorrectly, by the senior

17 executive team at the Countess of Chester, as it then

18 was, and the report was not fairly represented in the

19 very many meetings that the Inquiry has seen and

20 discussed.

21 The suggestion being that the report exculpated

22 Letby and/or dismissed the concerns raised by the

23 paediatrician, we would suggest is simply wrong and was

24 not a reasonable conclusion open to them, even given

25 the somewhat opaque nature of some of the

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1 after reflecting upon the CoCH review. It commissioned

2 an independent review in 2020 which identified a number

3 of criticisms, which I have reflected today, and which

4 are reflected in the written submissions that we have

5 made.

6 Following on from this, the RCPCH has remodelled

7 its invited review service. It has identified and

8 overhauled all the processes, and full details of this

9 are set out in the written witness evidence. I'm not

10 going to take you through that but, in summary, there is

11 a much higher degree of due diligence before a review

12 over a much longer period of time, with much greater

13 input from clinicians on the terms of the review and its

14 nature. There are revised handbooks in place. There

15 are more detailed guidance and training to reviewers,

16 and much more oversight from the RCPCH registrar, who is

17 a clinician and a trustee on the board of trustees.

18 There is also something called the invited review

19 programme oversight group -- I'm not going to give you

20 the acronym for it -- which provides operational

21 day-to-day management of the service, comprising both

22 staff and clinicians, including both the clinical lead

23 and the deputy clinical lead for the programme, and the

24 assistant registrar, who is a clinician, and the

25 registrar, who I've identified is also a clinically

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1 recommendations.

2 The failure to provide the unredacted report to

3 the paediatricians, furthermore, is inexplicable. What

4 the RCPCH says that there is no way that the report

5 could be read to say what the board minutes reflect,

6 which is that the allegations against Letby were

7 unsubstantiated and that there were not any immediate

8 concerns.

9 Whilst we understand that Mr Harvey attempted to

10 identify that what was meant by that were CQC immediate

11 concerns, we would suggest that it's for your Ladyship

12 to determine whether or not that is or isn't a credible

13 explanation in all the circumstances.

14 Mr Harvey, furthermore, should have reported the

15 need for formal action in respect of Letby for

16 misconduct to the various internal committees of the

17 hospital and referred matters to the relevant

18 professional bodies, sending the report, we suggest, to

19 NHS England, the CQC and the local neonatal network in

20 its unredacted form and promptly upon its receipt.

21 Mr Harvey did not tell the relevant regulatory

22 bodies of the RCPCH's view that there should be

23 a misconduct investigation in respect of Letby.

24 My Lady, the RCPCH evidence that you have heard,

25 both in written and oral form, sets out the changes made

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1 qualified individual.

2 Furthermore, as Mr Beer noted earlier in his oral

3 submissions, the invited review service has established

4 formal agreements with all four nations' relevant

5 regulatory inspectorate or bodies involved in patient

6 safety and quality improvement, which set out how and

7 when the RCPCH informs each about the invited reviews it

8 has undertaken. As far as we're aware, the

9 Royal College is the only medical Royal College that has

10 these agreements in place.

11 The contract, furthermore, between the

12 Royal College and the organisation commissioning the

13 review includes a specific clause that the RCPCH

14 reserves the right to contact the relevant regulator and

15 has on at least one occasion referred an organisation to

16 the relevant regulatory body following an invited

17 review.

18 Furthermore, in contrast to what happened in 2016,

19 there is a dedicated process for follow-up after

20 a review has concluded and a report has been shared with

21 the service --

22 **LADY JUSTICE THIRLWALL:** And how is that different from what

23 (*unclear*) the last time?

24 **MS SCOLDING:** Well, there is a formal requirement for

25 follow-up and a requirement for the organisation to

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

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

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

25 **MS SCOLDING:** Yes.

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

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

12 **MS SCOLDING:** Yes.

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

15 **MS SCOLDING:** Yes.

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

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

21 **LADY JUSTICE THIRLWALL:** No --

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

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

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

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

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

6 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

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

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

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

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

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

18 Particularly in respect of neonatal care the focus  
 19 upon saving the tiniest and most precious of lives, we  
 20 would suggest, makes people consider that those caring  
 21 for them are benevolent in their intentions. This is  
 22 not the only case where allegations are not believed  
 23 against healthcare professionals. It seems, at least in  
 24 2016, the views of the healthcare staff was that, "It  
 25 could not happen here", rather than, "It could happen

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

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

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

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

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

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

4 The Local Authority Designated Officer, or LADO,  
 5 has been in existence since 2004, but yet nobody knew or  
 6 was aware of either the terminology or of the role.

7 This is obviously somewhat of a surprise to those who  
 8 may have undertaken work in respect of social care or  
 9 education when the role is well known and understood.

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

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

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

4 **LADY JUSTICE THIRLWALL:** When was that work begun?

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

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

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

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

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

5 **LADY JUSTICE THIRLWALL:** With a very high mortality.

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

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

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

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

19 **MS SCOLDING:** Yes.

20 **LADY JUSTICE THIRLWALL:** That was --

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

24 One of the issues is there is often clinical  
25 uncertainty as to the precise reason that this has  
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1 review individuals, both within the hospital and within  
2 the ICB, come together to discuss those cases where  
3 there is a lack of clarity about what should happen.

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

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

13 **MS SCOLDING:** Yes.

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

16 **MS SCOLDING:** Yes.

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

25 **MS SCOLDING:** No.

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

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

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

21 However, obviously this case is a salutary lesson  
22 in what happens when you don't undertake those  
23 processes. So our view would be that there needs to be  
24 some sort of collective process in which the coroner,  
25 the specialist neonatal unit, the relevant child death  
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1 **LADY JUSTICE THIRLWALL:** -- to the possibility of deliberate  
2 harm?

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

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

25 We also agree with the evidence of Dr Garstang

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

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

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

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

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

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

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

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

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1 so.

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

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

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

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

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

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

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

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

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

9 The Royal College has identified clearly that  
 10 there is a lack of focus upon children which has  
 11 resulted in poorer health outcomes for children over the  
 12 past ten years, and that there has been chronic  
 13 underinvestment in paediatric services. There are over  
 14 50,000 children in England who are having to wait more  
 15 than a year for health treatment.

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

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

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

4 There are --

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

8 **MS SCOLDING:** Yes.

9 **LADY JUSTICE THIRLWALL:** -- indicators.

10 **MS SCOLDING:** For children.

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

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

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

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

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

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

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

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1 Board rather than the hospitals --

2 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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1 which obviously we would suggest is self-explanatory.

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

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

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

25 Last but by no means least, we focus upon  
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1 didn't do that.

2 **MS SCOLDING:** No, it didn't.

3 **LADY JUSTICE THIRLWALL:** No, no. Thank you.

4 **MS SCOLDING:** Thank you very much.

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

9 **MR KENNEDY:** My Lady I'm very grateful.

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

13 **Closing submissions by MR KENNEDY**

14 **MR KENNEDY:** Can I at least make a start.

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

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

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

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

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

15 Thank you, my Lady.

16 **LADY JUSTICE THIRLWALL:** Thank you very much, Ms Scolding.

17 Just before you go --

18 **MS SCOLDING:** Yes, of course.

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

23 **MS SCOLDING:** Yes.

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

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

3 **LADY JUSTICE THIRLWALL:** Yes, thank you.

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

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

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

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

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

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

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

6 **LADY JUSTICE THIRLWALL:** Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 The involvement of Letby's family tended to  
16 confound.

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

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

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

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

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

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

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

14 The consistent evidence that you've received in  
15 relation to SUDIC is that it was not normal practice in  
16 2016, whether at the Countess of Chester or elsewhere,  
17 for paediatricians to commence a SUDIC process following  
18 the in-hospital death of a neonate who had not been  
19 home. Whilst that is an objectively unsatisfactory  
20 situation, that appears to be the effect of the evidence  
21 that you have received, and we would suggest that so far  
22 as those who failed to act are concerned, it is  
23 difficult to criticise their actions when they appear to  
24 have been consistent with the normal practice of the  
25 profession. That practice appears to have been

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

8 From March 2016, we accepted that there were  
9 a number of failings in terms of the immediate response  
10 to the concerns about the increase in mortality and the  
11 association with Letby and, secondly, to the  
12 investigation of the paediatricians' concerns in the  
13 periods after the deaths of Children O and P on 23 and  
14 24 June 2016.

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

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

25 As we've indicated in our written submissions, we  
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1 consistent with a reading of the SUDIC guidance in force  
2 at the time when that guidance is read in its entirety.

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

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

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

24 Any guidance should be unambiguous as to the  
25 intention of the underlying process and it is, as we  
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1 explored with Sir Robert Francis KC, unsatisfactory for  
2 there to be a multiplicity of guidance which speaks  
3 with, albeit subtly, different tones and conclusions.  
4 So we suggest and we acknowledge, as my learned friend  
5 Ms Scolding KC has acknowledged, that it is a task  
6 itself and funding is required but we suggest that  
7 a single authoritative and clear source of guidance is  
8 likely to be of greater benefit for practitioners on the  
9 ground.

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

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

24 Now, it may be that the prevailing guidance should  
25 have been rewritten, but as my learned friend Mr Skelton  
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1 an unexpected collapse.

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

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

23 So there is caution required, we suggest, of not  
24 judging the quality of the recording by what was later  
25 revealed about Letby's actions.  
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1 KC identifies on behalf of Families Group 1, the  
2 guidance appears to be and continues to be predicated  
3 upon the requirement for an investment or circumstance  
4 to trigger the report.

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

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

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

22 So, my Lady, his evidence was that if there was  
23 an event -- and he gave the example of a drug error --  
24 then that would trigger a Datix report but if there  
25 wasn't, a Datix report would not be completed simply for  
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1 We also observe that insofar as concerns were  
2 raised about the reporting culture on the unit, they  
3 appear to have arisen after the end of June 2016. There  
4 is reference to them in the Kelly-Millward paper that  
5 was prepared as part of the Silver Command exercise.

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

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

23 Finally, I would just remind you, if I may, of the  
24 evidence that Ruth Millward gave in relation to the  
25 reporting culture. What she told you -- and this was  
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1 page 161 at line 6 of her evidence, so week 8, Day 1 --  
 2 was that the paediatricians were very transparent about  
 3 gaps in care that had happened and they were very clear  
 4 where there was elements of suboptimal care and what  
 5 they planned to do to remedy that in the future.

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

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

11 **LADY JUSTICE THIRLWALL:** This would be a convenient moment.

12 **MR KENNEDY:** That would be a convenient moment.

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

15 (3.19 pm)

(A short break)

17 (3.40 pm)

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

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

25 **MR KENNEDY:** Yes, of course.  
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1 care, as has been implied. It was necessary because of  
 2 what had happened up to that point and, as we see it,  
 3 therefore, the delay in identifying the actions of  
 4 Letby.

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

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

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

23 We've addressed the prevailing approach to  
 24 reporting collapses. The proposition that is advanced  
 25 ignores, in our submission, the fact that all of the  
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1 (Pause).

2 **LADY JUSTICE THIRLWALL:** Please go ahead.

3 **MR KENNEDY:** Thank you.

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

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

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

18 Firstly, it is, we suggest, not correct to say  
 19 that after the end of June 2016 the neonatal unit  
 20 required micromanagement to ensure an adequate standard  
 21 of care. Certainly it is right, it was the subject of  
 22 closer scrutiny and regular reporting to the board.  
 23 You'll recall there were arrangements for regular  
 24 updates on the neonatal unit. But we suggest that that  
 25 was not necessary to ensure an adequate standard of  
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1 deaths were reported on Datix, they were all considered  
 2 by the local network and they were all the subject of  
 3 internal reviews, accepting that others have commented  
 4 on the adequacy or otherwise of those reviews.

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

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

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

23 You'll recall -- and this was page 38, line 4 of  
 24 his evidence -- that his evidence was that he did not  
 25 walk in and see something happening. Rather, when he  
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1 went in he found an endotracheal tube to have been  
2 dislodged and Letby not responding to this.

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

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

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

17 The short point that we make is that the response  
18 of the former execs to the disclosure made on  
19 15 March 2017 is not consistent with the position that  
20 they now seek to advance, namely that it was  
21 a disclosure that would have materially influenced their  
22 thinking and materially altered the way they managed  
23 Letby.

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

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1 Sian Williams who in turn reported to Alison Kelly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 made.

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

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

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

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

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

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

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

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

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

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

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1 directly to the Trust board.  
 2 And, finally, the introduction of a weekly  
 3 learning bulletin that is shared with all doctors,  
 4 nurses and trainees across the Trust.  
 5 Finally, in terms of changes, the Trust has  
 6 appointed, as you will have seen in our closing  
 7 submissions and as set out in Jane Tomkinson's written  
 8 evidence, the Trust has appointed a child death review  
 9 lead. That was a post that did not exist in 2015/2016.  
 10 The Trust requires that all sudden and unexpected deaths  
 11 of babies are managed in accordance with the  
 12 Pan Cheshire SUDIC Guidelines and its own child death  
 13 guideline, which Dr Davis has updated, and you'll recall  
 14 you received a draft of that in one of Dr Brearey's  
 15 supplemental statements.  
 16 As I said earlier, the objective must be, as we  
 17 explored with Sir Robert Francis, uniform national  
 18 processes and guidance.  
 19 There's undoubtedly been progress. Others are far  
 20 better placed to speak to that progress than me. We  
 21 just identify two matters, and in part this is in common  
 22 with NHS England. So we referred in our written closing  
 23 to the Cascade system, which is intended to address, at  
 24 least in part, the need for duplicate reporting, so that  
 25 a death reported to MBRRACE is transmitted on to the

1 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
 2 Mr Kennedy.  
 3 **MR KENNEDY:** Thank you.  
 4 **LADY JUSTICE THIRLWALL:** So we'll rise now and start again  
 5 tomorrow morning at 10 o'clock with submissions from  
 6 Ms Blackwell.

7 (4.08 pm)

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

1 CDOP process.  
 2 And, secondly, the proposal in the closing  
 3 submissions of NHS England for the consolidation of  
 4 child death review and SUDIC. As I said to you, and  
 5 I've said now on a couple of occasions, the Trust would  
 6 support in terms of SUDIC, safeguarding or otherwise,  
 7 any recommendations that ensure simplified, streamlined  
 8 and structured reporting of neonatal deaths.  
 9 My Lady, the Trust clearly wishes that these  
 10 changes had not been necessary. That it has made these  
 11 changes may provide little comfort to the families of  
 12 Letby's victims, but we hope it will provide reassurance  
 13 to those who now use the Countess of Chester Hospital  
 14 and those who will do so in the future.  
 15 So far as the Families are concerned, we hope that  
 16 they will understand that the Trust has learned from the  
 17 events that you have inquired into and I make it clear  
 18 that the Trust is determined to continue learning and  
 19 implement the changes that are necessary.  
 20 My Lady, that is what I have to say orally.  
 21 I just finish, I think, as others have finished,  
 22 by paying tribute to the Families for the dignified way  
 23 that they have conducted themselves in these proceedings  
 24 and to reiterate the apology that I have made on  
 25 a number of occasions in the course of my oral closing.

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