Tuesday, 18 March 2025

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning, everyone.

Apparently there's a problem with the feed to the media room, which is currently being looked at. I'm sorry, I think this is only the second day when we haven't started on time.

What I've suggested is that we're given updates, but I'll come back into the room at 10.15 and we will start then.

So I'm sorry to inconvenience you all.

THE HEARING MANAGER: My Lady, I believe there's an interim solution found if you wish to proceed.

LADY JUSTICE THIRLWALL: So we can --

THE HEARING MANAGER: Yes, I'm told that there's a, albeit interim, solution.

LADY JUSTICE THIRLWALL: Whatever an interim solution is, if it means we can start then let's start.

Ms Blackwell.

Closing submissions by MS BLACKWELL

MS BLACKWELL: My Lady, the senior managers wish to express their deepest condolences to the Families of all the babies who died or suffered a collapse at the Countess of Chester Hospital in 2015 and 2016. They stand by and repeat their contention that it was only ever their

desire to help run a hospital in which all patients were safe, and in all their actions and decisions this was their primary motivation.

Ordinarily, hindsight imposes a clarity where at the time there was simply none for those trying to understand the factors at play. However, as I stand here today, ten years after events began to emerge, there remains an ever-growing concern about what was in fact happening at the NNU demonstrating that the picture has not entirely resolved.

The senior managers hope that through their evidence they have been able to convey that the actions they took were undertaken in good faith. Their aim at all times was to understand what was causing or contributing to the increase in deaths and collapses, and to address any potential cause, to keep patients safe. Honest reflection has enabled them to see, however, that there were things that they got wrong.

It has been difficult for the individuals we represent to read some of the written closing submissions, and difficult to hear the oral closing submissions made on behalf of some of the Core Participants, difficult because of the depth and ferocity of criticism, difficult because the closing submissions reflect what may be hardened positions

adopted well before the start of the evidential hearings, but reflection has brought clarity on what the senior managers got wrong, and so now I turn to address these matters, not in any particular order.

Communication with the Families could and should have been better. The senior managers have explained how they struggled to identify what ought to be shared with families during the period of immense uncertainty about the cause of deaths and collapses. It was never the case that the senior managers had any desire to hide information from the Families and keeping them in the dark. In part, the senior managers feared compounding the grief of the families at a time when they couldn't provide them with solid answers. They recognise in hindsight that this approach was misguided, and for this they offer their sincere apologies to the families.

LADY JUSTICE THIRLWALL: You say that they could have done better --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- but what should they have done?

MS BLACKWELL: They should have been more open, they should have been more candid.

But the tenor of the evidence provided to my Lady by Sir Robert Francis KC is that it's difficult to avoid the tension between being open with families and

potentially prejudicing future investigations or proceedings, and it was this tension with which the senior managers wrestled throughout 2016 and 2017.

They got it wrong, and they're sorry for the hurt and anxiety that this has caused.

I will address later in my submissions the actions and decisions that were take following the escalation of concerns in late June 2016. However, the senior managers would like to make clear from the outset that they accept that the police should have been involved at an earlier stage. Even in the absence of evidence to formally document and clearly explain the concerns, they could have approached the police for advice on the best way forwards.

LADY JUSTICE THIRLWALL: And when do they say that should have happened?

MS BLACKWELL: From the end of June of 2016.

It's worth noting that there was no guidance available on what senior managers should do when faced with allegations of this nature, in circumstances where the concerns were rooted in a gut feeling. The Inquiry will be considering this issue and how the provision of advice in this area can be improved, and the senior managers welcome any recommendations around the creation of guidelines for those finding themselves in a similar

position.

It has been suggested that Mr Chambers actively sought to stall and obstruct the police being called. This is not accepted by him, nor is it supported by the evidence of the other senior managers. Their concern was that they went to the police at the right time when the reason for increased mortality had some clarity around it and could be fully articulated. They wanted to be in a position to assure the police that other factors had been more thoroughly investigated and eliminated as potential explanations. Furthermore, they had been given clear advice from Stephen Cross that calling in the police would have significant consequences for the hospital and, therefore, the Families that it served.

The legitimacy of these concerns was reflected in the evidence of Simon Medland KC (as he then was), as set out at paragraph 9 in our written closing submissions.

It is also accepted by the senior managers that there was a breakdown in the relationship between them and the paediatric consultants towards the end of 2016 and into 2017, and Mr Harvey told my Lady:

"... one of the greatest regrets of my career is the breakdown in the communication between the

paediatricians and the Executives and with me in particular. I recognise how intense and difficult a situation that was. I recognise the strength of feeling they had and the suffering they had associated with the grieving process, and I can fully understand their anger in terms of the perception of the Royal College report because it didn't reflect what they felt and recalled [what] they had reported to the College."

The senior managers were clear in their evidence to the Inquiry that it was not their intention to create or to perpetuate a culture of fear. There was a good relationship in place between the senior managers and consultants prior to the end of June 2016, but this became strained as problems grew.

It is acknowledged that the consultants should have received more pastoral care and that more could and should have been done to support the paediatric consultants who were feeling under immense pressure at the time. Efforts were made to address the breakdown in the relationship as it was always appreciated that patient safety could well be affected by a lack of cohesion between the teams, as acknowledged to my Lady by Dr Gilby, who told the Inquiry that:

"Mr Chambers was very concerned about the

breakdown in the relationship, and he emphasised the need to address that, to fix it, and he had already made some effort to identify a team of people who were professional mediators who might be able to help ..."

The Countess of Chester --

LADY JUSTICE THIRLWALL: So I understand the apology about communication and there should have been more pastoral care for the doctors. What are they talking about there? What's meant?

MS BLACKWELL: Well, in hindsight, the managers accept that the consultants were struggling to get their point across and that perhaps there should have been some sort of process within the hospital, a pastoral process, in order to support them, other professionals to whom they could have spoken and who could have supported them.

LADY JUSTICE THIRLWALL: But that's only with hindsight, is it --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- that they say that? It wasn't clear to them at the time?

MS BLACKWELL: Well, at the time they were struggling to understand the depth of feeling held by the paediatric consultants in the lack of what appeared to be any direct evidence of what they said that they feared.

The Countess of Chester Hospital has submitted in

its written closing document at paragraph 283 that Ms Hodkinson described Mr Chambers' style as one that could be interpreted as intimidating and aggressive. In fact, what she said in evidence to the Inquiry was:

"He was passionate ... he got emotional and I think sometimes those emotions meant that he said things that came across [that way] .... Some people might see it like that ... but I don't think he meant to come across as intimidating."

She also said:

"He couldn't have cared any more about making a difference within the Countess."

And:

"... he was a fantastic Chief Exec."

How the Inquiry seeks to determine this issue has become problematic, we submit, because throughout the course of the evidence Counsel to the Inquiry asked questions of the senior managers on the basis of the written evidence received from the consultants, in particular Dr Brearey and Dr Jayaram, and it appeared to the senior managers, rightly or wrongly, that the Inquiry may have had a narrative which it was determined to follow, rather than seeking the truth from these witnesses.

The consultants were repeatedly described and

presented as experts, and the senior managers as having deliberately ignored their advice. But at paragraph 13 in our written submissions we set out that the senior managers' concern with a line of questioning which accused them of deliberately and knowingly protecting a murderer, which is vociferously denied.

LADY JUSTICE THIRLWALL: Shall we just have a look at that, Ms Blackwell.

MS BLACKWELL: Yes, my Lady.

LADY JUSTICE THIRLWALL: The phrase "harbouring a murderer" that came, I think, and you'll correct me if I've got this wrong but my memory of it is that that was evidence given by Eirian Powell that she had heard Dr McCormack say that in a meeting.

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: So that's that. I think Dr McCormack says he didn't say that he said something different --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- so that's something -- if it matters, it's something I'll have to resolve.

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: So the questions were about that.

MS BLACKWELL: Well, Counsel to the Inquiry had adopted that phrase and suggested to Mr Harvey --

LADY JUSTICE THIRLWALL: We know then she said, in fact, something like "That's what was happening."

MS BLACKWELL: Yes, "That's what you were doing in the hospital."

LADY JUSTICE THIRLWALL: Yes, yes, but, I mean, one just ought to keep a bit of perspective that what matters to me is the answers to the questions --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- not the questions, but I just wanted to be clear that that's what we're talking about.

MS BLACKWELL: It is.

LADY JUSTICE THIRLWALL: Yes, all right. Well, we can move on, then.

MS BLACKWELL: Yes, my Lady.

The senior managers accept that the grievance procedure concerning Letby ought to have been paused whilst investigations concerning the increase in neonatal mortality were ongoing. It is acknowledged that the continuation of this procedure contributed to tension and feelings of mistrust between the paediatric consultants and the senior managers and duly impacted the ability and willingness of staff to raise concerns. The senior managers accept that they could and should have better reflected on how the grievance procedure might have had an impact on those raising concerns about

Letby and the difficult position in which the consultants found themselves.

Mr Harvey is recorded as stating in his interview for Letby's grievance procedure that this "was by far the most difficult situation I have ever had to deal with", which accurately reflects the feelings of the senior managers both then and now. They were attempting to balance a situation whereby the consultants didn't want Letby working on the NNU but they believed that there was no evidence to support the allegations made against her.

LADY JUSTICE THIRLWALL: I'm sorry, so they understood the consultants did not want Lucy Letby on the unit --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- and the reason for that was?

MS BLACKWELL: The reason for that, by the time at which we are talking, which is post-June 2016, because they were concerned that she was deliberately harming babies.

LADY JUSTICE THIRLWALL: Yes, and the evidence for that was the fact of the unexpected, unexplained collapses, the increase in the number of deaths. It's just when you said there's no evidence to support the allegations, I was just wondering where that was coming from.

MS BLACKWELL: No, they believed at the time that there was no evidence because nobody had seen Letby do anything,

the thematic review in May of 2016 had not identified any deliberate harm, although there had been association with Letby raised in the annex to that document. But after the deaths of Child O and Child P, when we suggest for the first time deliberate harm was being suggested by the consultants, the senior managers accept that at that time any grievance procedure brought by Letby should have been paused.

The grievance was ultimately upheld, as my Lady knows, by an independent Chair and, as the Inquiry is aware, it was recommended that the paediatric consultants provide Letby with a letter of apology and engage in mediation, which is not an unusual outcome in the context of a grievance. Mediation is also common, as my Lady will be aware, within NHS organisations where there's been a breakdown in relationships between staff members.

The senior managers have read what other Core Participants have had to say about the suitability of Mr Green in this process, but the choice of his involvement was made in good faith.

The senior managers also acknowledge that safeguarding procedures were not followed, and they should have been in circumstances where concerns were raised about a staff member potentially harming babies.

A common theme throughout the oral evidence in the Inquiry was that concerns about deliberate harm by a staff member were not recognised by anyone as a safeguarding issue per se, including those with safeguarding responsibilities, and in light of this witnesses didn't consider initiating safeguarding procedures.

In addition, as the Inquiry has heard, many clinicians didn't appreciate that the SUDIC system applied to deaths in healthcare settings. We know from the submissions made to your Ladyship yesterday by Mr Sheldon on behalf of the DHSC that that organisation is intending to take forward improvements to the system and our clients support this, of course.

The senior managers endorse a recommendation to clarify and raise awareness of the application of safeguarding procedures in cases where an unspecified allegation of deliberate harm has been made in circumstances and where evidence of wrongdoing may be growing.

The Inquiry has obtained many thousands of documents, received hundreds of witness statements and called live evidence from a significant number of witnesses in order to answer my Lady's Terms of Reference as set by the Secretary of State, and in

consideration of all of this material, we invite my Lady to take account of the following general matters which make up, we say, the whole picture.

First, the context in which the witnesses were operating. The Inquiry must guard against ignoring the full real-world context in which the witnesses were working. It would be all too easy to ignore the fact that the senior managers were responsible for the operation and running of a busy, 600-bed hospital, treating thousands of patients on a daily basis with a staff body of well over 4,000 people. As with many working in a hospital setting, their responsibilities were carried out during lengthy office hours and often in the evenings and weekends.

It is impossible to judge any of these professionals' actions without regard to this. None of the managers, clinicians or nurses called to give evidence had the luxury of time or the wealth of resources available to the Inquiry legal team to inform their decision-making.

The senior managers' responsibilities involved the balancing of differing duties and obligations, including the obvious duty of care to the patients, a duty of care to staff, and duties of care and candour to the patients and parents.

Simon Medland KC (as he then was) recognised this in what he described to my Lady as the duties of care which were "not always aligned".

There is also a wider context which ought to be taken into consideration, we submit. As Jeremy Hunt described to the Inquiry, death and indeed collapse is not unusual in a hospital and he noted that the risk is that death becomes normalised, although he conceded that it is often traumatic for clinicians personally and this may affect their ability to accept that they may have made a mistake.

And on the number of deaths the Inquiry has heard from Professor David Spiegelhalter, who described the neonatal mortality rates at the Countess of Chester Hospital in 2015 and 2016 as being high but not indicative of being an outlier, observing that Blackpool hospital had eight deaths compared to the Countess of Chester's nine.

Second, hindsight bias and exceptionality.

LADY JUSTICE THIRLWALL: But that's part of Dr Spiegelhalter's evidence, isn't it?

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: And he then went on to say, given the number, you would expect an investigation.

MS BLACKWELL: It should have alerted, yes.

LADY JUSTICE THIRLWALL: Yes.

MS BLACKWELL: Second, hindsight bias and exceptionality. Throughout the Inquiry there have been repeated references to the Beverley Allitt case, the suggestion being that as a fact there is always a possibility that a health professional might be causing deliberate harm or even murdering patients and, therefore, this is something that ought to be in the minds of nurses, clinicians, managers, senior managers and board members if there is unexpected or unexplained patient outcome.

When asked about the Beverley Allitt case, Dr Brearey told my Lady that it is one thing to be aware of the case historically and another thinking to be considering that it might be happening on your unit.

The Inquiry has heard that cases such as Beverley Allitt are extremely rare and in virtually all incidents where there is an unexpected or initially unexplained patient outcome, the root cause will lie in the state of care and treatment. The inherent improbability of deliberate harm perhaps explains why there is no published guidance for senior managers or healthcare professionals in what do in this situation.

As Professor Mary Dixon-Woods observed in her evidence to my Lady, the procedures for dealing with these kinds of transgressive unusual incidents have

remained underdeveloped in the NHS and there needs to be clarity in what to do. She also described the common phenomenon of cultural entrapment, which she observed as being "normal behaviour" which can happen anywhere, any time, not necessarily the result of bad people being in management, but, rather, normal people becoming trapped in their first understanding of a situation, not realising that they're stuck in a loop of their first understanding or appreciation of a situation.

Equally, what might appear more obvious over nine years after the final death and after three and a half years of police investigation, a ten-month criminal trial and retrial and the Inquiry's own 18-month investigation was simply not obvious at the time. Hindsight bias may well have unfairly founded much of the criticism of those who were operating in the real-world context of the hospital at the time. It is easy with the benefit of hindsight to identify features of each child's collapse or death which were significant. These were far less obvious, perhaps, in real time, in isolation, in the context of a neonatal unit treating and caring for babies in great need of medical care. The Inquiry must ensure, we submit, that hindsight bias does not permeate into its conclusions and its report.

Similarly, the Inquiry needs to be alert to relying upon sweeping statements not based on fact, an example of which is the evidence of Detective Chief Superintendent Nigel Wenham referred to at paragraph 97 in the written closing submissions of the DHSC who told the Inquiry:

"... a lot of the doctors ... did raise concerns repeatedly and continued to raise those concerns [that] they were shut down, sadly."

Whilst there may be some strength in suggesting that this happened from the end of June 2016, there is no reliable evidence, we submit, my Lady, that these concerns were being raised with the senior managers before this time.

And so I now turn to the contemporaneous evidence of growing concerns in order to address in part the written and oral submissions made by Mr Kennedy KC yesterday on behalf of the Countess of Chester Hospital.

On the timing of disclosure to them of concerns in relation to Letby's actions, the senior managers have been consistent throughout their evidence to the Inquiry. The first time concerns of deliberate harm being caused to the babies on the NNU were articulated followed the death of Child P at the end of June 2016. Prior to that point, it had never been stated starkly to

any member of the senior management staff that there was a concern that a member of staff was deliberately harming babies. If having heard the evidence the Inquiry finds that a clinician or clinicians harboured real concerns that Letby was deliberately harming babies prior to the death of Child P at the end of June of 2016, fundamental questions for your Ladyship to resolve will be: why it was these individuals did not clearly and unambiguously report these concerns either to the police or anyone else; why they did not act on their concerns, given their professional duties and codes of conduct; why relations between senior managers and some clinicians became strained in the latter part of 2016 and 2017 when there had been no previous history of difficulty.

This is touched upon at paragraph 40 of the written closing submissions provided to your Ladyship on behalf of the DHSC and repeated by Mr Sheldon in his oral submissions yesterday:

"... that the evidence received by the Inquiry does not generally suggest that the culture at the [hospital] was poor or unusually bad before this point ... many members of staff praised ... [the] friendly and supportive atmosphere and said that they would have felt comfortable to raise concerns."

Indeed, as the Inquiry is aware, in 2016 the Care Quality Commission produced a favourable inspection report rating the Trust is good and had commented and commended the leadership and managers at the hospital saying:

"There was clear leadership ... Senior Managers were visible, approachable, and staff were supported in the workplace."

It remains unclear from the evidence when such concerns about deliberate harm began to crystallise. When Dr Brearey was asked about this during his evidence, he was not able to identify a point at which he was of the mind that Letby was harming babies telling the Inquiry that he: "was aware of her association from the first three" deaths, after which "it was more of a growing nagging concern than any one seminal moment".

We submit that Dr Brearey's conduct suggests that it was after the death of Child P.

As regards to Dr Jayaram, the picture is far less clear. For example, in relation to the collapse of Child K on 17 February 2016, the notes from the transport team who transferred the child out of the hospital was:

"The baby dislodged the breathing tube."

During his evidence at the first criminal trial he

confirmed that at that time, as he allegedly walked in on Letby standing over Child K's cot failing to assist, the alarm inexplicably failing to go off and noting that the feeding tube had been inexplicably dislodged he had a lot of suspension in his mind.

By the time of the second criminal trial he had concluded that the tube had been deliberately dislodged by Letby, that he had seen and concluded that she had deliberately harmed Child K, but he neither acted on those conclusions nor reported this deliberate harm to anyone, this in spite of having a meeting with Dr Odeka of the Care Quality Commission that very afternoon during its February 2016 inspection. Rather, Dr Jayaram waited after over 12 months, until March 2017, before communicating anything about his assessment at that cot that she had deliberately harmed Child K to the senior managers.

The Inquiry will have to resolve the issue of why it was that Dr Jayaram did not act on what he now says he saw and believed to have happened. It is notable, perhaps, that Dr Jayaram gave evidence before the Coroner at the inquest of Child A in October 2016 and raised no concerns about deliberate harm then either. If he was concerned that Child A had been deliberately harmed, that information should have been explicitly

shared with the Coroner, rather than trying to sort of throw as many breadcrumbs as possible for the Coroner to pick up without explicitly saying what that suspicion was, a failing accepted in his evidence by Dr Jayaram to the Inquiry.

Whilst Dr Jayaram's explanation for his reticence in October of 2016 might be that he had been ignored and bullied by the senior managers, this cannot be suggested in February 2016 when there was no evidence of a breakdown in relations between the clinicians and the senior managers.

The evidence received by the Inquiry is that, prior to the death of Child P, the deaths and collapses were being treated by all, clinicians, nurses, staff, and those senior managers who were made aware of the increase in mortality as matters which were explicable by a combination of issues around care, treatment and the sickness of babies. That is evident, we submit, from the contemporaneous records, including emails, minutes of meetings and reviews, and by what was done by the individuals involved and, of course, what was not done by them.

The Inquiry ought to be guided, so far as possible, by such contemporaneous material, rather than the recollections contained in witness statements of

those Rule 9 responses that were received by the Inquiry up to ten years after the relevant period. There is an overpowering likelihood that, to a greater or lesser extent, these recollections have been tainted by the convictions of Letby.

The wisdom of undertaking such a careful consideration of historical recollections is underlined by the number of witnesses whose evidence has included the qualifying statement of "If I had known then what I know now" on topic of Letby's convictions. Equally, the Inquiry ought to guard against ignoring the apparent reluctance of certain witnesses to give evidence which may be viewed as supporting Letby in an Inquiry whose starting point was her guilt and in relation to which on more than one occasion my Lady made it clear that the role of the Inquiry was not to question these convictions because my Lady was bound by the Terms of Reference.

In addition to which, and despite being pressed by certain parties to postpone the start of the public hearings, concerns about the safety of Letby's convictions were dismissed as noise, and others, including Counsel for the [Families], had insisted that anyone raising concerns ought to be ashamed of themselves.

LADY JUSTICE THIRLWALL: Can I just ask you, Ms Blackwell, the apparent reluctance of certain witnesses, which witnesses do you have in mind? Are you talking the clients that you represent?

MS BLACKWELL: No.

LADY JUSTICE THIRLWALL: So these are different --

MS BLACKWELL: Some of the nursing witnesses, yes.

As my Lady is aware -- and I was coming on to deal with this but will wait --

LADY JUSTICE THIRLWALL: No, take your own time. As long as it's dealt with.

MS BLACKWELL: All right.

LADY JUSTICE THIRLWALL: Yes.

MS BLACKWELL: Thank you, my Lady.

The serious incident panel that was convened after the deaths of Child A, C and D records nothing in respect of any concerns about the deaths being unnatural. Of the six clinicians in attendance only one, Dr Brearey, has subsequently recalled that there was a reference to Letby and of her being present in relation to the deaths. And on this point, in his Rule 9 statement he states that he was not, in his words, "overly concerned ... at that time".

At the conclusion of that Serious Incident Panel it was agreed by all that no further investigation was

required, nor any additional action to be taken, and my Lady will remember that, following that meeting, Ms Kelly sent Dr Brearey an email inviting him to contact her with any further matters he wanted to discuss but he confirmed in his evidence to the Inquiry that he didn't contact her with anything or any concerns.

In August and September, no concerns about deliberate harm being the cause of the death of Child E or the collapses of Child F and Child H were reported by any clinician to the senior managers, and indeed there were other deaths in September on the unit which did not appear on the indictment in relation to Letby about which Dr Brearey was aware, but about which he had no concerns.

Child I died in October. Again, as with the other babies, no concerns in respect of deliberate harm were articulated then. Dr Brearey produced a mortality review for Child I on 31 October, cognisant of the deaths of Children A, C, D and E, which summarises the cause of Child I's death as likely to have been:

"... from abdominal pathology, probably NEC or its complications."

And which then goes on to criticise the movement of Child I from hospital and back again.

This review goes beyond a deferential diagnosis. It asserts a likely cause. If the Inquiry finds that at the time of writing this review Dr Brearey had real concerns that the cause of Child I's death may have been as a result of deliberate harm by Letby, which he appeared to suggest in his oral evidence, then the Inquiry may wish to resolve the question of: why he failed to refer to this in his review; why, as the neonatal lead, he failed to clearly articulate such concerns and, moreover, escalate them.

So when the Countess of Chester Hospital submit, my Lady, that by the end of October 2015 it would have been appropriate to have excluded Letby from the ward pending its own investigations, this is not, we say, a realistic conclusion based upon the contemporaneous evidence which Dr Brearey himself believed and recorded, and it is certainly not, we say, something which can attach to the senior managers who were not on notice of any of these matters.

Between the death of Child I and the thematic review meeting held on 15 February 2016 there were no further deaths. However, there was the collapse of Child J, although not a child in respect of whom Letby was found guilty of attempting to harm.

The fact that the thematic review was convened

involving, amongst others, Dr Brearey, Dr Subhedar and Eirian Powell is perhaps inconsistent with the suggestion that any clinician involved at this stage held the belief that a member of staff was deliberately harming babies. Rather, it suggests that the cause of the rise in mortality was believed to be clinical in nature.

Whilst the recollections of those who attended the meeting differ, they are consistent about the fact that at no stage was it suggested or discussed that these deaths could have been the result of deliberate acts perpetrated by a member of staff.

Dr Subhedar, the external independent participant, did not identify anything untoward about the cases reviewed. He could not recall in his evidence, staffing or a concern about a particular member of staff, being discussed. If that was a belief held by any participant at the meeting, there can be no justification for not clearly and unambiguously communicating this to Dr Subhedar either formally in the meeting or informally outside of the meeting. If such a concern had been raised, it is reasonable to conclude, we submit, that he would have recalled this, and Dr Subhedar told the Inquiry that if Dr Brearey had been concerned that a member of staff was harming babies, he would have

expected him to raise a safeguarding issue at local level. Indeed, at the conclusion of the meeting further steps were agreed which were directed at a clinical or care management cause, namely to do another review of the 12-hour period prior to death or collapse. There was no action in relation to exploring the events being reviewed and the action of any particular staff member.

Whilst it has been asserted by Dr Brearey that he sought an urgent meeting with Mr Harvey on 15 February 2016 following the thematic review meeting, there is no documentary evidence to support this, nor does Mr Harvey recall this, nor would this be in any way consistent with the tenor of subsequent emails from Dr Brearey of which the Inquiry is in possession, nor did Dr Brearey make any attempts to speak to Mr Harvey in person or indeed any other members of the senior management team following the meeting.

On 17 March, as the Inquiry is aware, Eirian Powell emailed Ms Kelly in relation to the thematic review copying in amongst others, Dr Brearey and Dr Jayaram. She included references to "high mortality" and "commonalities" of a particular nurse and doctor.

The evidence to the Inquiry of Mr Harvey and Ms Kelly was that nothing within this email conveyed to

them any sense of urgency. There's nothing within this email that expresses a concern that a member of staff is deliberately harming babies. And all those copied into the email had an opportunity to either write an additional email or clarify the concern. If that was a concern or a belief held by any of the individuals copied into the email, there is no reasonable explanation for failing to communicate further by email, by telephone, or by personal approach.

It is, we submit, particularly striking in light of the evidence given by Dr Jayaram in relation to what he says he witnessed on 17 February in relation to Child K, only nine days after the review meeting, the absence of this urgency is something that influenced and informed the decision-making of Ms Kelly and Mr Harvey.

The thematic review was sent to Ms Kelly on 21 March. Some three weeks passed between the receipt of the report and a follow-up email from Ms Powell asking for Ms Kelly's thoughts. There should have not been such a delay.

But it is notable that there were no emails sent by Dr Brearey or Jayaram in the intervening period, those who have suggested that by this time they entertained concerns about Letby deliberately harming babies, nor did anyone go to Ms Kelly's office or to any

of the senior managers' offices or contact them in anyway. This behaviour, we submit, is not consistent with a belief that there was a murderer on the ward. This is important contextual information which Ms Kelly and Mr Harvey took into consideration when making their decisions.

Nowhere in the thematic review is there a suggestion of a possibility of deliberate harm as an explanation for the increase in mortality rates. Absent such an assertion, the only reasonable interpretation of its contents is that the causes or factors being considered are care-related, not criminal. It indicated a natural cause of death in respect of all the babies, save for Child A. It goes on to identify themes, not causes, which connected some of the deaths, including sudden and unexpected deterioration, but, as my Lady is aware, that as a theme was not included by Dr Brearey until a second iteration of the thematic review was prepared and after suggestions being made to him by Dr Subhedar. The timing of arrests, delayed cord clamping and the use of UVCs are identified as themes.

However, absent is a clear articulation of any concern that a member of staff is harming babies in combination with the actions identified along with the areas to improve practice. This had the inevitable

effect of focusing minds on issues of care. Nobody asked for additional training or supervision of Letby or even removing her from a patient-facing role within the hospital at that time.

If the Inquiry accepts the submissions made at paragraph 62 of the written closing document submitted on behalf of the Countess of Chester Hospital that Dr Brearey's hesitancy in making his concerns more explicit across the Trust as reasonable, then we submit that this excuse cannot extend to him being too coy to raise them with the senior managers at this time. If he had formulated a real concern of deliberate harm, then he should have said so and with clarity. His behaviour suggests that he had not formulated such concerns because on 4 May he sent an email to Ms Kelly and Mr Harvey, and nothing in that email suggests a belief on his part that Letby was deliberately harming babies. This would be completely inconsistent with the statement that he made in the email "Eirian has sensibly put her on day shifts" without any suggestion of Letby requiring supervision or some of the mitigation or indeed being removed from the ward. Accordingly, it was reasonable, we submit, for Ms Kelly to form an impression that this email related to support for Letby and concerns around her welfare. Indeed, Dr Brearey's email suggests that

he anticipated Letby's return to night shifts at some point when he wrote:

"It would be very helpful to meet before she is due to go back upon night shifts. There is some pressure regarding staff numbers with this at the moment."

There is nothing to suggest that at this point in time Dr Brearey had in mind that Letby was murdering and deliberately harming patients.

LADY JUSTICE THIRLWALL: Ms Blackwell, I think a few minutes after that Ms Kelly emailed Karen Rees, didn't she, enclosing that email from Dr Brearey?

MS BLACKWELL: She did.

LADY JUSTICE THIRLWALL: And she says -- well, you know what the email says.

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: Perhaps you can just take us through it.

MS BLACKWELL: Well, the email, my Lady, confirmed that she had identified that Letby was a common feature, that Letby was an association, but not that there was any consideration in her mind because there had been no identification by any of the clinicians that Letby was deliberately harming patients.

LADY JUSTICE THIRLWALL: But she says in terms:

"If there's a staff trend here and we've already changed her shift patterns because of this, then this is potentially very serious!! I'll check the report they send through. I did not notice there was a staff trend!!"

MS BLACKWELL: Yes, but, my Lady, the email --

LADY JUSTICE THIRLWALL: I don't want to take a lot of time on it but it does appear at that point Alison Kelly was concerned about it.

MS BLACKWELL: She was concerned but the concern stretched and extended only to Letby's welfare, because that is the manner in which Dr Brearey had emailed her, concerned about the staffing problems that were caused by taking Letby off night shifts, concerned about the movement of Letby on to day shifts, and in expressing the expectation that she was going back on to night shifts, there was nothing in the way in which he expressed himself either to Eirian Powell or to Ms Kelly to indicate that he had any concern that she was deliberately harming or murdering babies.

LADY JUSTICE THIRLWALL: Thank you.

MS BLACKWELL: At the thematic review meeting on 11 May of 2016 there were a number of possible factors discussed to explain the increase in mortality.

If Dr Brearey held the suspicion at that meeting

that Letby was murdering babies, then the Inquiry may want to ask why he didn't articulate this in the clearest of terms. The issues again being highlighted, as they had been in the written document, related to care and possible competency issues.

There was a follow-up email after the meeting, which my Lady is well aware of, in which Dr Brearey described the meeting as having been helpful. And the Inquiry has not disclosed to any of the Core Participants any emails from any of the recipients of that email, including Dr Jayaram, taking issue with its contents or querying the absence of any action being taken in relation to Letby.

Between that meeting and the death of Child P at the end of June of 2016, there was no further contact from Dr Brearey or any of the clinicians to any member of the senior management team.

LADY JUSTICE THIRLWALL: Just before you continue, Ms Blackwell, in your written submissions -- and I appreciate you're omitting quite a lot for perfectly good reason --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- I'm sure, but just you refer to the meeting on 11 May and the fact that Eirian Powell and Ann Murphy were speaking with emotion about Letby,

and Eirian Powell was reassuring people there were no performance issues regarding Letby. Is it not a reasonable inference for me to draw, and I would like your help about this, that the reason they were doing that was precisely because everyone knew, however it was articulated -- to use your word, however it was "articulated", people understood that Letby was under suspicion?

MS BLACKWELL: With hindsight and looking at the situation now, that might be a conclusion that the Inquiry can draw, but at the time --

LADY JUSTICE THIRLWALL: No, I'm asking about at the time --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- whilst sitting there, why are these people making a defence of Lucy Letby?

MS BLACKWELL: Because they genuinely believed and felt that she was a good nurse. The fact that they are supporting her competency does not necessarily leave us the only alternative the fact that Letby was causing deliberate harm, because it may equally have been the fact, and in our respectful submission this was the tenor of the meeting, that there was simply an unfortunate association of her being on duty. And as my Lady is aware, she was a well-qualified nurse. She was on the ward more often than other nurses because she did

overtime. Those were the sorts of matters that were being discussed, not a determination to even consider at that time that she was deliberately harming babies.

LADY JUSTICE THIRLWALL: Thank you.

MS BLACKWELL: Between the meeting on 11 May and the death of Child P at the end of June, there was no further contact from Dr Brearey or any other clinician with any member of the senior management team, and Dr Brearey in his email to Ms Kelly on 28 June says that there had "been a watchful waiting approach since" the thematic review but now there was a consensus that Letby "should not have any further patient contact".

It is perhaps worthy of note, my Lady, that in the same email Dr Brearey is suggesting that other measures should be employed which, in his words:

"... I think would be helpful [to] include a deep clean and reducing the number of allocated cots on the NNU, at least temporarily ... [to] improve nurse staffing ratios and reduce the risk of infection by [improving] the space around the cots ..."

And so he was in his role as neonatal lead conscious that there were improvements to clinical care that needed to be considered.

And the Inquiry has heard, my Lady, that immediately after the death of Child P in the hot

debrief that was being led by Dr Rackham, Dr Brearey sat next to Letby and told her that he hoped she was going to have a good rest over the weekend. No clinician had ever witnessed her doing anything untoward in relation to a baby or at least not escalated that to any senior manager, and by this time nothing had been identified in respect of any concerning insulin results or rashes or skin discolouration. These undefined concerns about Letby, as I have touched upon, were not shared by the nursing staff, in particular Eirian Powell, who was firmly of the view that she was a good and competent nurse.

The collective view of the senior managers was that a better understanding of what was going on was required and, given how extremely rare acts of deliberate harm by healthcare professionals are, we submit that it was entirely reasonable to approach the undefined concerns raised by the clinicians with an open mind and have regard to all possible explanations, both likely and unlikely.

Many doctors on the NNU were unaware of suspicions of deliberate harm until the end of June 2016, and, as my Lady is aware, a significant number of nurses considered the increase in mortality to be due to natural causes, many having explained in statements to

my Lady that they had no concerns regarding Letby.

It has been suggested, my Lady, that the senior managers were more concerned with protecting their own reputations than ensuring the safety of babies, and it has been suggested by Mr Baker KC on behalf of Family Groups 2 and 3 that there may have been a financial motivation, that is the success of or the flow of funds into the Babygrow Appeal in the decision-making in the aftermath of the deaths of Child O and P. The Inquiry has received no evidence which supports that assertion.

The suggestion that the senior managers were reluctant to act on concerns about Letby for reputational reasons appears to have been prompted by an entry made in the risk register by Karen Townsend in July of 2016, which read:

"... potential damage to reputation of neonatal service and wider Trust due to apparent increased mortality within the neonatal unit ..."

Both Mr Chambers and Mr Harvey gave evidence to my Lady that they could not specifically recall that entry on the risk register. But insofar as reputation was concerned, their only concern, we suggest, was maintaining public confidence that the NNU was safe at that time.

The senior managers have emphatically refuted the

proposition that either their own reputation or that of the Trust was prioritised over safety. This suggestion begs the question, how was knowingly keeping a suspected killer on the neonatal unit likely to enhance the reputation of either the managers or the Trust?

The Inquiry has heard evidence about the internal and external reviews commissioned by Mr Harvey following the meeting with the paediatric consultants to better understand the concerns, and these are summarised in paragraphs 67 to 91 of our written closing submissions. In addition, a decision was taken to downgrade the unit to a level 1, and undertake some internal investigations. If the senior managers had not kept an open mind and had acted instead without question on the allegations made by the consultants that Letby was deliberately harming babies, then there would have been no downgrading of the unit, no internal or external investigations, and this may well have increased the risk of more babies collapsing and/or dying and hampered the search for the truth about what happened.

My Lady, the Inquiry is aware that the RCPCH report was commissioned by Mr Harvey to conduct what was in fact a service review in light of the increase of unexpected incidents. The Terms of Reference requested that the RCPCH consider whether there were any

identifiable common factors or failures that might in part or in whole explain the apparent increase in mortality.

The senior managers respectfully maintain that the commissioning of an independent review was a sensible course of action at that stage. Rightly or wrongly, Mr Harvey's expectation at the time of instruction was that this review would incorporate a Casenote Review and he could not foresee how they could fulfil their belief without doing one. My Lady is also aware that attached to the report was annex 4, which confirmed that medical situations of each of the babies reviewed had been considered by the RCPCH, but there was misunderstanding on both sides as to what could be achieved.

And once it was completed, there was further misunderstanding, in Mr Harvey's mind, as to the identity of those with whom the report could be shared. He was reliant on the expertise of the RCPCH and followed what he understood to be their advice. Notwithstanding that, it is now accepted that the report should have been shared with the paediatric consultants at an earlier stage than transcribed.

LADY JUSTICE THIRLWALL: So when is it accepted it should have been shared?

MS BLACKWELL: It should have been shared when it landed

back with Mr Harvey, because the paediatric consultants had been part of the review. They had provided interviews and additional material for the RCPCH to perform its function.

As to why the RCPCH report was not shared with the Families sooner, Mr Harvey explained in evidence that until a full case review had been completed, he didn't consider that the requirements of the report had been fulfilled, and he explained that he felt uncomfortable sharing the report until he was able to provide a much fuller picture.

It is a matter of deep regret to the senior managers that some parents become aware of the report when it was leaked by others to the press and in some cases were not aware of it until it was raised in other legal proceedings. The senior managers are profoundly sorry that this was how some families came to learn of the report. This should not have been the case.

At the time the report was leaked, the senior managers and others had been in the process of formulating a detailed communication plan to ensure that all parents and other stakeholders were notified of its completion but matters were overtaken.

My Lady is also aware of the circumstances in which the reports of Dr Hawdon and Dr McPartland were

undertaken. The Inquiry has sought to examine whether the commissioning of these external reviews was appropriate or not. Mr Harvey accepts that none of the external reviews were specifically designed to identify deliberate harm, and it is a matter of regret to Mr Harvey and to other senior managers that the police were not contacted sooner. But we submit that it was not unreasonable for the senior managers to have regard to the professional conclusions of those experienced in neonatal matters.

In relation to a number of the indictment babies, as my Lady is aware, there were post-mortems identifying natural causes of death and in relation to many it was determined by the Coroner that no further investigation was necessary.

My Lady is aware of the circumstances in which the senior managers went to the police and the meeting that they had with the Coroner and Assistant Coroner at which it is right to note that the letter from the paediatricians dated 10 February of 2017 was handed over to both Mr Rheinberg and Mr Moore.

It is acknowledged that there's a difference in recollection as to what was discussed at that meeting, but there is no evidence before the Inquiry, we respectfully submit, that the Coroner was deliberately

misled by any of the senior managers. As such, any suggestion is refuted by the senior managers in the strongest terms.

My Lady, the former managers support the initiatives which are now in train to implement learning from the Kark and Messenger reviews, as referenced in the submissions made on behalf of NHS England. They note and welcome the Government's consultation on the regulation of managers and the steps taken in preparation for that consultation.

And the Inquiry called evidence from, amongst others, Professor Judith Smith on the importance of senior managers being adequately supported and trained to properly equip them for the challenges of managing a health organisation, including ensuring an open, positive and safety-focused culture.

The senior managers agree with the submissions made on behalf of NHS England as regards the importance of proper training and support for managers and welcome the steps being taken in this regard.

My Lady, may I now turn to address you on the application to pause proceedings.

LADY JUSTICE THIRLWALL: Yes, of course. Just before you go there, can I just ask you about one section of your submissions, perhaps 63 and 64, which is a criticism of

one of the barristers who was on the Inquiry team in relation to the summary that she gave of the evidence of the nurses. You haven't repeated that.

MS BLACKWELL: No.

LADY JUSTICE THIRLWALL: Can I assume that you no longer rely on it?

MS BLACKWELL: My Lady, I had sought to deal with that when I addressed my Lady in terms of the nurses who had in their witness statements offered support for Letby and said that they had no concerns about her. The point being made in those paragraphs was that that level of support was not included in the summary that was read out to my Lady.

LADY JUSTICE THIRLWALL: I think you might want to revisit that. I can't immediately find my reference to it but I'm pretty confident that it was made clear that a number of nurses supported Lucy Letby and said positive things about her, that was said in the summary, and then every statement was uploaded on to the website --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- so that everyone could see what was said. It just seemed rather unfortunate that half of the summary was omitted and no reference to the fact that all the witness statements had been put on to the

website.
MS BLACKWELL: Of course, it's quite so that the witness statements were uploaded to the system.
LADY JUSTICE THIRLWALL: Yes, so there was no misleading of anybody about anything that the nurses had had to say; is that right?
MS BLACKWELL: Yes.
LADY JUSTICE THIRLWALL: Yes, thank you.
Now to the application --
MS BLACKWELL: Yes.
LADY JUSTICE THIRLWALL: -- or to the letter.
MS BLACKWELL: Yes.
My Lady, the senior managers wrote to the Secretary of State for Health and Social Care and to your Ladyship on 21 February of this year requesting that the Inquiry either be suspended under section 13 or paused under section 17.
My Lady, section 13 of the Inquiries Act of 2005 provides the Minister with a power to suspend the Inquiry at any time if it appears to him to be necessary to allow the completion of any investigation relating to any of the matters to which the Inquiry relates or the determination of criminal proceedings arising out of any of those matters.
Sub-paragraph (2) confirms that the power may be

exercised whether or not the investigation or proceedings have begun, and subsection (3) confirms that before exercising that power, the Minister must consult the Chair.
Section 17 of the Act --
LADY JUSTICE THIRLWALL: And you've written to the Minister as well, haven't you?
MS BLACKWELL: Yes, we have, yes.
LADY JUSTICE THIRLWALL: Yes. So section 17.
MS BLACKWELL: Section 17 deals with the duty of the Chair in relation to the Inquiry's evidence and procedure, and confirms that:
"... the procedure and conduct of an inquiry are to be such as the [Chair] of the Inquiry may direct."
And in relation to subsection (3):
"... as to the procedure or conduct of an inquiry, the [Chair] must act with fairness and with regard also to the need to avoid any unnecessary cost ..."
Section 43 of the Act provides definitions in relation to some of the words used within the course of the Act. It offers no further explanation or assistance in relation to procedure or conduct, and so it is our respectful submission that those two words should have their ordinary meaning applied.
The "procedure", then, is the way or particular

way in which the Inquiry accomplishes its aims, fulfils its Terms of Reference.
And "conduct" is the manner in which the Inquiry is managed.
As my Lady is well aware, the Terms of Reference have as its introduction the convictions and sentence of Letby and confirms that the offences took place at the Countess of Chester Hospitals. Those are, therefore, we respectfully submit, the bedrock, the foundation of the Terms of Reference.
The Terms of Reference are then split into three areas of investigation (a) the experiences of the parents at the Countess of Chester Hospital of the babies named on the indictment, (c) the effectiveness of NHS management and governance structures and keeping babies safe, and (b) the conduct of those working at the hospital with regard to the actions of Letby in terms of whether suspicion should have been raised earlier, the responses to concerns raised and whether the Trusts culture, management and governance structures and processes contributed to the failure to protect babies from Letby.
But the Terms of Reference go on and confirm that the Inquiry will in operate within the legal framework of the Inquiries Act, that the procedure and conduct of

the Inquiry will be conducted by the Inquiry Chair, therefore echoing what it is in section 17, that the Terms of Reference are decided by the Secretary of State, that the order in which the issues are to be considered at the time that the Terms of Reference were drafted had not been decided but the priority was to conduct a thorough inquiry as swiftly as possible.
And the final paragraph of the Terms of Reference confirmed that the Inquiry Chair will provide a final report and, if appropriate, interim reports to the Secretary of State as soon as is practically possible. When that is practically possible it proves to be a matter for the Chair in her conduct of the procedure and conduct of the Inquiry.
The request for the suspension under the power of section 13 or the pause under my Lady's duty of section 17 --
LADY JUSTICE THIRLWALL: Which is it so far as I'm concerned?
MS BLACKWELL: -- so far as you're concerned, my Lady, the pause is under section 17, the duty to act with fairness and to avoid unnecessary cost -- was made pending the outcome of the CCRC's consideration of an application made by Letby in respect of her criminal convictions.
We understood at the time of writing from what had

been publicly stated and has now been confirmed in the letter received by the Inquiry yesterday from Ms Mortimer at Bhandal Law, Letby's solicitors, that the application relates to all of her convictions and it was received by the CCRC on 3 February of this year.

The CCRC has begun working in assessing the application and it anticipates further submissions being supported by further experts' reports, which we know from Ms Mortimer's letters are in the process of being provided.

The CCRC has set up a team to consider the case. So this is not a case of waiting in a queue for consideration. It is actively being considered.

A meeting has been set up between Letby's defence team and the allocated commissioner to talk through what is described as being a large authoritative body of new clinical evidence, and although the CCRC is not able to determine how long it will take to review the application, the balance of which we understand will be submitted this week, it is assessed by Letby's solicitors that it is being undertaken expeditiously.

We submitted in our letter that in relation to your Ladyship, section 17(3) provides the opportunity, should your Ladyship deem it appropriate, to pause the procedure and conduct if my Lady is concerned that to

carry on at this point may lead to unfairness or the expenditure of unnecessary costs.

It is understood that the application touches upon many aspects of new evidence, including evidence as to the causes of deaths and collapses, together with complaints of disclosure around the original trial, part of which is supported by the opinion evidence of an international panel of independent experts who, it appears, have considered the evidence presented at Letby's trial. These experts are distinguished and recognised leaders in their field, and include Neena Modi, professor of neonatal medicine at Imperial College, a past President of the RCPCH and the BMA and the current President of the UK Medical Women's Federation who was served with two Rule 9 requests by my Lady's Inquiry legal team and has provided two witness statements to the Inquiry.

This evidence suggests that there is an alternative explanation for all of the deaths and unexplained collapses, namely poor clinical management and care and natural causes. And we also now understand that several of these experts have confirmed their determination to give evidence at the Court of Appeal and at any retrial should that become necessary.

LADY JUSTICE THIRLWALL: Sorry, seven of the experts on the

panel --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- have said --

MS BLACKWELL: That they are prepared and ready to give evidence at the Court of Appeal and, if necessary, at any retrial.

At face value, the new evidence merits and is, therefore, being given serious consideration by the CCRC. However, it is for the CCRC alone to assess the evidence, and it would be wholly inappropriate either for the Inquiry or Core Participants to seek to usurp the function of the CCRC in that regard.

But where there is a real possibility, my Lady, that Letby's convictions may be referred by the CCRC to the Court of Appeal and there quashed, to ignore this procedure which is now in process, we say, would potentially lead to an unfairness. The convictions of Letby are the very cornerstone of this Inquiry.

LADY JUSTICE THIRLWALL: So what would the unfairness --

MS BLACKWELL: Well, my Lady.

LADY JUSTICE THIRLWALL: -- the potential unfairness --

MS BLACKWELL: Yes, potential unfairness. When one looks at paragraph (b) or Part B of the Terms of Reference, the Inquiry is duty-bound to investigate the conduct of those working at the hospital with regard to the actions

of Letby, so the midwives, the nurses, the doctors, the managers, the senior managers.

Where there are -- as we say there has to be accepted now, given the stage that the CCRC are at -- real concerns over the fact that Letby has been wrongly convicted, then for the Inquiry to progress any further in assessing the actions of those midwives, those nurses, those managers and those senior managers is potentially unfair to them, as witnesses to the Inquiry, as people whose conduct will be criticised in terms of their handling of Letby.

If the Inquiry is determined to continue to its conclusion, considering the closing submissions which have been provided over the course of the last two days, engaging in what may well be a protracted and costly warning letter process and drafting its report, it will currently do so in the absence of considering these alternative hypotheses that are now being raised, and in doing so it may be disregarding serious issues that have been identified in the provision of care at the Countess of Chester Hospital.

It defeats the very purpose of this public inquiry, which must be to fully and fearlessly understand the circumstances in which these babies came to die or suffer unexplained consequences and the

reaction of those around the events when they were happening. If there is evidence to indicate that there are alternative explanations, then it is wrong, we respectfully submit, for the Inquiry to ignore this because it is inconvenient.

It seems to us, my Lady, that there are several choices for the Inquiry from today.

Firstly, to carry on with its business and to refuse this application.

Second, to pause or suspend the Inquiry until the decision of the CCRC is made --

LADY JUSTICE THIRLWALL: Can I just ask you at some point to come back to whether I have the power to suspend. I think at least two other Core Participants have said I don't.

MS BLACKWELL: No, I agree with that, my Lady. There is no power to suspend within the Act.

LADY JUSTICE THIRLWALL: Yes.

MS BLACKWELL: But this application is made on the basis that there is a duty for you to pause if continuing would lead to either unfairness or an expenditure of costs.

Of course, if my Lady is not with us on that, then we would nevertheless invite my Lady to consult with the Secretary of State, as he is duty-bound to do with the

Chair of the Inquiry, and to pass on any concerns that my Lady has about the continuing of the Inquiry following on from the submissions today.

So, in other words, if my Lady isn't persuaded that you have the power to pause, nevertheless the submissions which we make are capable of being passed on to the Secretary of State through the Chair, because he has a duty to consult with you before he considers whether to suspend.

LADY JUSTICE THIRLWALL: Yes. Well, you've written to the Secretary of State --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- and if he is considering suspending, then he obviously will have to consult with me.

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: But I think what you're suggesting is something rather different, which is that if I don't think that I should pause, I should nonetheless tell him what I think.

MS BLACKWELL: If you have concerns that to continue would lead to unfairness --

LADY JUSTICE THIRLWALL: Oh, I see.

MS BLACKWELL: -- or to an expenditure of unnecessary costs.

LADY JUSTICE THIRLWALL: So if otherwise I would pause if

I had the power to do so --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- then I should pass that on to the Secretary of State.

MS BLACKWELL: Quite so.

LADY JUSTICE THIRLWALL: I follow. Thank you.

MS BLACKWELL: The option which I was going to turn to, my Lady, is a hybrid position, which would be pending the consideration of Ms Letby's appeal by the CCRC to proceed only in respect of the parts of the Terms of Reference which are not conditional on Letby's convictions or could be completed without reference to Letby's convictions. Whilst appreciating that this would not be without challenge, it seems to us that progress might be made in relation to Parts A and C of the Terms of Reference, which focus in turn on the experiences of the parents of the babies named in the indictment, Part A, and the effectiveness of the NHS management and governance structures and of the NHS culture, Part C.

It is not unusual for a public inquiry to publish interim reports and, as we have established, my Lady, your Terms of Reference anticipate that an interim report or reports might be appropriate. And it is our respectful submission that interim reports could be

published in relation to these two parts of the Terms of Reference, including recommendations for change and improvement, so that those may be implemented as soon as practicable.

At that stage, or by that stage, the Inquiry may very well be in a position to know what the outcome of the CCRC process has been, and if the decision of the CCRC is to refer Letby's convictions back to the Court of Appeal, then the appeal process would be fully reinstated and the Inquiry would have to consider and the Secretary of State would have to consider how that issue might impact on future events.

My Lady, the senior managers have been accused by some of attempting opportunistically to suspend the Inquiry's work. This is not the case. A consideration of the alternatives to murder and the extent to which the senior managers may well be held responsible for poor clinical care and the state of the NNU demonstrates that this would not necessarily exonerate them. On any view, there were significant issues affecting the Countess of Chester Hospital at the relevant time which led to the deaths of babies on the neonatal unit, which should not have happened. If Letby's conviction are ultimately quashed, questions will, of course, remain for the senior managers, but these questions will then

be based on a wholly different factual scenario, so there is no attempt here at an evasion of accountability.

My Lady made reference at the outset of these closing submissions yesterday to the letters that have also been written to my Lady from Sir David Davis MP and now also from Letby's legal team, and it stands to reason that those requests for the Inquiry to pause have been done entirely independently of the senior managers.

To do nothing, we respectfully submit, leaves the Inquiry in danger of being seen as ignoring the reality of what is happening outside of its doors, thereby ignoring the risk that the Terms of Reference for this Inquiry might unravel. We considered that it was better to raise these matters and ventilate them before my Lady in order for the Inquiry to make an active decision about this, rather than simply carry on regardless.

It may be that the Inquiry considers that the action point will arise and will only arise when the CCRC refers the case back to the Court of Appeal.

Mr Kennedy KC on behalf of the Countess of Chester Hospital in his oral submissions to my Lady yesterday did not confirm the position of the Countess of Chester Hospital that was set out in their written document if the CCRC does refer Letby's convictions back to the

Court of Appeal. In the written document, they submitted to my Lady that, at that stage, the Countess of Chester Hospital may wish to revisit its stance on supporting a pause of proceedings, but we hope that our submissions will be borne in mind, my Lady, as matters progress onwards from today. This is, of course, the final opportunity for Core Participants to make submissions on this issue, which it seems to us is an ever-evolving picture.

If this Inquiry is a search for the truth, then, my Lady, there is now, it seems, evidence being provided to the CCRC that the causes of death may be different, that the juries in the Crown Court proceedings may have been presented with a misleading and incomplete picture, and this Inquiry should consider carefully, we respectfully submit, before producing a report based upon the bedrock of Letby's convictions.

Whilst the awaited decision of the CCRC cannot be predicted in time or decision, the increasing concern expressed by world-class experts that the prosecution case was based on medical misunderstandings and poor expert evidence and other concerns raised that evidence was withheld from the jury are in real danger of dissolving that bedrock into a beach of shifting sands.

My Lady, those are our submissions unless I --

LADY JUSTICE THIRLWALL: Do you want to say anything else about cost?

MS BLACKWELL: Yes. I have addressed my Lady about the ongoing cost of --

LADY JUSTICE THIRLWALL: Yes, because effectively the hard yards have been done and the costs --

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: -- have been spent.

MS BLACKWELL: That's right, but --

LADY JUSTICE THIRLWALL: The hard yards for everybody else. I am not saying --

MS BLACKWELL: Quite so.

LADY JUSTICE THIRLWALL: -- there aren't some more to come.

MS BLACKWELL: Yes. There is still work, of course, for my Lady's Inquiry legal team to complete. The warning letter process, which I've referred to as being protracted and possibly costly, we don't know, but also the drafting of the report and the costs that are incurred in that procedure too.

LADY JUSTICE THIRLWALL: But I infer from what you're saying that one could do A and C and the cost argument would not prevail but B we shouldn't do because --

MS BLACKWELL: Significant --

LADY JUSTICE THIRLWALL: -- it's the fairness argument.

MS BLACKWELL: Yes.

LADY JUSTICE THIRLWALL: Yes, all right.

Thank you. We'll take the break now and we'll start again at quarter to 12.

(11.21 am)

(A short break)

(11.44 am)

LADY JUSTICE THIRLWALL: Mr Skelton.

Closing submissions by MR SKELTON

MR SKELTON: My Lady, I represent the Families of Children A, B, I, L, M, N, and Q.

It's the Families' primary position that when concerns arise that a healthcare professional may have deliberately harmed a patient, immediate steps must be taken to prioritise and protect the safety of patients. For obvious reasons, that response becomes evermore pressing and necessary where the harm in question is murder.

It does not require a sophisticated risk assessment to tell you that if there is even the remotest possibility that a murder has been committed in a hospital and there is a risk that further murders may occur, the gravity of that harm is such that urgent intervention is required to protect other patients and to identify and stop the culprit.

This is not a mandate for alarmism or

overreaction. Rather, it is the rational exercise of common sense and basic moral duty, two of the axioms of medical professionalism, for which no policy, no guidance and no training should be necessary.

But there are in any event, my Lady, policies and procedures that do tell healthcare professionals what they must do in such circumstances, and in 2015 and 2016 the most important of these related to safeguarding, which mandated that when a doctor, nurse, manager or anyone else in a hospital was concerned that a child may have been harmed, they were obliged to proactively refer that concern to their organisation's safeguarding team, to the local authority designated officer, the LADO, and to the local authority safeguarding board.

The principles that underpin these obligations were set out in the clearest terms in the 2015 policy "Working together to safeguard children", most obviously the needs of children are paramount. Everyone has responsibility for safeguarding, and nothing can stand in the way of sharing information and taking steps that will protect the safety of children.

My Lady, as the Families have set out in their written closing statement, the foremost and the gravest failure by the medical, nursing, managerial and executive staff at the Countess of Chester is,

therefore, that they did not notify the police, initiate safeguarding procedures and remove Letby from the neonatal unit when they first became concerned or aware of others' concerns that she may have killed babies.

Between 8 and 22 June 2015, three babies died in quick succession in the NNU, Child A, Child C and Child D. None of these children had been expected to die and staff on the unit were rightly concerned that there may have been some common cause between the deaths.

At the time of Child D's death, Dr Brearey, the lead neonatal consultant, and Eirian Powell, the unit's manager and a senior nurse, had already identified that Letby was present for all three deaths. In their oral evidence to this Inquiry, Dr Brearey said that by the time he met Ms Powell to discuss the three deaths on 2 July 2015, he had a concern that someone might be harming babies. Ms Powell said that when she discussed the possibility that a member of staff had harmed the babies with her nursing colleagues, this was just after June 2015, and then, as she put it, "all the time", and those colleagues were Yvonne Griffiths, Yvonne Farmer and Ann Murphy.

So the possibility of murder and the possibility that Letby was the murderer were already being

considered and discussed at the Countess of Chester Hospital from July 2015 onwards.

Given the seriousness of the potential conduct and harm and the risk that it could reoccur, it is, therefore, extraordinary that these two senior healthcare professionals and those to whom they spoke did not exercise common sense and recognise their moral duty was to protect their patients. They should have notified the police, initiating safeguarding procedures and remove Letby from the unit. These were the only safe and rational steps to take unless and until Letby had been conclusively ruled out as the cause of the baby's deaths.

Having heard the evidence from Dr Brearey and Ms Powell, the families are disappointed that the hospital has not conceded these important early findings in its closing statements to you.

My Lady, you've heard many witnesses give various reasons why they didn't take the basic steps that I've outlined. Some of these have interlocking themes.

First, the consultants who first became concerned about Letby initially doubted their own judgment and didn't at that early stage consider they had enough information to be sure that she had attacked children. They may have even hoped that other information would

come to light that would provide alternative non-criminal explanations for what had occurred, but they were all experts in the health and treatment of sick babies, and individually and collectively they all recognised that there were common themes that raised at least the possibility of deliberate harm and made it impossible for them to rule it out.

These factors are now very familiar to you, the babies' collapses and deaths occurred suddenly and unexpectedly, they didn't respond as expected to emergency resuscitation efforts, medical causes of death were not identifiable, or were unclear, and Letby was the one member of staff who was always there.

Second, the consultants themselves and those they spoke to had professional and cultural values that made the possibility of murders and more so multiple murders difficult to accept.

It is extremely rare for healthcare professionals to murder patients and so far outside the experience and response skill set of the vast majority of doctors, nurses and hospital managers. Such murders are also an anathema to a system and culture that is devoted to improving lives by the provision of high-quality medical care.

As Professor Mary Dixon-Woods explained early on

in this Inquiry, it can be very difficult for healthcare professionals to accept that transgressive conduct has occurred on the part of a colleague, particularly where that conduct is extreme. To do so runs contrary to human and organisational sense-making, and cultural entrapment can occur when positions become embedded and overlaid with denial, defensiveness and the inability to accept challenge, as was seen amongst Letby's supporters at the time and can still be seen today.

Doctors and nurses in acute care also work very closely and intensely in small teams, which gives rise to powerful relationships and loyalties and *esprit de corps* that is necessary for effective work but which may make it even harder to comprehend such conduct.

Third, it was obvious that a draconian and unpleasant step for senior managers to take would be to impugn the integrity of a competent junior colleague with whom they worked intensely in a team for several years. While worrying they were wrong, they would also have been anxious that Letby's forcible removal from the unit would have a negative impact on her emotional state and her mental health, and would potentially damage her future career if their concerns proved to be permission placed. There are obviously associated concerns in some quarters that Letby could

bring a legal claim for constructive dismissal, with all the associated negative consequences and costs.

There would also have been a concern that her removal could have compromised the effective delivery of care in the unit by damaging strong relationships between staff, and sowing worry, insecurity and gossip and distraction.

And, of course, there was a misplaced worry, planted and exploited by Stephen Cross, the director of corporate and legal services, that the unit would become a police crime scene, unable to operate and forced to reject its patients.

Finally, one of the most significant concerns on the part of those raising the concerns or suspicions in 2015 and 2016 was that they would find themselves criticised, ostracised and censured as a result. This could have been by way of accusations by colleagues and managers that they were wrong and were scapegoating and victimising Letby. It could also have been by way of formal counter-accusations that the facts were being misrepresented, that Letby was being bullied and that medical staff were covering up their own substandard care, with possibility that these matters could have escalated to disciplinary proceedings internally at the hospital, or externally at the GMC and NMC.

In the worst-case scenario, this could have led to a loss of jobs or even careers, or at least a fear that that might take place, and these concerns proved to be borne out by the treatment of the consultants by senior nursing managers and the executives in and after 2016.

Therefore, my Lady, to a degree it is understandable that each of these four broad factors arose and inhibited the thinking and actions of the consultants and lower level managers, but the critical question is whether in the circumstances that presented in 2015 and 2016 they justified not calling the police, not initiating safeguard and not removing Letby. The answer, my Lady, without equivocation is no. As I have said common sense and moral courage were required. It should have been recognised that the safety of vulnerable child patients was the paramount and only operative concern, and that while there was a risk that harm could recur, steps needed to be taken to protect patients.

Excuse me.

In other words, there was categorically not, as Tony Chambers the former chief executive has sought to argue, a balance to be struck between competing duties to patients and duties to staff at the hospital. It was and should have been obvious that the possibility of

murder and the risk of recurrence outweighed all other considerations.

My Lady, the failure on the part of the consultants and unit managers to contact the police and initiate safeguarding processes and remove Letby in and after July 2015 became more acute and chronic and indefensible as time went on and more babies were harmed and died.

The full narrative of specific failings is set out in the written statements of the Families I represent and in compelling detail in the submissions put in by Families Group 2 and 3. I cannot do justice to it today but there are five obvious events where clear-headed intervention was also needed.

In August 2015, Child F's grossly abnormal blood results were indicative of a substantial and deliberate overdose of insulin but were wrongly dismissed by Dr ZA as "fantastical" without discussion with the wider medical team. This was a grave error.

It was also a serious collective failure, as Dr John Gibbs, a fellow consultant and the former paediatric clinical director, accepted.

In October 2015 you've heard that Child I's repeated collapses and eventual death led to a significant increase in the level of suspicion on the

part of the consultants, individually and collectively, that Letby was killing babies, leading to the repeated discussions between them, but again nothing was done.

This is now accepted by the hospital as being a critical inflection point that should have led to robust intervention. As I have stated, the Families' position remains that this should have occurred several months earlier.

In February 2016, Child K was found by Dr Jayaram with a dislodged endotracheal tube, deteriorating while Letby stood by doing nothing. He accepted that this was not communicated to anyone at the time and should have resulted in a Datix report. But given the seriousness of his own concerns by this stage, those concerns that he was already harbouring about Letby, which prompted him to go back and check the baby at the time, you may find it extraordinary that he did not recognise that she had tried to kill the child and take the necessary action.

In April 2016, Child L's grossly abnormal blood results which, like Child F's results in August, indicated deliberate insulin overdose were also overlooked by the medical team. Again, this failure was accepted by Dr Gibbs.

Lastly, in June 2016, even after the deaths of

Child O and Child P, when the consultants finally insisted that Letby be removed from the unit to protect other babies, neither they nor anyone else contacted the police or started the safeguarding process. Many witnesses, even the executives, accept that this should have been done.

My Lady, the second major criticism of the consultants and NNU managers is that they failed to investigate the deaths and collapses of babies on the unit using the applicable systems, sudden unexpected death in infancy and childhood, SUDIC, serious incident investigations and Datix.

The Families have also included detailed analysis of these systems in their written statements, so again I will only focus on the key points.

The medical, nursing and managerial staff were right to want to identify any common themes within and between the cluster of deaths and collapses that occurred on the neonatal unit. Where they fell into error was given precedence to and pursuing their own investigations, which were insufficiently comprehensive and robust. The standard processes for reporting and investigating sudden deaths and collapses should have run in parallel to and have been co-ordinated with the police and safeguarding investigations that I've already

outlined.

SUDIC is the national system for investigating sudden and unexpected child deaths. In accordance with the policies applicable at the time, the obligation to conduct a Joint Agency Response applied as much to deaths in hospital as it did to deaths in the community, so individuals who should have been triggered after the deaths of Child A, C, D in June 2015 and thereafter Child E, Child I, Child O and Child P.

But the evidence indicates that the staff at the hospital didn't review view it in that way, and several witnesses have explained that they were not alone in doing so. This is lamentable, because it is precisely these types of death, unusual deaths, that may be caused by deliberate harm that may be difficult to detect that the SUDIC system is designed for. It is also indicative of a failure of national governance for which NHS England, not the hospital, is ultimately responsible.

The hospital staff did, however, fail to use the serious incident investigation procedure appropriately. According to the applicable framework at the time, serious incidents were events in healthcare where the potential for learning is so great or the consequences to patients, families and carers, staff of organisations

are so significant that they warrant using additional resources to mount a comprehensive response.

Serious incidents can be isolated single events or multiple, linked or unlinked events signalling systemic failures.

As I have stated, by the end of June 2015, there had been a cluster of unexplained and unexpected deaths on the unit. There was also a concern that these deaths were linked by some systemic or common cause, and the registrars and consultants had raised the concern that unusual rashes had been seen on Child A, Child B and Child D. The consultants failed to recognise that these factors warranted a joined-up investigation to find the causes for the sudden increase in deaths and to ensure that they identified any common causes.

This failure is accepted by Ruth Millward in her written statement to this Inquiry. It should have been conceded by the hospital in its closing statements.

Finally and briefly, insufficient professional curiosity was paid to the subsequent unexpected collapses of babies that occurred after that of Baby B.

In May 2016, Dr Brearey asked that these types of collapse be reported to him and Ms Powell but this request was too late and too weak. Instead of encouraging an improvised and arbitrary reporting

system, the senior doctors and managers should have ensured from the start that all such deteriorations were reported using the Datix system. This was designed to capture such information for the purposes of identifying and managing risks. The build-up of information on Datix would have proved more and more valuable as time went on.

My Lady, the third criticism of the consultants and the neonatal unit managers is that they failed for many months to escalate the consultants' concerns and growing suspicions to the hospital's executives or to any of their internal governance committees in the clearest and most urgent terms.

It is a remarkable feature of the contemporaneous documents, including the 2016 thematic review and associated emails, that the true and awful nature of the consultants' suspicions about Letby were never articulated properly. Phrases like "deliberate harm" and words like "murder" are never mentioned, nor do they appear to have been uttered during many of the informal and formal meetings that took place in the weeks around July 2015. Instead, for many weeks, concerns were not communicated at all or not communicated explicitly. It was left to the recipients to work out what was meant by "staffing issues", or for managers and executives to

deduce that it was suspicious that Letby, who was generally thought of to be a competent nurse, was nevertheless associated with many unexplained deaths.

I've already sought to explain why it was that the consultants were unable to voice their concerns and suspicions, but these explanations cannot stand as excuses, given the seriousness of the situation they were presented with. Dr Brearey rightly recognised this in his oral evidence.

Likewise, they do not excuse the executives' failure to intervene decisively. It was their job to proactively find out precisely what the consultants were concerned about. There is no reason to think that doctors would have been anything other than transparent about why they suspected Letby. The basis for their suspicions was not a secret, nor was it difficult to explain or to understand.

Turning then to the executives, it's often the way in public inquiries, as it is in other legal proceedings, that particular opprobrium attaches to those participants and witnesses who show the least insight into their own actions and motivations, who cannot bring themselves to take responsibility for their own mistakes, who seek to blame others and who try to the end to avoid being held personally accountable for

what went wrong. So it is with the Countess of Chester Hospital's executives in this Inquiry, Tony Chambers, Ian Harvey, Alison Kelly and Sue Hodkinson.

In their evidence and in the submissions made by their counsel to the Inquiry, they appear to have lived in and to still be living in an alternate and internal contradictory reality, one where no murders and attempted murders occurred, or, if they did, the executives did everything reasonably in their power to protect patient safety and it wasn't their fault because no one else told them or stopped them from happening. This is arrogant, self-serving fantasy.

The Families' written closing statement sets out the many ways in which the executives failed them and indeed their own staff, particularly the paediatric consultants.

First and foremost, in February and March 2016 when Alison Kelly and Ian Harvey first became aware of the thematic review into the untoward increase in neonatal deaths and the basic nature of the consultants' concerns about Letby's apparent association with the deaths, they failed to approach the situation with independence and objectivity.

They failed to take an immediate grip on the situation and arrange an urgent meeting with the

consultants to list their suspicions.

They failed to exercise clear-headed judgment and to accord credence to the consultants' concerns, which were based on specialist medical knowledge and experience that none of the executives had.

They failed and still appear to fail to understand the many factors that may have made it difficult for the consultants to voice the true reality that they suspected Letby of murder.

They placed far too much reliance on the more convenient judgments of the unit's manager and other non-executive nursing managers that Letby herself was the innocent victim, without recognising the lack of objectivity or expertise that underpin that judgment and how unreliable and unsafe it, therefore, was.

In truth, contrary to what they assert in their submissions, they lost sight of their duties to protect patients.

They failed to remove Letby from the unit pending on conclusive determination that she did not present a serious ongoing risk to patients.

They failed to follow their own policies, safeguarding, whistleblowing, SUDIC, serious incident investigation, which are designed to assist, not hinder, an effective response to what was obviously a difficult

and complex situation for the staff in the neonatal unit.

They failed to notify the police, which they now accept.

Not only this, but the executives withheld critical information about the spike in neonatal mortality and the consultants' concerns from the CQC, whose inspectors were present in the hospital in February 2016, from their commissioning body, NHS England, and from the local Senior Coroner. This pattern of information evasion and control demonstrate poor judgment, misplaced priorities, reputation management and fear of external scrutiny.

These omissions became even more indefensible following the deaths of Child O, on 23 June, and Child P, on 24 June. By that point, the consultants were, finally, insisting that Letby be suspended from the unit, and in various meetings they did, finally, articulate their suspicions of murder in clear and unambiguous terms.

But, as the Families set out in their written statement, it is extraordinary that basic good judgment was not exercised by the executives in those meetings and that the police were not called immediately. Instead, over a period of several months, a pointless

and protracted process of independent investigation, the Royal College of Surgeons' review, the consequent reviews by Dr Hawdon and Dr McPartland was embarked on with the approval of the executives. In the meantime, the consultants were effectively sidelined and muted, Ian Harvey having told them:

"All emails cease forthwith."

These reviews, as you have heard, were initiated and tightly controlled by Mr Harvey in a way that is deserving of serious censure. He deliberately decided not to instruct the reviewers to address the most important and pressing issue, the possibility that babies had been killed by Letby, which in any event he knew was beyond their competence, as the reviewers themselves ruefully acknowledged in their oral evidence.

He deliberately excluded the consultants from the process of instruction, which was indefensible, given the gravity of the suspicions and concerns that they had raised and their direct knowledge of the care given to the babies who had died.

He also withheld the consultants' views about deliberate harm from Dr Hawdon and Dr McPartland. He then controlled and edited the content of the reviewers' reports, removing, for example, explicit references in the Royal College report to the consultants'

allegations, as it was put, about the link between Letby and the deaths.

Finally and perhaps most egregious, given Mr Harvey's manipulation of the review process, he and Tony Chambers misrepresented the reviewers' findings to their own hospital, stating that they effectively disproved the consultants' concerns and thereby exonerated Letby. That same false message was communicated about the outcome in respect of Letby's grievance, which was presented as a further proxy for a proper investigation of the consultants' concerns.

Throughout this period, although Sir Duncan Nichol, the Chair, was aware of the consultants' concerns, the board members never heard directly from the consultants themselves, both about their concerns and their views on the value of the investigations that had been conducted by the executives. In a properly functioning Trust, this would have been seen as essential.

At the Countess of Chester Hospital, the opposite was the case. The consultants and the board were kept apart to protect the executives' strategy of avoiding police involvement and external scrutiny of multiple potential murders.

The clear inference that must be drawn from the

actions summarised above is that the true purpose of the reviews was not to accord credence to the consultants' suspicions about Letby and investigate them robustly, but to proactively seek alternative non-criminal causes for the babies' deaths, including poor care by the consultants themselves.

The executives were effectively gambling that the various reviews would provide irrefutable, independent support for their true and unanimous view that the consultants' concerns were in fact baseless and vexatious. When this did not happen, and despite the false spins that Ian Harvey and Tony Chambers repeatedly attempted, the executives' plan ultimately derailed.

By early 2017, the consultants could no longer be appeased and became increasingly and rightly aggrieved by the inconclusive and secretive reviews, the inaction of the executives, the criticisms made against them during Letby's grievance procedure, and the threat of referral to the GMC. Only then, reluctantly and boxed into a corner, did the executives decide to contact the police.

And, my Lady, all of this process, this sorry tale, was facilitated by a weak and incurious board, led by Sir Duncan, which should have been proactive in demanding to understand the precise nature of the

consultants' concerns about Letby, should have insisted on being fully and fairly briefed on the available information and views, should have challenged the executives' biases and scepticism, should have rejected their decision to focus solely on noncriminal explanations, and should have insisted that the LADO and the police be notified immediately.

My Lady, before turning to other issues, it is worth pausing to consider briefly the question of causation. In other words, what would have happened if the many failures I've identified had not occurred.

The Families do not know if Child A, Child B, Child C and Child D were Lucy Letby's first victims, or if she started harming children earlier, and, if so, whether she could have been stopped sooner. But assuming that they were, then proper intervention in July 2015 would have included removing Letby from the unit pending the outcome of any investigations by the police, the safeguarding team, the SUDIC team and those charged with conducting the serious untoward incident investigation.

The precise outcome of those investigations, singly and collectively, is difficult to determine conclusively, though removal would, of course, have stopped any further offending. And given how police

notification in 2017 evolved inexorably into a formal murder investigation, it is logical and reasonable to conclude that a similar course would have been followed based on similar information at any time in 2015 and 2016.

At the very least, even if Letby had not been suspended immediately or a formal murder investigation had not been commenced by the police, she would have been disincentivised from further offending by the knowledge that formal processes were well under way.

It must also be expected that the net would have closed rapidly around her as all the available information, the inexplicable nature of the collapses and deaths, the unusual rashes, the abnormal insulin results, the suspicion results to Child K's deterioration and her general connections to the deaths became evermore obvious and evermore glaring.

Importantly, you may feel, the parents of babies would also have been closely involved in the investigation processes, which would have afforded them the opportunity to provide vital information, to ask questions, and to insist on candid answers.

In short, my Lady, there were many missed opportunities throughout 2016 and 2015 to stop Letby, and the painful reality is that with proper and timely

intervention by the Countess of Chester Hospital it is likely that no more children would have been harmed after June 2015 and Child E, Child I, Child O and Child P would still be alive.

My Lady, you heard a lot of evidence, including authoritative views from Sir Robert Francis KC about the importance of a duty of candour and the value of the principles of honesty, openness and transparency in the NHS, but those principles of are no value if they are not applied in practice.

The evidence you've received demonstrates that the duty of candour was systematically ignored while Letby was harming babies and afterwards during the period that the executives were looking in vain for medical explanations that would rule out the possibility that multiple murders had occurred in their hospital.

Parents were not told that their children had suffered unexpected collapses.

They were not told about the consultants' concerns and suspicions about Letby, even as those concerns escalated and caused staff in the unit to break into factions.

They were not told about the thematic review.

They were not told about the Royal College review or the consequent reviews by Dr Hawdon and

Dr McPartland.

Their input was never sought into any form of internal investigation.

During the preparatory phase for Child A's inquest, counsel for the hospital advised that the family should be told of the spike in neonatal deaths and the involvement of the single nurse but this was not done, for reasons that have not been explained and appear to have been deliberate.

At the inquest itself, two senior consultants, Dr Jayaram and Dr Saladi, were asked for their views on what might have caused Child A's death. Neither of them spoke of their suspicions that he had been murdered by Letby, an egregious and damaging omission for which both they and their hospital must bear responsibility.

These are just a few examples but they are indicative of a general disregard for the Families and a form of individual and corporate self-protection that should have no place in the NHS.

When making your assessment of this issue, my Lady, I would invite you to consider the touchstone of empathy that was emphasised by Mother A in her evidence, the need for hospital staff to consider matters from the perspective of the mother of two vulnerable patients, one of whom had died and one of

whom had survived a near fatal collapse, both caused by Letby.

You may also wish to consider the straightforward approach articulated by Dr Susie Holt, another consultant, in her oral evidence, whose benchmark of good treatment was how she, her friends and her family would want to be treated. That basic principle extends not just to substantive care, but to all of the communications that surround and are consequent upon that care.

My Lady, in their written closing statements the Families have set out 12 basic recommendations that in their view derive from the events that you have investigated and will help future patients and their families. For present purposes, I wish to highlight just two of them.

Recommendation 1 is that it should be mandated to report the possibility of deliberate harm by a healthcare professional. As the Families say in their closing statement, the repeated failures of individual healthcare staff at the hospital to exercise good judgment in response to the concerns and suspicions about Letby indicates that existing policies and training on patient safety and safeguarding may be ineffective when confronted by extreme transgressive

conduct. Objective, sensible decision-making was overridden by countervailing rational and irrational motivations. There's no perfect solution for this but one important and invaluable step would be for the Department of Health and Social Care to publish a single short document that clearly and unambiguously sets out the steps that must be taken immediately when information arises indicating that a healthcare professional has or may have harmed a patient. This would apply to any and all concerns, suspicions or allegations of deliberate harm unless they are demonstrably irrational or malicious.

My Lady, I wish to emphasise this recommendation for several reasons. The first is human fallibility. I've already outlined some of the principal reasons why healthcare professionals at the Countess of Chester Hospital struggled to respond appropriately to Letby's crimes, self-doubt, incredulity, loyalty and so on. You may feel that any policy needs to be explicit that those reasons can never outweigh the need to take urgent action to address serious patient safety concerns.

But there are also some familiar human characteristics at work. Some of the staff at the hospital were weak and lacking moral courage. Some were incompetent and ill-equipped to grapple with a complex

situation. Others, most obviously the executives, demonstrated a raft of negative qualities, arrogance, deceit, manipulation, bullying, lack of insight, that made them unfit for the senior positions they held.

So, in formulating your recommendations, you must proceed on the basis of a cold and realistic assessment that future healthcare professionals and managers will continue to demonstrate these type of fallibilities and faced with a similar situation will fail again unless there are the strongest mechanisms in place to stop them from doing so. That is why, when it comes to dealing with the possibility of deliberate harm, the most serious consequence to patient safety, the Families argue that the new policy must be short, clear and compulsory, leaving no room for doubt about what should be done and highlighting the personal consequences that will follow for anyone who does not take appropriate action.

LADY JUSTICE THIRLWALL: Mr Skelton, thank you. I understand short, clear, all of which is very persuasive, but I just wonder how such a document copes when people can't believe it and want, as it were, to see it with their own eyes. Are you submitting, perhaps you are, that you need to make that explicit --

MR SKELTON: Yes.

LADY JUSTICE THIRLWALL: -- the fact that you can't believe that this is true is neither here nor there, the fact that it may be true is what matters or something along those lines?

MR SKELTON: Yes, the types of countervailing factors I've talked about, the sort of unconscious and conscious biases, prejudices and loyalties which exist need to be recognised and placed in the document so that those who start to have those biases and begin to feel that they can't speak up or voice their concerns are told in no uncertain terms that they do not outweigh their duties to the patients, their duty to safeguarding, and that, likewise, there must be teeth to this guidance because otherwise people will not follow it.

LADY JUSTICE THIRLWALL: Thank you.

MR SKELTON: My Lady, recommendation 2 is that access to administration of insulin on neonatal units be restricted and more effectively controlled. There's an equally strong case, as the other Family Group set out in their submissions, for the presence of exogenous insulin to be flagged in blood results as requiring immediate attention of the treating consultants.

My Lady, insulin may be a common drug in hospitals and in the community, but it must be recognised that it is also an extremely dangerous drug in the hands of

a malevolent actor. Letby tried to kill two children with insulin. Beverley Allitt and Victorino Chua used insulin to kill multiple patients.

These are Never Events that take and ruin lives, attract national attention and damage confidence in the NHS, so it shouldn't be left to local hospitals to institute controls over access to and administration of insulin. That is a recipe for inconsistent and non-existent safety standards. Instead, whichever unit in the Department of Health and Social Care takes over policy responsibilities for this area of medical practice must mandate or work with others to mandate that hospitals implement basic standard safety measures, such as electronic access and records, that will ensure that everyone who accesses insulin in hospital can be identified and their actions checked where necessary.

My Lady, I turn now, finally and briefly, to the issue of suspension or pause, as it has been put.

The Families' position is that Lucy Letby has been convicted after a protracted trial during which she had access to the finest criminal legal team and numerous medical experts across all relevant specialisms, none of whom were ultimately called to give evidence to support her defence. The Court of Appeal have twice dismissed her applications to appeal, in the first instance

comprehensively, having heard evidence from the Canadian neonatologist Professor Shoo Lee, who is now spearheading her latest team of medical experts.

Cursory analysis of the report published by those experts identifies multiple problems with their analysis. What has been presented with great fanfare as new and incontrovertible evidence turns out to be old and full of analytical holes. Critical medical and non-medical evidence and expert medical evidence from the trial and from this Inquiry is ignored or dismissed, and medical hypotheses are advanced based on fragile towers of speculation.

Little or no thought has also been given, it appears, to the dignity and privacy of the Families and the babies that the experts have publicly discussed, by stark contrast to the way this Inquiry has proceeded.

My Lady, I make these points not with a view to encouraging you to assess the merits of Letby's application to the Criminal Cases Review Commission or any subsequent appeal. That is not a matter for you and it is not ultimately a matter for the Families or any of the other Core Participants in your Inquiry. But I do make them with a view to emphasising the thoroughness and stability of Letby's convictions and the failed appeals, which form part of the bedrock of this Inquiry,

compared to the instability of both the outcome and the timing of any appeal that may take place at some indeterminate time in the future.

From the Families' perspective, the only fair and sensible course is for you to complete your work and submit your report based on the established facts of the criminal convictions and the many additional facts that you have carefully adduced over the last seven months. These provide a comprehensive picture of individual, collective and systemic failures to respond appropriately to Letby's suspected offending between 2015 and 2017. Otherwise, the Families, the Core Participants, the NHS and the public will be waiting indefinitely for your assessment of what went wrong at the hospital, and the recommendations that you need to make for the immediate improvement of patient safety in the NHS.

These, the Families argue, are compelling reasons why you should complete your work.

LADY JUSTICE THIRLWALL: What do you say about the submissions in respect of unfairness?

MR SKELTON: Clearly you have a duty of fairness, whether one finds it within the statute or as a common law public duty as a public body. Fairness applies to everybody. It applies to the Families, it applies to

the consultants, it applies to all of the hospital staff and it applies to the executives as well. You inevitably need to balance it. It is always a balancing exercise. But we say in the circumstances where there are established stable convictions and you have heard evidence supportive of the convictions in fact and heard also evidence of multiple failures that do require urgent attention, that fairness to the Families, to the hospital, to the NHS, to the public, outweighs any unfairness that may materialise, we say will not materialise but may materialise, in the future should Letby's appeal proceed.

So the balance is firmly in favour of proceeding.

My Lady, likewise in respect of the hybrid proposal of producing an interim report, this does not work. The facts of the murders are woven into the factual narrative that you will need to consider. The Families want you to make findings as to when intervention should have taken place, what it should have entailed and what its effect would have been. The recommendations you make are reliant on those findings and will lose most of their force if they are disassociated from their factual consequences or the true facts of what happened.

My Lady, finally, as was said in the written

closing submission, the Families wish to thank you and your counsel, solicitor and administrative team for the diligence with which you have conducted this complex Inquiry. Hearing and reading the evidence has been extremely difficult for the Families I represent, but it has been made easier by the respect and sensitivity which you and your staff have treated them and the conspicuous rigour that has been brought to bear on the evidence and indeed on the statements that you have received over the last few days.

Thank you.

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.

Mr Baker.

Mr Baker, we'll break at a convenient moment of your choosing, sometime around 1 o'clock.

MR BAKER: Yes.

Closing submissions by MR BAKER

MR BAKER: My Lady, I appear on behalf of Family Groups 2 and 3, so that's Child C, Child D, Child E, Child F, Child G, Child H, Child J, Child K, Child O, P and R.

We've prepared lengthy written submissions which address the factual background and our submissions in relation to the chronology of the case --

LADY JUSTICE THIRLWALL: Yes, thank you.

MR BAKER: -- and I don't propose to read those out in their

entirety but what I would like to do is look at themes that emerge from the submissions.

LADY JUSTICE THIRLWALL: Certainly.

MR BAKER: Before I go through those themes, I would like to say something about the Families whom I represent, although this statement could apply equally as well to everyone whom Mr Skelton represents as well.

Before the events of 2015 and 2016, these Families had no common connections, save for the fact they were looking forwards to bringing into their lives babies who they were anticipating with love and hope. They now share a common link created through a terrible chronology of events. Eight Families have struggled with the grief of losing their babies before their lives had begun, and for others they have continued to care for children with severe disabilities with the knowledge that those disabilities were caused deliberately. All of the Families have been severely affected by these events. All of them carry permanent scars that bond them together.

Almost all of the submissions made before you refer to the dignity of the Families in these proceedings and they have undoubtedly been very dignified in the way that they've approached this, but we should not overlook their courage and bravery. They

have sat together through two trials, two failed appeals and this Inquiry, and they've done that with one common goal. Firstly, to discover the truth and achieve justice for their children but also to make sure that others don't have to experience the same harm that they did.

Their common voice before this Inquiry has been a plea to ensure that this should never happen again, not to allow other people to experience what they have experienced, not to allow the list of victims to accumulate. And in saying this, they stand alongside a legion of other victims whom have shown the same courage through other inquiries, whose voices have too often been overlooked, leaving us doomed to repeat history and add yet more to the numbers of that host.

In engaging with this process, they have not set out to force people to change their minds. They've not had press conferences or appeared on the news or in documentaries or in the media. They followed the process with open minds and have asked only a few things in return, that they be afforded dignity, that they be allowed to grieve in private and that the public remember they are real people who have suffered real loss that they will have to live with for the remainder of their lives.

Whatever side of the debate people are on, people should remember that the dead and harmed are not public property to be dissected on television or on the Internet.

People are entitled to hold opinions but should bear in mind the subject matter of what they talk about, and opinions can be vocalised just as well with sensitivity and humanity towards victims.

As identified in my opening submissions before this Inquiry, the anonymity of victims, important as it is, can sometimes dehumanise them in the eyes of those who read about their experiences, and I'm sad to observe in closing that this observation seems more true when we look back on the last few months.

This Inquiry by its Terms of Reference and in the way in which it has been conducted has never involved an analysis of Letby's convictions. Instead, the Inquiry has looked at how an NHS Trust investigates suspicions of deliberate harm and then how it reacts when allegations of deliberate harm are made.

The Families would hope that the one thing that should unite everyone who reads the evidence given before this Inquiry is a sense that the NHS should do better when faced with these issues. The Families' submissions highlight that the evidence before the

Inquiry demonstrates a number of things.

There were poor systems for investigating unusual deaths.

There was a failure to reach or to react to unusual blood tests.

There was a failure of safeguarding structures, a failure to listen to concerns when raised and a deliberate cover-up.

There was a suppression of evidence, a lack of candour with Families, and then the persecution of whistleblowers.

The message coming through the evidence is that there was a total and absolute failure of culture at the Countess of Chester Hospital, and on the part of individuals a total failure to meet the basic standards to be expected of senior, powerful and well-paid NHS executives.

The volume of the noise surrounding this Inquiry should not be allowed to distract from the message at its heart. The failure of basic patient safety mechanisms within NHS trusts cannot be allowed to continue in this way. Many features of this case are common and have been repeated through multiple inquiries and investigations into healthcare disasters. If they are not addressed they will continue to cause harm to

patients and to their families by many different routes.

This is a harm that it is in everybody's interests to avoid. There will be countless people on both sides of the debate, no doubt, who will or will be the victims of harm due to failures of safety culture within the NHS. This Inquiry provides an opportunity to address those issues now, not at some indeterminate point in the future, not at a point when the NHS will be able to sit back and comfort itself that these events occurred in a distant history where the past was a different country about which nothing needs to be done.

Having heard the submissions on behalf of the Department of Health and NHS England, the Families are particularly concerned about whether the lessons from this case will be ignored. They did not perceive a clear motivation for change in those submissions. They saw reflected in them the same momentum towards inertia that has followed previous inquiries into NHS failures. They have asked me to say on their behalf that this is not good enough, that the submissions by those organisations provide them with no hope that anything will change.

To them promises to consider or review or discuss or consult are not promises to bring about change. Lessons need to be learned, or else another group of

injured families will find themselves in the same position, begging for the same things and adding their names to the host of bereaved or injured.

Before I move on to dealing with the themes, I think I would rather say something about the application that has been made --

LADY JUSTICE THIRLWALL: Yes, certainly.

MR BAKER: -- and then give time to the Families.

I've set out within the annex to my submissions a full response to that application, addressing in detail the issues that we have within it or the evidence presented.

My oral submissions before this Inquiry are intended to be about the Families, their experiences and their wish for change.

From the moment that she faced accusations at the Countess of Chester Hospital, Lucy Letby cynically tried to change the narrative away from the suspicions that were levelled against her by pleading for her own victimhood and seeking to recruit others to support her.

The Families see nothing different in the approach taken in response to appeals, nothing different in a decision to hold a press conference just before Christmas and nothing different in decisions to hold press conferences during pauses in this Inquiry.

It has been suggested to you already, and we would repeat, that it is not within your powers to suspend the Inquiry. That is a decision that rests with the Secretary of State alone, pursuant to section 13 of the Inquiries Act.

It is applied before you or said to you that you may also have a power pursuant to section 17 of the Inquiries Act to pause or suspend the Inquiry. Those submissions to us are not entirely clear, my Lady, because section 13 of the Inquiries Act is particularly clear, that the power to suspend rests only with the Secretary of State. To suggest that you would also have a power to suspend under section 17 arising out of the fact that it would cause unfairness to a party to continue would strike us as being entirely inconsistent with the decision under section 13 to grant the power to suspend solely to the Secretary of State.

So we would say, my Lady, that any suggestion that you might pause and pause for these purposes would mean suspend an Inquiry pursuant to section 17 cannot be correct.

Now, my Lady has been asked to communicate our views and your own views to the Secretary of State and so we will set out what our views are on the application.

The first point that's made against the application is that the purpose of this Inquiry has never been to look into the question of whether Letby's convictions were sound. Although that point has been made a number of times in applications by Letby's legal team that the scope should be expanded and they should be allowed to be involved, that has never been part of the scope of the Inquiry. The scope of the Inquiry looks at various common patient safety themes, which have been discussed in other inquiries, and the findings of this inquiry will be valuable, whatever the outcome of an appeal, if indeed there is one.

Now, this is a valid point and it means that the scope of the Inquiry is unaffected by the outcome of any appeal, although it is right to observe, of course, if there had been no convictions, there would never have been an inquiry.

The Families would observe that the actions of the executives in response to concerns being raised is obviously unaffected by the question of whether those convictions are correct or not, because for the most part the actions of the executives arise in June 2016, following the point when the murders cease, and so much of the focus of the actions on the executives arises during the period following the offences having been

committed, and the analysis of that conduct goes to the heart of assessing culture within the Trust, and cultural issues have broad relevance across a number of different issues.

Now, the Families would say there are two more obvious points against pausing the Inquiry.

The first is that Letby's rights of appeal to the Court of Appeal have been exhausted. She has already brought two appeals, both of which have failed, and her only remaining chance is an application to the CCRC.

The CCRC's role is not to retry the case but rather to consider whether there is new evidence which would give rise to a real possibility that the Court of Appeal might quash a conviction. Only then does any form of appeal process begin. And it is clear from the press conferences and indeed from the communication from Letby's legal team that this process will be based upon the suggestion that fresh evidence has been obtained.

It has been suggested by the executives that the evidence produced gives a real prospect that the CCRC will refer the matter back to the Court of Appeal. Ms Blackwell suggested in her submissions that it would be wholly inappropriate, though, for you or the Core Participants to look at the evidence.

I agree that it would be wholly inappropriate,

my Lady, for you to assess the prospects of an appeal in this case, but it is important, as Mr Skelton says, to apply some analysis to the quality of what has been put forward and the likelihood of whether that evidence will lead to a quick and sudden reversal of those convictions.

This is not a case, my Lady, where incontrovertible new DNA evidence has been produced which almost immediately exculpates a prisoner of an offence that has been committed.

The evidence that has been put forward which has been promoted by Ms Blackwell in her application, having been described as real evidence provided by world-class experts and appended to her application, should be looked at and should be considered as to whether this is the sort of thing that is likely to bring around the sort of quick reversal of the conviction that Letby's supporters have suggested.

Now, my Lady, we would suggest, based upon what has already been through the Court of Appeal, that Letby will have a serious mountain to climb in convincing the CCRC or indeed the Court of Appeal that this is fresh evidence. The prosecution at Letby's trial called numerous experts to give evidence, a paediatrician, a neonatologist, a professor of haematology, a professor

of paediatric endocrinology, a radiologist, a paediatric pathologist. Letby had available to her a similar range of experts and, as the Court of Appeal noted at paragraph 5 of its judgment:

"The defendant mounted a robust approach to the evidence that was called. Serious allegations were put to the numerous professional witnesses, including expert witnesses who were called on behalf of the prosecution.

"Two points may be noted at the outset. First, though the defence instructed a number of expert witnesses of their own and many reports were served from them before and during the trial, no evidence was called on the applicant's behalf. The entirety of the evidence called for the defence consisted of the applicant's own testimony and that of an estate plumber who worked at the hospital since 1986. He gave evidence about certain plumbing problems that had occurred at various points in the unit and of two particular incidents in the unit but not on the date or around the time of any incident on the indictment.

"Secondly, to make a somewhat basic point, what has been put to the prosecution witnesses in cross-examination is not evidence, save to the extent it was accepted by the witness.

"More specifically, in the context of this appeal,

suggestions made in cross-examination which were not accepted by the prosecution witnesses and were not supported by evidence called on behalf of the applicant are, as the respondent has submitted, irrelevant."

The elephant in the room, my Lady, and the one which neither Letby nor her legal team are prepared to explain, is why she didn't call the evidence at trial. The Families note that her counsel appears regularly in the media, is rarely asked a question, and when he is asked a question, refuses to answer. It is, we're afraid, a question that needs to be answered. The only reason why a defendant would choose not to call their own experts to give evidence is because they know that those experts, if tested in court, would be likely to convict them. A defendant cannot choose not to call their experts at trial and then ask for permission to roll the dice again when the gamble doesn't pay off. That is the definition, my Lady, of "expert shopping".

The next obstacle for Letby is that the Court of Appeal has already considered Dr Shoo Lee's evidence as part of the first appeal, to the extent that he was called to give evidence during the appeal, and concluded that this evidence directed itself towards a wrong issue: see paragraph 187 of the judgment or paragraph 537 of my submissions.

The evidence produced in support of the application to adjourn does not cover the same range of issues that were heard by the jury at the trial and which were covered by the prosecution experts. There is no evidence from a radiologist to explain why air would be found in the hearts and blood vessels of babies who died from air embolism. There is no evidence from the pathologist to explain why bubbles of gas would be found in the brains of babies who were alleged to have died from air embolism. There is evidence from an engineer, albeit one the panel accept is not an independent expert, about insulin, but there is no evidence from a paediatric endocrinologist.

The panel, my Lady, have conducted a Casenote Review, which my Lady heard from the evidence of Dr Hawdon in this Inquiry is, by its nature, superficial and ill-placed to identify homicide. It doesn't take into account all of the issues. It doesn't review the experience and evidence of eyewitnesses, or consider about notes being falsified, searches for families on Facebook, hoarded handover sheets, or the multitude of other evidence heard by the jury. In limiting its perspective to neonatal evidence, it doesn't even cover all of the relevant clinical or forensic issues. These issues have already been

discussed before the Court of Appeal, who refer to the breadth of the evidence heard by the jury in support of conviction.

The Families would say, for all the bells and whistles that might be attached to a press conference, there is nothing remarkable or new about the evidence being presented. The theories may have altered, but this could hardly be said to be new evidence.

Sadly, whilst it is not uncommon for genuine miscarriages of justice to be highlighted through the CCRC, it is also not uncommon for cases of alleged miscarriages of justice to be brought before the media in a blaze of publicity only for the evidence in support of them to flicker and falter.

It is entirely unclear what progress Letby's lawyers have genuinely made with their applications. She has filed a preliminary or outline application with the CCRC, but has yet to file her evidence. The letter from Bhandal Law received yesterday, a firm that was mentioned for the first time yesterday, suggests that evidence will be filed with the CCRC imminently, and that would expect a quick referral back to the Court of Appeal.

My Lady, this should not be taken at face value. In December 2024 at a press conference, Mr McDonald,

Letby's barrister, assured the assembled press that he had prepared documents that were ready to go to the Court of Appeal and the CCRC. Nothing was submitted to the Court of Appeal, and the most we have is a statement that is envisaged that evidence will be submitted to the CCRC this week. Given that a preliminary application was filed with the CCRC on 3 February 2025, the day before a planned press conference, the Families have no faith that genuine progress will be made with any application. It is notable that the same process is being followed by the same team in relation to Ben Geen and has been stagnating in the CCRC for the last ten years.

It seems highly unlikely that Letby's statement that the CCRC will not take long to consider the application before referring it back to the Court of Appeal is correct. The CCRC is likely to want to understand why Letby chose not to call her own expert evidence in trial. As those who representing her don't appear to be able to provide a coherent answer to that question, it is difficult to see how they will overcome it. It is fanciful, we would say, to suggest that this will be a quick or easy process, or that a successful appeal is anything like a probability.

This is not a case, as I said in submissions

a moment ago, where unequivocally new and determinative evidence has been found which demonstrates innocence.

The Families will say that the applications to stop the Inquiry are, on Letby's part, an attempt to control the narrative on the part of the executives to avoid criticism. Neither should stand in the way of the important work that you are undertaking.

Finally, my Lady -- and I will suggest pausing in a moment before I move on to more substantive submissions -- the suggestion that this will bring about any real saving in costs is fanciful, my Lady. We're here making our closing submissions to an inquiry. The question that any real saving in costs will be achieved at this stage is unrealistic.

Submissions in relation to prejudice and fairness, again, cut across a number of different parties. The Families have committed to this Inquiry in the hope that real change will be achieved that will protect other Families in lots of different contexts. The prospect of bringing about improvement in the NHS to avoid harm being caused to other people is a real prospect, much realer, we would say, than any fanciful appeal on behalf of Letby. We cannot let the noise in the background stop the work that this Inquiry can achieve.

If we pause this Inquiry now and it's another

ten years or even five years or even a year before anything can resume again, momentum will be lost. Momentum to change will be lost. The opportunity to make a difference exists now, and pausing will cause serious harm to that opportunity.

That is the greatest fairness, not only to all the Core Participants but to the wider public.

Insofar as fairness to the executives are concerned and the hybrid approach, it's unworkable. As Mr Skelton said, the events and the reactions of the executives are all interwoven into questions of culture that you need to look at. The reactions of the executive board to the complaints and issues that were raised to them go to the very heart of whether this was a failing culture at an NHS Trust. In analysing whether something is a failing culture or not, that is the crucible out of which recommendations will come. If we take that out of the equation, then it leads to nothing being achieved.

So, my Lady, that's all I would propose to say about the application and, with your permission, I will pause there and resume after lunch.

LADY JUSTICE THIRLWALL: Very well. Thank you, Mr Baker.

So we'll rise now and start again at 2 o'clock. Thank you.

(12.53 pm)

(The luncheon adjournment)

(2.02 pm)

LADY JUSTICE THIRLWALL: Sorry to keep you all waiting.

MR BAKER: Before the short adjournment, I said I was going to move on to the themes, and I can summarise those in outline as follows: that babies were allowed to die or be harmed because of failures to identify that crimes were being committed and to stop them; the Trust and its leaders put reputation ahead of patient safety; that the culture within the Trust, which should have prioritised safety failed; that the Trust and its leaders lied to Families, misled external organisations, misled its own board of directors and ultimately tried to avoid a police investigation at all costs; that the Trust persecuted and bullied those who brought these issues to its attention.

Going to the opportunity to avoid harm, there appears to be little doubt that Letby's attempt to poison Child F with insulin in August 2015 provided a clear opportunity to detect her actions and prevent further crimes. I've referred to that as a bright line within the chronology after which point no further harm should have been allowed to occur.

Within the alphabetical chronology, that is from

Child G to Child P.

The Families are concerned not only with the bright line but also with missed opportunities that existed before then. The deaths of Children A, C, D and E were not adequately investigated and that a lack of professional curiosity or incompetence or both on the part of individuals who treated them and/or inadequate systemic structures for the investigation of sudden death prevented crimes from being identified sooner and provided an environment within which Letby operated unhindered.

My Lady, Mr Skelton has already addressed you in his written submissions in relation to Child A and Child B, so I will begin with Child C.

Child C died in June 2015. His collapse and death were sudden, unexpected and unexplained.

Letby's behaviour surrounding Child C was extraordinary. She left the baby she was allocated to care for in nursery 3 unattended, in order to repeatedly intrude into a family room where Family C were caring for Child C. This behaviour concerned her colleagues. She had no place to be there and because of this the condition of the child that she had been allocated to look after deteriorated and they became more unwell.

This is part of a pattern of odd and ghoulish

behaviour by Letby which troubled some of her colleagues and which is identified throughout this Inquiry. It also forms part of a picture of evidence that was there to be found if questions had been asked.

Child C's death was ascribed to a cardiac condition that we say was actively doubted by his treating clinician Dr Gibbs and which was subsequently proven to be incorrect.

The circumstances leading up to Child C's collapse and complexities surrounding his resuscitation should have been investigated more thoroughly. His death should have been categorised as unexpected and unexplained. Care should be taken not to allow unexpected or unexplained deaths to be treated as normal, and there should be a greater index of suspicion where unexpected and unexplained deaths occur in clusters and, of course, my Lady, this brings us back to the point made by Professor Spiegelhalter that sometimes events occur that remain within a curve of expected outcomes from a statistical point of view but appear to be at one extreme end of the scale or not. Sometimes statistics can draw to our attention something that needs to be investigated and no more.

In this case a cluster of deaths doesn't axiomatically prove murder, but clusters of deaths need

to be understood and the reasons for them need to be understood, and that should prompt investigation.

Child D also collapsed and died in June 2015, the third baby to die that month. The unusual features surrounding Child D's death should have been fully investigated. It should have been appreciated that it did not accord with what ordinarily would have been expected for sepsis or infection. It should have been noted that there had been a highly unusual episode of transient skin discolouration at the time of her collapse, and this should have been investigated and considered alongside similar reports involving Children A and B. It is clear that these events were considered unusual at the time and not consistent with the signs and symptoms normally seen in paediatric practice.

Now, my Lady, you will recall that when Child D's death was reviewed by Dr Mecrow, an independent consultant paediatrician instructed by the Coroner, Mr Rheinberg, he described her death as disturbing for being so sudden and unexpected, that she had been treated with a regime of antibiotics that should have been completely effective against neonatal sepsis at or shortly after birth, that she had been making good progress and had collapsed in a wholly unexpected and

unpredictable way. On analysing the papers and documents in her case, he could find no evidence of deficiencies in care provided to her, and he observed that the circumstances of her death were disturbing for being so sudden and unexpected.

As we said in opening, those features were there to be seen at the time.

Child E died in August 2015. His given cause of death, necrotising enterocolitis, was not consistent with his condition prior to or following his collapse. A post-mortem should have been arranged which would have identified that he did not have NEC, further investigation would have revealed that his death was unexpected and unexplained, and accounts surrounding the patches of skin discolouration noted prior to his death would have correlated with skin discolouration noted in the cases of Children A, B and D. It would or should have been recognised that this transient discolouration was highly unusual and not consistent with the discolouration commonly or uncommonly seen in paediatric practice.

My Lady, the unusual transient skin discolouration seen with Child A, Child B, Child D and Child E which were remarked upon by those who saw them as being something they had seen only once in their careers up to

that point or since. Now, this formed basis of concerns raised by junior doctors and escalated to more senior clinicians.

Ms Blackwell KC urged you to guard against hindsight bias in analysing past events. The term was used without specificity and sounds as, we say, a dog whistle to the defence theory that all these deaths were thought to be obviously caused by natural causes until police investigations commenced.

Now, that is simply not correct. The contemporaneous evidence shows a discolouration was regarded at the time as being highly unusual by people who had seen it for the first time then and had never seen it since. It was the subject of concern and discussion at the time by the junior doctors. It was simply the fact that these features were never put together and analysed at the time.

Why wasn't there greater curiosity? Why were deaths written off without proper investigation? And why were these parents not treated better?

A particular feature of Child E's death warrants closer analysis. You heard, my Lady, evidence that Child E along with his twin brother were being fed with expressed breast milk from his mother, so it was necessary for Mother EF to make her way to the NNU on

a regular basis with their milk.

During the evening of 3 August 2015 she made her usual journey to the neonatal unit, arriving there at about 2100 hours. She was confident in her recollection about the time because she was working to a feeding schedule.

In her evidence before the Inquiry she recalled that as she came on to the corridor of the unit she heard screaming and crying. She had been visiting the neonatal unit for almost a week by this time and said:

"I'd never heard a baby cry like that ..."

In her evidence before the criminal trial, she described the sound as more of a scream than a cry. As she walked into the room, she realised the cry was coming from Child E. Child E had blood around his mouth and was screaming. Letby was standing close by, between the incubator and the workstation, but not providing support to Child E. Mother EF recalled that Letby was "dismissive" of her concerns. She told Mother EF that she had contacted the registrar who was on his way. She said:

"Go back ... you go back to the ward and if there's any problems I'll ring you."

Mother EF had encountered Letby before and previously felt that she was kind, but on this occasion

perceived a distinct change in her attitude. To her Letby appeared abrasive and would not look her in the eye.

When asked to reflect on what she had witnessed when she walked into nursery 1 on 3 August, she said before this Inquiry:

"An attack on my son. An interrupted attack. I thought I caught her off guard. Something had happened for him to be bleeding. Stable babies don't bleed."

Mother EF went back to the maternity ward from where she called her husband. She wanted to speak with him because she knew that something wasn't right. He reassured her that Child E was in hospital and would be safe.

During the criminal investigation it was confirmed, using Mother EF's mobile phone records, that a call to Father EF was made at 2111 hours, consistent with her account that she went to the neonatal unit at about 2100 hours, and saw Letby then.

Letby's clinical notes record that Child E suffered a gastric bleed at 2140 hours and that the registrar was called at 22.10, an hour after Mother EF's visit.

The timing in the notes is confirmed by

Dr Harkness, a registrar who attended. Dr Harkness recalled that he was called by Letby to attend at around 2200 hours to 22.30 on 3 August 2015.

Mother EF gave evidence before the Inquiry that:

"I found out that the notes had been changed to suit a different narrative of when Child E's bleed started and that's why the registrar hadn't been contacted, because he didn't know I'd been there and he didn't know that Child E was bleeding at just before 9 o'clock."

Mother EF lives with her decision to follow Letby's instruction to leave the ward. Her sense of guilt is real, if unfounded, and it echoes a common experience for all the parents who we represent. She struggles to come to terms with a sense of if she had refused to leave, her son would be alive.

That information, my Lady, was there to be found at the time.

Dr ZA --

LADY JUSTICE THIRLWALL: Mr Baker, just before you continue, there's a problem with the transcript. It seems to be because of coming and going. Do we know why that's happening?

I think we're now up to date. Sorry, I just felt it was necessary to interrupt you because we seem to be

getting further and further behind, and it looks as if it's all right now. So we'll continue. If anyone has a difficulty, please will you just raise your hand and we'll pause while it's sorted out.

Sorry, Mr Baker.

MR BAKER: Thank you, my Lady.

That information was there to be found. If Mother EF had been questioned at all about what she had experienced and what she had seen, she would have explained that the timings in the medical notes do not correlate with her experiences. The only reason they wouldn't correlate is that Letby had doctored the notes.

Now, that was evidence, if it had been found out at the time, that would have been regarded as extremely suspicious and extremely serious.

Dr ZA gave evidence that she categorised Child E's death as due to necrotising enterocolitis, a diagnosis that she now accepts was unjustified and contradicted by the evidence that was available to her, not least the pre-mortem X-rays that effectively ruled the condition out. In this respect her actions went beyond a lack of curiosity and instead amounted to a total absence of insight.

Miscategorising Child E's death removed the input of the Coroner, prevented a post-mortem and stalled

further investigations. It led to Child E's death being regarded as being by natural causes. It influenced Dr Brearey's actions subsequently and it took him out of the cohort of suspicious deaths.

Ms Blackwell KC in her submissions again addressed you on the risk of hindsight bias affecting how we review the decisions of others.

Now, hindsight bias is, of course, real but it's also a lazy smokescreen thrown up in clinical cases. We do not need to worry about hindsight bias when looking at issues like this. It is and would be known at the time that it was obviously wrong to give a cause of death without confirming that this was accurate.

If these events and their timings had been discussed with Mother EF at any point, it would or should have led to a realisation that her account contradicted the events documented in the clinical notes, raising the suspicion that the notes had been falsified. During the course of the Inquiry that evidence was there to be found. If NEC hadn't been given as a cause of death, then a post-mortem would have been carried out. That would have been found that NEC wasn't the cause of death, it would have led to further investigations, opened also the potential for this account of Mother EF to have been discovered.

Child F collapsed with hypoglycaemia in August 2015. The results of Child F's insulin tests in August 2015 were noted by Dr ZA but disregarded. She concluded that they must have been due to a technical error with the laboratory. That possibility was ruled out by Anna Milan, a clinical scientist working at the Liverpool Clinical Laboratories who was highly concerned that the result showed a high level of insulin and undetectable C-peptide, a finding that demonstrated that manufactured insulin had been given.

Dr ZA never spoke with the laboratory to ask whether the laboratory error was possible. Had she done so, she would have been reassured that it was not.

These results, we submit, represented clear evidence of a malevolent force at work within the unit and provided the clearest opportunity to detect and stop Letby. The Families will say that this represents a bright line within the chronology, after which no babies should have been harmed. The failure to detect and act upon these findings represents a clear missed opportunity to stop further harm. Most disturbingly it was receipt of the same results in the Grantham and Kesteven Hospital in 1991 that halted the crimes of Beverley Allitt.

They failed to achieve the same result in the

Countess of Chester Hospital 26 years later.

The suggestion that we might be clouding our judgments with hindsight bias when judging the response to those insulin results is brought into sharp focus by this observation. Dismissing abnormal blood test results would have been as wrong in 1991 as it was in 2015, as it would be now. No hindsight bias comes into it.

The case of Beverley Allitt, since I mentioned it, provides a consistent parallel through the evidence in this case, and a key recommendation of the Clothier Report was that the crimes of Beverley Allitt should serve to heighten awareness in all those caring for children of a possibility of a malevolent intervention as a cause of unexplained clinical events.

Having considered the universal revulsion to the crimes of Beverley Allitt alongside the sense of hope contained within the Clothier Report that such events should not be repeated, the Families cannot help but feel a profound sense of sadness that a little over 20 years later that recommendation had been wiped out not only from the collective memory of the NHS but from those who were working within the Countess of Chester Hospital.

LADY JUSTICE THIRLWALL: Mr Baker, just before you continue,

because obviously I want everyone to hear what you're saying. Apparently we need a restart of the transcript because if it's not restarted it will just keep doing what it's doing, which is not acceptable, so I'm very sorry. How long will it take, the restart?

Five minutes. So if you don't mind, shall we say we'll break until half past 2?

MR BAKER: Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you.

(2.20 pm)

(A short break)

(2.34 pm)

LADY JUSTICE THIRLWALL: Mr Baker.

MR BAKER: Thank you, my Lady, I was just saying before we broke that the memory of Beverley Allitt had been wiped out by the time we come to these events, both in the collective memory of the NHS but also in the memories of the individuals working at the Countess of Chester Hospital.

Now, of course, as events recede into history their impact diminishes, but it's also right that while it may be easy to learn from the lessons of historical disasters, it's quite another thing to appreciate that the same events are unfolding on your doorstep, and we do recognise that on behalf of the Families. But whilst

the crimes of Beverley Allitt may have appeared to be a remote event, even though they occurred 20 years before, there would have been warnings from the more recent for those working at the Countess of Chester.

At the start of the relevant chronology, so a little before these insulin results were received, Victorino Chua, a nurse working at a local trust, was convicted of murdering two patients and attempting to cause 21 other patients grievous bodily harm with intent by poisoning them with insulin.

Again, hindsight bias falls away, my Lady. A few months before the test results were received, a nurse had been convicted of murdering and harming patients with insulin in a local trust. These types of crimes, the fact that these events could occur, should have been very clearly in the minds of those who were living these events.

Now, although categorised by Dr Gibbs as a collective failure on the part of the entire paediatric team, most of the blame for the failure does rest with Dr ZA. She ultimately decided to disregard the more abnormal results, and that decision had serious consequences for all of the victims who followed Child F.

Now, although Dr ZA's decision is ultimately

a case of human error, it is important to consider how such an error might occur and how it might be avoided in the future. It's perhaps inevitable, my Lady, that doctors or nurses will be slow to accept the possibility that their colleagues are deliberately harming patients. Cases of deliberate harm are thankfully very rare and entirely at odds with the behaviour that you would ordinarily expect from individuals working in a healthcare setting.

Whilst it was helpful for the Clothier Report to highlight a need to be wary about the possibility that a colleague is causing deliberate harm, this is the type of recommendation that might be quickly lost within the real world.

In this case, Dr ZA was provided with direct evidence that her patient had been administered with unprescribed exogenous insulin but failed to recognise it as a possibility or act upon it.

The laboratory passing that test result on to the hospital believed that they had discharged their duty in notifying them of the result, but took no action to ensure that there was a direct dialogue between the clinical scientist and the consultant who was responsible for decision-making. Had there been a mandatory requirement that a laboratory speak with

a consultant responsible for the patient's care, then the opportunity for Dr ZA to attribute the result to a lab error, if that's what she did, would have been greatly reduced.

The Families will say that any recommendations made mirroring the recommendation in the Clothier Report that the possibility that unexpected or unexplained deaths are caused by deliberate harm should be embedded through the creation of clear, mandatory duties.

I would agree with Mr Skelton in that respect that mandatory duties need to exist where one raises a suspicion about deliberate harm, but other mandatory duties need to exist for cases where people might not quite make that leap. For example, if a test result is obtained that raises the possibility of deliberate harm, it should be a mandatory requirement that the person reporting that test to the hospital and the person receiving the result of that test discuss the possibility that the result represents evidence of deliberate harm and ensures that it is further investigated.

A third check and balance might also be necessary to counter the possibility that the individual receiving the test results might deliberately seek to suppress them.

During the latter part of 2015, a number of clinicians working within the neonatal unit began to suspect the possibility that somebody might be causing deliberate harm to babies, and the Families would submit that by the time we get to October 2015, by the point of Child I's death at the latest, there were active suspicions regarding Letby's involvement in the deaths. This should have led to effective safeguarding action, but did not.

We note that in their submissions the Countess of Chester Hospital agree that Letby should have been suspended pending investigation at that point, ie by October 2015. We agree when looking at that issue in isolation but would add that Letby's presence at the deaths of Child A, C, D and E had already been noted and similarly appropriate action should have been taken then.

In his written submissions on behalf of the Countess of Chester Hospital, at paragraph 48, Mr Kennedy KC answers it is an unanswerable hypothetical as to whether investigations at that time would have resulted in referral to police. In response to that we would make three observations.

Firstly, the Inquiry will recall the evidence of Dr Gilby and her concern on being taken through the

records by Dr Brearey that the collapses were highly unusual and to her eyes suspicious. She felt that one of those incidents in isolation would have concerned her.

The Inquiry should note the resonance between this observation and that of Dr Mecrow, the independent expert who reviewed the death of Child D for the Coroner. These were not common deaths but seen at the time and properly regarded since as highly unusual.

Secondly, that the suggestion that the deaths were thought to have plausible natural explanations is not something that would necessarily have stood up to a more rigorous analysis. Indeed, when those deaths were investigated subsequently, they were not simply written off as a collection of natural deaths linked by coincidence.

Finally and more importantly, had those investigations commenced after the collapse of Child F and had they involved Child F, as they should have done, they would have revealed that he had been poisoned with exogenous insulin.

These factors individually and collectively were more than capable of triggering the intervention of the police. They would not have led competent investigators to rule out malevolent intervention. The outcome then

would or should have been a decision to call the police.

The commencement of a review into neonatal deaths in October 2015 took place within the context of suspicions regarding unexpected and unexplained deaths and collapses in the neonatal unit. These events should have triggered a more co-ordinated formal response. The process appears to have been undertaken informally by Dr Brearey and Eirian Powell, without defined goals beyond investigating the rise in neonatal deaths.

The analysis did not consistently incorporate unexpected collapses and deteriorations in children, even where the child who suffered the collapse was linked to one of the deaths being investigated. For example, the investigation examined the case of Child E but did not review the records of Child F, his twin brother, who also suffered an unexpected deterioration in his condition at or about the same time.

The SUDIC procedure, although in place locally, was not effectively followed. It is unclear why the procedure was not adopted or adhered to. It would have provided an effective framework within which to investigate unexpected and unexplained deaths.

The local Coroner was not provided with consistent evidence regarding the deaths or the suspicions arising from them. Dr Gibbs did not communicate his concerns

regarding Dr Kokai's conclusion of the cause of death for Child C to the Coroner, something that may have prompted further investigations.

Dr ZA advised the Coroner that Child E died from NEC and the diagnosis was not properly supported by the evidence, seemingly with a view to sparing the family the distress of a post-mortem.

Child D's death was not reported to the Coroner but the fact that her death had occurred amongst a group of other deaths that became linked to suspicions regarding Letby's conduct was not reported and the inquest continued on the basis that the death was natural, albeit perhaps influenced by clinical negligence until the police investigation was triggered. Only then was the Coroner's investigation suspended.

Although Child A is represented by a different Family Group, the Families within this group consider that the Countess of Chester Hospital actively misled the Coroner with regard to suspicions surrounding Letby's role in the death by withholding key information.

Both the SUDIC procedure and the coronial process provided opportunities to highlight common links between the cases and reveal suspicions regarding Letby's role in the deaths. Neither could function properly because

they were not utilised, or else misleading information was fed into them. It does not take much imagination to conclude that either mechanism could have led to the earlier involvement of the police.

Insofar as awareness of the executives are concerned, on behalf of the Families we believe that Alison Kelly was aware by December 2015 at the latest that there had been a rise in neonatal deaths and that this was the subject of a review. We know that that position is also adopted by the Countess of Chester Hospital in their submissions, and we also adopt the position that Mr Harvey was aware of the same issues shortly thereafterwards.

During the early part of 2016, the outcome of the thematic review was escalated to senior executives, namely Ian Harvey and Alison Kelly. The Families will say that it was clear by the time that these escalations took place that a substantial number of paediatric consultants had genuine concerns about the possibility that babies had been deliberately harmed. It is, of course, for the Inquiry to determine when those concerns were first escalated to the senior executives but there is no doubt, in our view, that those concerns existed. They should have been escalated clearly and without delay.

If they were escalated at the time that the thematic review was finalised, the response from the executives was slow and inadequate in taking until May 2016 before a face-to-face meeting was arranged. However, we make no submissions as to whether they were in fact escalated effectively. It is, in our submission, one or the other. Either they were ineffectively escalated or the consultants did not shout loudly enough, or alternatively the executives didn't listen.

A further opportunity to escalate arose in February 2016 with the collapse of Child K. Dr Jayaram in giving evidence before this Inquiry was at pains to say that he did not walk in to see Letby in the act of harming Child K. But it is clear, if his evidence is accepted, that he must have felt at the very least that he either walked in on the aftermath of some event or that he saw Letby failing to intervene to assist a baby who was obviously in distress.

His reasons for not acting more decisively at the time are difficult to understand, even with the benefit of hindsight, but most probably represent a failure of courage on his part. As he now implies reluctantly, he probably thought more about his own reputation and standing and preferred not to be the person who put his

head above the parapet. This might be regarded as a failure of Dr Jayaram's character, a failure of the culture in the Trust that made him reluctant to point the finger, or a combination of both.

The Families consider that it is likely that concerns regarding Letby's connection with the deaths were either beginning to filter through to the senior executives by March and April 2016, or were being explicitly blocked by Eirian Powell.

On 7 April 2016, a decision was made to move Letby from working night shifts to working day shifts. Whatever reasons were offered for that decision by Eirian Powell, the Families will say that it is clear that this was done because of inferences that had been drawn from the thematic review. This resonates with Dr Brearey's account that he had been struck by the fact that all of the unusual deaths had occurred at night, a fact which appeared to him to be suspicious. It is another factor that lends weight to Dr Brearey's account and diminishes the credibility of Eirian Powell's account.

The evidence suggests that whether or not they had been communicated in clear terms before, the meeting on 11 May 2016 involved a discussion surrounding Letby's potential involvement in the collapses and deaths. The

only appropriate response to this information was an immediate safeguarding exercise to prevent Letby causing further harm to babies on the NNU. The watch-and-wait policy encourage by Mr Harvey and Ms Kelly was entirely inappropriate and put further lives at risk. In the circumstances, it led to the deaths of Child O and Child P at least.

There were further opportunities to avert harm. The attacks on Child N occurred after this meeting and involved a series of unexpected and unexplained collapses of the sort that had become typical for Letby's victims. Dr Saladi failed to notify Dr Brearey of Child N's collapses despite having received an email from Dr Brearey asking for such events to be reported.

The nursing staff involved in Child N's care had not received a similar communication for Eirian Powell and were, therefore, not given the opportunity to report concerns that they might have had.

It is clear throughout this period that strong divisions had arisen between doctors and nurses and that this impaired the ability of the system to react to concerns when they were raised.

The Families will say that Eirian Powell provided a strident defence of Letby, offered assurances about her character and sought to deflect allegations made

against her. This undoubtedly influenced the response of the executives at the meeting on 11 May 2016. Indeed, there is evidence to suggest that lobbying by Eirian Powell and her colleagues in advance of that meeting may have led to the outcome of the meeting being a foregone conclusion before it occurred.

It is axiomatic that individuals within any workplace will struggle to accept that their friends or favoured colleagues could be guilty of wrongdoing. A proper response to safeguarding issues, my Lady, should seek to bypass the impact of personal loyalties or gut instincts which are potent forces for derailing an effective safeguarding response and should be excluded from the process. The Families will say that the key factor in determining an effective safeguarding response should be the mandatory duty to escalate and follow process once concerns have been raised.

Those who might hesitate from pursuing an allegation because of a fear that it might trigger an adverse reaction from colleagues or managers could be empowered by mandatory duties. A clearly defined algorithm for response would have avoided the potentially disrupting effects of emotion-based human factors had a clear framework been in place supported by clearly defined mandatory duties, and an effective

neutral response. The divisions between doctors and nurses would have been neutralised. There would have been no debate as to the process which should have been followed, or of the respective duties of the individuals involved in decision-making.

The additional benefit of mandatory duties within that scenario is that those reporting their concerns and those co-ordinating the response would have appreciated the potential legal or professional consequences of not following the defined procedure. A response to a defined procedure would also appear more neutral and non-judgmental with regard to the individual who is the subject of the allegation. It would involve the clear implication of a clear framework without an apparently negative judgement on the part of the decision-makers.

The Families will say there were multiple opportunities to stop Letby, stop harm being caused to the babies in her care and that those opportunities continued even following the death of Child O. Prompt action by Dr Brearey following Child O's death may not have made a difference, given what in fact happened following Child P's death. However, within a properly functioning patient safety organisation, they should have done. With each successive failure from June 2015 until June 2016, babies and families were let down.

Harm was allowed to continue. Lives were lost and others irrevocably altered.

Following the deaths of Child O and Child P, there was a period when concerns were being raised forcefully, but there continued to be delays before Letby was moved away from the neonatal unit.

I'm now going to look, my Lady, at failures of culture.

Following the death of Child P, the behaviour of the senior executives demonstrated a total failure in the culture of the Countess of Chester Hospital. You've heard evidence as to what the paradigm of good culture within the NHS is. It's one that promotes patient safety above everything else.

Another feature of the healthy, safe, just culture is, as Sir Robert Francis highlighted, one that acknowledges the need for absolute openness and honesty. This encompasses a culture that accepts and respects the need to raise concerns about the actions of others without fear of criticism. The antithesis of a good culture is one that puts reputational or financial gains above the need for patient safety. It covers its mistakes and wrongdoing. It gaslights its victims. It lies, it denies, it defends and dissembles. It is unwilling or unable to seek out or accept information

that challenges its own sense that it is doing everything right. It persecutes whistleblowers who challenge that viewpoint.

The evidence before the Inquiry from some witnesses described how historically the Countess of Chester was regarded as a good NHS Trust. It had an open culture and safe practices.

Now, of course, my Lady, we cannot assess that effectively based upon the evidence that we have, but it is what people say. It was a place where people wanted to work. The Families will say that in the period being discussed here, whatever culture had existed before it failed completely.

The suspicions regarding the crimes of Letby were covered up and hidden from the Families, from external bodies, from the Coroner and from the public at large. This was done to preserve the reputation of the Trust and of the executives. In prioritising those factors over patient safety, there was an absolute failure of candour, honesty, openness and transparency, all key components of an effective patient safety-driven culture.

Senior executives deliberately deceived family members and allowed important information to be withheld from external bodies, such as the Coroner.

We've set out within our submissions the specifics of cultural failings, but we want to highlight those failings as typified by the actions of three of the executives.

Even when viewed alongside the evidence of his colleagues, the performance of Tony Chambers in the witness box was notably poor. The Inquiry should disregard any account that he gives that is not corroborated by a more obviously reliable witness. He was combative, angry, lacking in insight. He avoided answering any question which did not fit within his pre-prepared narrative. At times the Families were to suggest that he was disingenuous, he dissembled and he blamed others.

We would say, my Lady, his presence in the witness box made it easy to understand accounts by paediatricians of his bullying and intimidating behaviour. If further corroboration for that behaviour were needed from a source other than his performance in the witness box, it can be seen in Ms Hodkinson's letter -- note, sorry, of 12 May 2017, a note of his plan to dismiss the consultants, bypass Speak Out Safely protocols and report them to the GMC. When he was questioned about this, he sought to deny that this had been his plan, accepting that it would be particularly

reprehensible behaviour if it had been his plan.

In attempting to deny that note, my Lady, he showed himself not only to be reprehensible but also to be dishonest. The submissions, we would say, as Mr Skelton has said, on behalf of the senior executives for this Trust enter into the realms of fantasy.

Tony Chambers failed to accept personal responsibility for anything that happened following his involvement in June 2016, now or at any time. The Families will say that he was almost biologically instinctive towards self-preservation. He showed himself to be incapable of being reflective or self-critical thought and that the contemporaneous accounts recording his inability to understand why he faced a vote of no confidence or why he could not be appointed a chief executive elsewhere demonstrate a staggering lack of insight. This carried through into his evidence before this Inquiry.

In the face of everything, when asked whether he took personal responsibility for any failures, he failed to identify anything of substance.

Although apologies have been offered today about the failure to call the police in 2016, those apologies were not reflected in the evidence given by Mr Chambers before the Inquiry. That apology is, even if coming

from Mr Chambers, as with most statements made by Mr Chambers, tainted with a caveat. He didn't apologise for obstructing contact with the police, but rather he apologised for not calling the police soon enough.

The suggestion the executives had always intended to call the police but were just waiting for the right time is, the Families would suggest, pure fantasy. The Families will say that Tony Chambers was doing his best to prevent the police commencing a formal investigation, right up until the point when it actually commenced. His response when the consultants effectively bypassed him was to create a plan to dismiss them, as revealed in his note of 12 May 2017.

His were not the actions of someone who was working collaboratively with the consultants to find the right time to contact the police. His were the actions of somebody who was outraged at having been bypassed.

That Tony Chambers ever reached the position of a chief executive in an NHS Trust is of the greatest concern to the Families, secondly only to a concern there might be other versions of him within similar positions of power, entirely free from regulation.

The Families will say that he spearheaded the culture of cover-up and deceit that followed the decisions in June 2016 not to contact the police. He

was driven in that by a desire to preserve his own reputation and/or by an inability to understand and reflect properly on the issues that were being raised with him.

His approach may have been influenced by profound tribalism that drew battle lines between doctors and nurses. In Tony Chambers' case, however, it is tempting to conclude that his main priority was himself.

Ian Harvey was a more intelligent witness than Tony Chambers but should not escape criticism. Analysis of his role and events shows him at the heart of the cover-up, misleading Dr Hawdon and the RCPCH and misleading the Families when he interacted with them.

Although Mr Skelton has addressed in detail the issues surrounding the inquest into the death of Child A, we would echo his submissions. It is inconceivable, in our view, that Mr Harvey was unaware of the issues surrounding Letby's potential involvement in the death of Child A and the relevance of those to the coronial process.

Alison Kelly, who sits alongside Mr Harvey in these submissions, was a similarly unimpressive witness who failed to accept any personal responsibility for any of the failings in management or direction.

In his submissions at paragraph 281, Mr Kennedy KC

highlights a number of examples of her tendency to blame others rather than to accept personal responsibility. We would adopt that analysis and add to it.

The quality of a good leader in any organisation is the ability to accept responsibility when things go wrong. A common charge that could be levelled at all of the senior executives is that their desire for self-preservation and instinctive need to avoid responsibility permeates their actions throughout the period being discussed by the Inquiry and their conduct towards the Inquiry. Their application to stop the Inquiry, to avoid any criticism, is entirely typical of that attitude.

There are two key examples in relation to Ian Harvey and Alison Kelly and their role in what we describe as the cover-up.

The first is the interactions with the Families.

The precipitating cause of the interactions with the Families appears to have been the completion of the RCPCH report which was referred to by The Sunday Times in around February 2017. No parent or clinician had been shown either final versions of the report before that time, despite it having been in the hands of the executives for many weeks and months by that time.

That Ian Harvey's reply to the press enquiry had

been disingenuous was immediately obvious, but still nothing he would accept. He said:

"This was a report that we had asked for and invited from The Royal College. At the time of requesting the review and in the interests of transparency we were open with our board, our governors, our staff, patients and a wide range of stakeholders including the local media. We received a final report in December 2016 and it is due to be published next week. We have carried out additional independent reviews as requested as part offer this process. Medical Director at The Countess of Chester Ian Harvey said: 'We have done all we can to keep parents informed and our clinical teams will be contacting them again ahead of the review being published ..."

The impending publication of The Sunday Times piece forced the Countess of Chester Hospital to communicate the outcome of that service review to the parents. The Families believe that had this piece not been published by The Sunday Times, they would never have learned of the existence of the report, nor the substance of the complaints raised.

The impact of the release of that story might have on the Families only appears to have been appreciated by the Countess of Chester at the last minute, leading to

late disclosure and further stress and anxiety for family members. The delivery of a letter to Mother EF by black cab, 30 minutes before publication, is entirely indicative of the executive management's approach to the parents, their duties of care, candour and honesty towards them.

The claim in that letter there had been previous attempts to contact them is simply untrue. The only contact that Mother EF had at all from the Countess of Chester Hospital to that point was a repeated request to return a breast pump that had been given back before she even left the hospital. Since then, Mother EF had not been provided with any bereavement support whatsoever and nor had her consent been sought for the inclusion of her child in Dr Hawdon's case review. Neither were any of the Families warned of potential impact of the RCPCH report, its publication or told about the impact of it being published upon them.

The imminent publication of The Sunday Times report also prompted a cryptic phone call to Mother C from Sian Williams. This immediately aroused suspicion and anxiety within Mother C about what had been found.

Following the posting of the report, Mother C made a further telephone and in person contact with Sian Williams on 6 February 2017 and her questions were

not answered, concerns were explained away, despite the obvious anxiety and distress she was exhibiting.

Mother C had previously been informed, unlike the other parents, of concerns surrounding the NNU in the summer of 2016 and attended an impromptu meeting with Sian Williams and Alison Kelly, who told her that the investigation was just a formality to check staffing levels because there had been a small increase in the number of deaths, but they didn't think it was significant. They said there was nothing more to say at that stage and they could find out more once a report had been done.

In evidence Sian Williams accept that this was untrue and it was misleading but told the Inquiry the executives had given her instructions about the limits of what she could say. As was put to her, she had been given those words of reassurance at the same time Sian Williams herself considered that police should have been called in, and this was cover-up in the name of kindness.

Alison Kelly's evidence was that she simply could not recall the meeting. She offered no explanation or excuse beyond her reflection that:

"... we didn't get the communication right ... and we didn't get the balance right ..."

Those words of apology are inadequate. Mother C was lied to by Alison Kelly at that meeting.

After meeting with Sian Williams on 6 February, Mother C wrote to Ian Harvey by letter dated 7 February 2017. She set out for him in the clearest terms just what the impact had been from the Trust's disgracefully poor efforts to inform or update her in relation to the emergence of concerns about the NNU and the progression of the investigations. She immediately recognised and set out the facts that he and the other executives were seeking to conceal and suppress, by saying:

"The report does strike me as having some suspicion that there were some unusual features in the deaths ... and that perhaps there was something going on in the unit that caused or at least contributed ..."

This was a without context reaction from a bereaved mother to a redacted version of the RCPCH report. It demonstrated immediately the obvious advantages to treating patients and families with candour and respect and as partners in the investigation of safety concerns and, on the other hand, just what a self-justifying echo chamber the Countess of Chester Hospital management had become.

The approach to Mother C was essentially

patronising, hoping that she would not have the intelligence to see through the features missing from the redacted report and ask further questions.

It is the context of Mother C's reaction to the RCPCH report that makes Ian Harvey's subsequent correspondence and meeting conduct so egregious. His first strategy was to delay. When Mother C received no reply to her letter, she telephoned the hospital on 13 and 14 February without success, eventually successfully obtaining an appointment to meet Ian Harvey a week later on 20 February 2017.

Extraordinarily, no note of that meeting has emerged from the disclosure provided to the Inquiry by the Countess of Chester Hospital at odds with normal practice. No letter was ever sent to Mother C to summarise and record the events discussed, and no contemporaneous note has ever been provided. This is in variance with Mr Harvey's usual practice, which is revealed through various notes of meetings and interactions that he engaged in.

Mother C set out her recall of the meeting:

"Ian Harvey apologised to us for poor communication. He advised that some small areas that could be improved upon had been noted in the review of Child C's care, but nothing of concern ... there was

nothing that could be changed about [the] care that would have affected the outcome and prevented his death. We were relieved to hear this. This is what we had wanted to hear, and we were aware that nothing ever goes perfectly so we had expected some areas of improvement to be noted. The conclusion of the investigation would allow us to move forward and not to have this investigation and uncertainty hanging over us ..."

When Ian Harvey gave evidence he stated that he could not recall the detail of the conversation. Mother C's account was unchallenged when she gave evidence and remains undisturbed. The inference, therefore, stands that the Families raised in opening.

If the Inquiry accepts Mother C's evidence on this issue, Ian Harvey lied to her. At the time of the meeting he was in possession of a report from Jane Hawdon that criticised the quality of the care provided to Child C and concluded that his death may have been preventable had the standard of care been better. Ian Harvey was aware at the time of this meeting that serious concerns had been expressed by consultants in the unit that Lucy Letby had been deliberately harming babies on the unit, including Child C. He was aware that Mother and Father C had been provided with an incomplete version of the RCPCH report,

which omitted references to that issue.

Ian Harvey's subsequent correspondence with Mother C reinforced the misleading and dishonest approach he had taken.

If his evidence is accepted on the point, by the time of his letter to Mother C on 28 April 2017 he had reached a point where he knew that police were going to be called and an investigation undertaken but, as was put to him, he told her none of that, he gave her a completely misleading impression of the state of affairs.

The Families were informed about the Hawdon report in April 2017. Even then, they were not provided with more than extract pages from her case note. The extracts had themselves been substantially amended by Ian Harvey, a fact which he did not disclose, and this was the first point where Mother EF saw the contents of the records created by Letby on the night of Child E's death.

Mother EF was able to appreciate for the first time that the information in the records was wrong and that Letby had falsified the notes. Thankfully and by chance she was able to obtain her mobile phone records and corroborate her own recollection. This valuable information was almost lost due to the delays in sending

out the reports.

Dr Hawdon was personally shocked that her report had been provided to the Families in the way that it was, insufficient covering information and explanation had been provided. It was inappropriate to share them outside of a face-to-face meeting, particularly in a time of grief.

We should not lose sight of the fact that the version of the Hawdon report that Ian Harvey provided to Mother C was one he had amended from the original. He did not tell Mother C that he had done this, nor did he inform Dr Hawdon that he was passing off his amendments to her reports as the original.

Moving then on interactions with external bodies.

On 22 December 2016 the Care Quality Commission held an engagement meeting with the hospital. The hospital was represented by Ian Harvey, Alison Kelly, Sian Williams and Ruth Millward and Julie Hughes and [Deborah] Lindley from the Care Quality Commission. The agenda for the meeting noted neonatal services to be a key risk area under the heading "Strategic Update For [the] Trust". There was discussion of the RCPCH report but it was not disclosed to the CQC. There is no mention of Letby nor of the consultants' concerns, which mirrored the approach taken by Alison Kelly when first

reporting the fact of the RCPCH review on 30 June 2016. The CQC were not informed that Dr Hawdon had been instructed to conduct a forensic Casenote Review, let alone that she had reported that she had been unable to fulfil her instructions.

The first person outside of the Countess of Chester directorship to be shown the final redacted disseminated version of the RCPCH report was Letby herself on 31 January 2017.

On the day before she was given that special treatment, the consultants had taken the opportunity of reiterating their requests to be shown both the RCPCH report and Dr Hawdon's report. Again, Tony Chambers refused to accept that the delay in communicating and implementing the RCPCH's immediate recommendations put patient safety at risk, even when it was pointed out to him in evidence.

There were further engagements with the CQC in February 2017. The minutes recorded the picture communicated to the CQC on that occasion was that the outcomes of the investigations were limited to "lessons to be learned around transport processes and the incident reporting system".

This might be thought to be something of an understatement. Alison Kelly was prepared to concede

that:

"... [perhaps we] should have shared a bit more information that time, but we were still gathering the information internally ..."

She agreed that the CQC had been told nothing of Dr Hawdon's instructions nor that she had reported that four of the deaths remained unexplained and required further investigation, but she denied that the effect of those omissions was to mislead the CQC.

On 14 February 2017, at a meeting of the executive directors three days before the CQC had visited it, it had been noted that having now seen the RCPCH and Hawdon reports, the consultants were adopting a "firmer position" that the neonatal deaths were "not natural causes", yet not a hint of this was communicated to the CQC. Quite the opposite.

Perhaps the most revealing of Alison Kelly's answers came when it was put to her it would have been perfectly appropriate to tell the CQC that a consultant neonatologist had recommended more investigations for four babies, and she replied simply:

"We could have told them, but we didn't have the answers at the time so ..."

In that answer there was a direct echo of a managerial culture and tone set by Mr Tony Chambers.

Since there was no pleasing PR-appropriate answer available, the problem was not disclosed.

Ms Kelly displayed no reflection or understanding of the danger of that approach even to the point of her appearance in the witness box before the Inquiry.

The inappropriate culture and tone set within the Countess of Chester Hospital under Mr Chambers' management had become indelible.

It is not only the CQC who were misled during this period. In November of 2017 Alison Kelly wrote to NHS England explaining why the Countess would not share the RCPCH report with them at that time. The terms of that letter advanced as part of the justification was that a review team had assured the Trust that there were no immediate actions or concerns. That entirely ignored and obscured the fact that the report made a series of recommendations under the heading "Recommendations: Immediate". The clear intention of the letter was to delay provision of the RCPCH report to NHS England at a time when the executives had it to hand, and could easily have provided if they had chosen to.

As with the CQC, Ms Kelly's justification for that approach was that the executives collectively "wanted to make sure that we had a fuller picture". This, we say, can be seen as a euphemism for "we wanted to be sure we

were presenting good news rather than problems".

Here, as elsewhere, Ms Kelly repeated her defence that the misleading of NHS England about the availability of the report was not done intentionally, an explanation we would say simply cannot stand in the light of the consistent and deliberate strategy to avoid scrutiny.

My Lady, these cultural failures sit amongst a number that are set out within our written submissions. They are also reflected clearly in cultural failings and problems found in other Trusts at previous inquiries, and we've drawn your attention in our submission to the Mid Staffordshire Report, the Bristol Report and the Ockenden Reports, the Kirkup Reports.

The evidence of Helené Donnelly we found to be particularly important on this point, and the points where she was describing her experiences from Mid Staffordshire a number of years before these events occurred. She was asked the questions:

"Is it your experience that Trust managers, on occasion, are resistant to taking such a step?"

Which is about going to the police. And she said:

"Yes.

"Question: Based on concerns about the

reputations of either themselves or the Trust, is that a problem?"

And she said:

"Yes, absolutely. I do think this harks back to my concerns around HR practice as well, [in] that the focus is on reputation of the organisation and protecting the organisation and not necessarily on doing the right thing and having transparency and openness to make sure we can all be assured that either there is a problem and therefore it needs to be addressed through the appropriate routes and channels or actually there isn't a problem but we looked into it robustly and thoroughly and transparently and everybody can then be assured. And those things don't necessarily happen."

The culture and the problems and the failures involve a collision between the need for patient safety as a priority in one direction and the pragmatic pressures that appear to be applied to managers to protect reputation of themselves and the Trust and ensure finance streams into the Trust, and those things seem to be brought into tension in a way that often causes managers to act in a way that is contrary to patient safety, and that issue appears to have arisen in every single inquiry in one form or another that's ever been undertaken into a healthcare disaster, and it is

clear here it cannot keep happening.

Briefly with regard to the duty of candour, the duty of candour, my Lady, is a subset within patient safety. Patient safety requires openness, honesty and transparency. In order to create a culture that is safe, one needs to have openness and transparency. You need to be honest and recognise failures. People need to be able to come to you and say, "There is a problem. We're worried about the practice of this individual. This needs to be done to make things better." If a culture is open and allows that, that protects patient safety.

If people are allowed to go to patients and say, "We are sorry, something has happened. It's gone wrong. It has affected you and we are sorry about that and it's happened for this reason", it shows openness towards patient safety. So we can't view these things in silos. We have to recognise that they're all part and parcel of the same thing.

When things go wrong, though, we see them go wrong in every single area. Where patient safety fails, candour fails. Whistleblowers are persecuted. Openness and transparency disappears. And those are all the hallmarks that are easy to spot in a failing toxic culture.

My Lady, those are clear from here but it is sometimes not enough to say to a Trust, "You need to be candid." There was a duty of candour in place in 2015 when these events happened, and in their opening statement to the Inquiry the Countess of Chester Hospital said, "We've entirely failed to follow the duty of candour." Why did that happen? Why is it ignored? Because it is ignored for the same reasons that if patient safety fails and you don't have an honest and open culture, then people seek to take steps to sidestep the duty of candour. People seek to take steps to sidestep the Speak Out Safely policies, and they do that because the things are a hindrance to what they are trying to achieve by way of protecting reputation.

The people who are able to do that with impunity are unregulated hospital managers, and unless you embed into the system a means of regulating hospital managers, of bringing them to task when they don't fulfil these duties, then these duties are empty because there may well be a strong impetus from those who are regulated by the GMC or the NMC to be candid because their regulations tell them to be. If they are told or bypassed by a hospital manager who is unregulated to not follow the duty of candour, or it is ignored, there is nothing that anybody can do about that because that

person isn't regulated and they can't be brought task for it.

And that underpins in all of this the importance of there being regulation and accountability for senior hospital managers, individuals who are very well paid and hold positions of great power and responsibility. It was pointed out during the course of the Inquiry that it is somewhat anomalous that out of everybody operating within this hospital, the only senior important people who are unregulated are the hospital managers, unless they happen to be doctors or nurses by registration and still registered.

The position has now been reached, my Lady, where it is not enough to simply say this cannot happen again. We need to be aware of risks like this. We need to prioritise patient safety. People have been saying that for a long time and it hasn't changed.

We now need something tangible that forces change, and the position we say has now been reached where regulation of hospital managers with proper prioritisation of patient safety is the only way forward.

I want to end as I began by saying some words about the Families or some words from the Families. All of them have expressed their gratitude to this Inquiry

for the way it has been conducted by yourself, by the Inquiry team, by Counsel to the Inquiry, by everybody involved and the empathy that has been shown towards them.

Their common goal is to seek change so that other people don't have to go through what they have been through, and that isn't limited simply to avoiding the next serial killer in a healthcare setting but that is about changing patient safety culture so that individuals who come into NHS hospitals are saved from risks posed by a number of sources, whether that be poor medical care, whether that be deliberate harm or indeed whether that might be a culture that doesn't value or empathise towards them.

Mother C in her comments before the Inquiry said:

"The last ten years have been filled with grief, pain, trauma and confusion. We have been horrified to learn how the woman who murdered our son was protected by a pack mentality and afforded so much support without scrutiny, whilst ourselves and other families were left in the dark and at times actively lied to. There is absolutely no doubt that the actions of senior management delayed justice and their accounts and weak words of condolence demonstrate their lack of true reflection on the mistakes they made. The executives'

attempt to halt the Inquiry shows their own self-serving intentions and ongoing lack of respect or care for the Families. The media PR campaign aimed to garner public sympathy for Letby demonstrates a complete lack of understanding for Letby's crimes and the complexity of the case. The misinformed and inaccurate media circus surrounding this case, our son and the babies is potentiating the distress of all the Families involved.

"We are forever affected not only by Lucy Letby's crimes but by the way we have been treated by the Trust."

Mother D wrote a very evocative, beautiful, poetic piece that we've attached within the written submissions and I won't be able to do it justice by reading it out, but I would like to say this part of that:

"I would like to remind every single person who hears or reads our message we are here today because our babies lost their lives ... My baby died, my child did not survive the attacks and my heart did not make it through either.

"I am deeply affected every day, and broken beyond my tears.

"I sincerely hope this Inquiry will help in avoiding anything of this nature ever to happen again. I want people to remember that being brave, responsible

and selfless by speaking up and facing adversity is always the right thing to do.

"For the doctors that spoke up on behalf of our babies to stop a monster at work, for their relentless effort despite being disrespected, threatened and not valued ... I am grateful and this has brought me reassurance that good people do exist and can make a difference.

"Thank you."

Mother and Father J said:

"Throughout the whole process, from criminal investigations, trial and even more so through the public inquiry, I couldn't understand why it took the Trust so long to act. The main responsibility that the executive team had was to protect their patients. This should have always been their main priority and not staff budgeting and reputational concerns. Any staff member who was under suspicion of unexpected events or babies deteriorating or dying should have been removed at that point following their own safeguarding policy. This would have allowed to protect patients first but, secondly, protect that individual while investigations and policies were followed and protected those who raised concerns. The executive head has the overall responsibility to ensure this training and guidance is

pushed down the teams on the ground and carried on. They failed to push the button when they learned of concerns being raised. Their own policies stated that no evidence was required, just concern. This was a huge failure. In view of this and the other concerns of how the executives behaved and handled this situation, calls for personal accountability to be imposed at this level. The executive board of any hospital are responsible for thousands of people's lives and care. They need to understand that they will be held personally accountable for their decisions leading to financial implications, removal from professional activities and potentially prison."

I want to finish finally with words of evidence of Mother and Father K. It's Mother K's evidence before the Inquiry, and she gave evidence on 23 September 2024.

She said:

"There's no accountability for anybody in a senior position to make -- if they don't make the decisions based on the information that they're given, they need to be personally accountable for it. There's many organisations out there that have that in place. They're not dealing with lives but they're held personally accountable, they will be fined, they can be put into prison, because they haven't followed

procedures that are put in place to safeguard against these issues.

"That's exactly the same as what happened in the Countess, but they're dealing with people's lives and the impact is forever. It doesn't stop. It doesn't stop. For myself and my husband, the ripples are unbelievable and I never appreciated that and, you know, you're around and you hear it but you don't appreciate until you're in it and it has scarred your life. It's changed you. You look and you don't only just grieve your daughter, you're grieving who you were. I grieve for who we were as a husband and a wife.

"It just completely destroys what's around you and you have to pick yourself up and find out who you are again in this new world and it just ... doesn't go away and we live with it every single day and for nobody to take accountability for that or ownership for that is not right. It can't continue to be like that because this will happen again because what's the reason to stop them? There's no reason. They just protect themselves."

My Lady, unless I can assist any further.

LADY JUSTICE THIRLWALL: No, thank you very much indeed, Mr Baker.

Ms Langdale, it occurs to me we could probably

take a break now and then take your submissions.

MS LANDGALE: Is 15 minutes acceptable, my Lady? To have a break for 15 minutes?

LADY JUSTICE THIRLWALL: Certainly. So we'll start at quarter to 4.

(3.30 pm)

(A short break)

(3.45 pm)

Closing submissions by MS LANGDALE

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, on 21 February 2025, a request to pause the Inquiry was made by the former executives under section 17(3) of the Inquiries Act 2005. At the same time a parallel request was made by them to the Secretary of State for Health and Social Care to suspend the Inquiry under section 13 of the Inquiries Act 2005. The latter application is not under consideration by you, my Lady, as it is a decision for the Secretary of State, but it is plainly connected as it relies on the same facts.

As a starting point there is, we submit, an important difference between a power to pause and a power to suspend a statutory inquiry. The power to suspend an inquiry is vested in the Minister, not the Inquiry Chair. The explanatory notes to the 2005 Act

explain section 13, and that a suspension may be, for example, to ensure that an inquiry does not prejudice a criminal investigation. Section 13 says that the Minister may, at any time by notice to the Inquiry Chair, suspend the Inquiry for such period as appears to the Minister to be necessary to allow for (a) the completion of an investigation into any of the matters to which the Inquiry relates or (b) the determination of any civil or criminal proceedings arising from those matters.

The wording of section 13, in particular the test of necessity, has recently been considered by the Supreme Court in the matter of an application by JR222 for Judicial Review (Appellant) (Northern Ireland).

Lord Stephens made the following observations at paragraphs 60 to 65:

"(a) the purposes of a suspension were limited to those set out in sections 1(a) and 1(b) as set out above.

"(b) the existence of discretion to suspend an inquiry presupposes the ability to continue an inquiry while criminal proceedings are ongoing.

"(c) the power to suspend is vested in the Minister who must consult the Chair of the Inquiry before doing so.

"(d) the period of suspension is until the day specified in the notice or until further notice is given by the Minister.

"(e) if the Minister suspends an inquiry, they must provide their reasons and lay a copy of the notice before the relevant Parliament or Assembly."

The Supreme Court was of the view that there were two possible interpretations of section 13(1). On one view "for such period as appears to him to be necessary" only qualified the period of suspension and not the decision to suspend an inquiry. On another view, "for such period" may be read as a phrase within a sentence so that the qualifier of necessity applies both to the purpose of suspending the inquiry and the period of suspension.

Applying the ordinary principles of statutory interpretation as set out in R (Project for the Registration of Children as British Citizens) v Secretary of State for the Home Department [2023] AC 255, Lord Stephens concluded, at paragraph 82, in agreement with the High Court and the Court of Appeal that:

"The true interpretation is that section 13(1) naturally reads as one question which must be considered and answered as a whole. On this basis necessity

applies to both the purposes in section 13(1)(a) and (b) to the period of suspension."

It follows that the threshold for suspension of an inquiry is a high one, based on necessity to allow another investigation or proceedings to go ahead of the inquiry.

As with the power to suspend, the power to set up an inquiry is vested solely in the Minister. The Inquiries Act section 1 says that an inquiry can be established to investigate a matter of public concern. After an inquiry is announced, the Minister retains key responsibilities. The Minister appoints the Chair or Panel in accordance with sections 4 and section 10, sets the Terms of Reference in consultation with the Chair under section 5, has the primary duty to publish an inquiry report, section 25, and to end the inquiry, section 14, when it has fulfilled its Terms of Reference.

These powers available to the Minister are relevant, as they make clear the intention of Parliament in passing The Inquiries Act to give the Minister specific powers throughout the duration of an inquiry.

With that legal context in mind, an application to pause has been made by the former executives team under section 17(3) of The Inquiries Act. Section 17 provides

that the procedure and conduct of the inquiry are such as the Chair may direct, and that:

"In making any decision as to the procedure or conduct of an inquiry, the [Chair] must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or witnesses or others)."

It is submitted by the former executive team that you should pause the Inquiry for the following reasons:

Firstly, a preliminary application has been made to the Criminal Cases Review Commission based on new evidence from a panel of international experts who have considered the medical evidence given at Letby's trial. The submission made is that "this new evidence merits and is therefore being given serious consideration by the CCRC."

Secondly, it is said there is a real possibility that Ms Letby's convictions may be referred by the CCRC to the Court of Appeal and there quashed, and the Inquiry proceedings must be paused.

Thirdly, not to pause the Inquiry will create a "real risk" that you are not acting with fairness and/or avoiding any unnecessary cost because rather than proceeding on the basis of guilt, there is, I quote, "a real likelihood" of alternative explanation for these

deaths, and unexplained collapses, namely poor clinical management care and natural causes. The Inquiry will, therefore, be acting in breach of the duty to act fairly to individuals and witnesses, and if there is another explanation about how the babies can be harmed it would be wrong to ignore it.

And, finally, to continue to hear oral evidence and to publish a report runs the risk of incurring further significant costs on a false basis.

On the point of costs, the oral hearings have now been completed and you may consider that the majority of the costs in this public inquiry have already been spent. It is right that the preparation of your report will incur further costs, for example the preparation of warning letters to those who may be criticised and publication costs. However, albeit difficult to quantify, we submit there would also be significant costs incurred if the Inquiry were to be paused, because it will continue to exist for an unknown period of time.

We note at the outset that the request for you to pause before writing and completing your report is currently made for an indefinite period of time. There is some force you may think, my Lady, in the point made by Mr Baker KC that in practice the request made by the former executives is for a suspension.

Given the express power granted to the Minister pursuant to section 13 is subject to such a high bar when suspending an inquiry, we agree with the written and oral submissions of Ms Jenni Richards KC and Mr Andrew Kennedy KC that a decision by the Chair of an inquiry to pause under section 17 should be similarly constrained.

It is uncontroversial that it is open to the Chair of an inquiry to adjourn an inquiry for a particular purpose. That would normally be for a relatively short defined period. But if you were concerned the Inquiry should be paused for an indefinite period of time, or pending the resolution of any criminal process, then we submit that it would be for you to inform the Secretary of State of your view and to inform that, in your view, the Inquiry should be suspended.

Sir David Davis MP wrote to the Inquiry on 28 February 2025. He did not refer to section 17 but asked that, and I quote:

"Considering the extensive new evidence available, your Inquiry be paused until Ms Letby's avenues of appeal have been fully exhausted and the new evidence has been allowed to be fully tested before a court."

There is currently no appeal outstanding. If the Criminal Cases Review Commission exercises its power to

refer the case to the Court of Appeal, an appeal would be commenced in respect of any conviction in accordance with the Criminal Appeal Act 1995, section 9(2).

Yesterday you also received a letter, my Lady, from Bhandal Law, a firm of solicitors who now represent Letby. The letter asked you to suspend the Inquiry under section 13 of the Inquiries Act 2005. That request is mistaken in law for the reasons we have just outlined, the power to suspend is a power the Minister has, not you.

Sir David Davis also wrote to the Inquiry in August 2024. He raised concerns then about the convictions and expressed the view that the Terms of Reference should be broadened so as to not depend on the presumption that Letby's convictions were safe. Sir David Davis said that the deaths may not have been caused by murder but rather, firstly, the result of a systemic failure in a unit that was overstretched and underfunded. Secondly, by bad medical management of vulnerable neonatal babies on the unit.

Sir David Davis wrote:

"Both of these alternative hypotheses are supported by the Royal College of Paediatrics and Child Health's investigation in November 2016."

We now know, of course, that they were not.

The Royal College of Paediatrics and Child Health are a Core Participant in this Inquiry. Its investigation of the neonatal unit at the Countess of Chester in 2016 and any underlying material was heavily scrutinised by the Inquiry legal team. Seven statements were obtained from those involved in undertaking the RCPCH review. A number came to give oral evidence. The underlying documentation was disclosed to all Core Participants.

The RCPCH witnesses accepted in terms that its investigation or review should never have taken place, and would not have taken place had full information been provided by the hospital. Professor Stephen Turner, current President of the RCPCH, said in evidence that the review "went wrong from the start". Professor Turner accepted that the exploration of the causes of specific neonatal deaths was unsuitable for an invited review; that, ultimately, the report compiled did not identify any common factors or failings responsible for deaths, and the Terms of Reference were doomed to fail from the outset.

Ms Fiona Scolding KC, who represents the RCPCH in this Inquiry, made significant concessions in her closing address yesterday on behalf of the RCPCH. Those who place any reliance upon the RCPCH's report as

providing explanation for deaths of babies should read the transcript of Ms Scolding KC's address with care. Ms Scolding made reference to the fact that the review team thought that the police should be called at the time. Ms Scolding said that any suggestion that the review exculpates Letby was simply wrong and not a reasonable conclusion to make. Furthermore, she was clear that the review was never going to answer the question of why there was an increase in unexplained and unexpected deaths, and that the review did not provide those answers.

Doctors, nurses and managers in this Inquiry were variously asked about a number of issues related to the care provided in the hospital, including whether sicker babies were being admitted to the neonatal unit, pseudomonas, infection and staffing levels. Some nurses were also asked about a newspaper article which described them picking out names from a hat to decide who could leave early despite being in charge of a baby. You have oral evidence on all of these topics to assess, my Lady, including whether witnesses considered them explanations for the concerning rise in unexpected neonatal deaths and collapses at the time.

As you said when opening this Inquiry, you are not investigating the convictions in this Inquiry, but

rather what the response of those at the time was and should have been to what they knew or should have known at the time. You made it clear that the purpose of the Inquiry was to examine the wider circumstances, including the Trust's response to clinicians who raised the alarm, and the conduct of the wider NHS and its regulators.

With that in mind, we asked all organisational Core Participants in detailed Rule 9s to offer frank assessment of systemic deficiencies in patient safety, particularly as it affects babies.

It would not be appropriate for this Inquiry to make a determination about the international expert panel report and its evidential value. Whether the international expert panel report contains fresh or new evidence in respect of any or all of the deaths or deteriorations of the babies named on the indictment is currently a matter for the CCRC. As an aside, the letter on behalf of Letby received yesterday suggests that that there are in fact "19 detailed reports prepared by 16 experts" in support of her CCRC application. Any application will require rigorous analysis of the transcripts of evidence in the criminal case, including the evidence of Letby herself. Any alternative hypotheses for deaths or deteriorations

obtained subsequent to the convictions will be a matter for the criminal proceedings if there is a reference to the Court of Appeal.

In a public statement on 4 February 2025, the CCRC stated:

"At this stage it is not possible to determine how long it will take to review the application. A significant volume of complicated evidence was presented to the court in Ms Letby's trials."

The public statement noted that it usually receives around 1,500 applications for reviews (that is convictions and/or sentences), my Lady, each year.

Ms Kate Blackwell KC says that the CCRC has begun work in assessing the application and that it anticipates further submissions and reports being made to it. Furthermore, she says that a meeting has been set up between Letby's defence team and an allocated commissioner. No time period has been given for this.

If the case is referred by the Criminal Cases Review Commission to the Court of Appeal, the listing and hearing of any appeal in the Court of Appeal will also take time. On any view, the pause requested is for an unknown period in circumstances where currently matters have proceeded no further than an application to the CCRC.

Set against delaying your work now, my Lady, is a central purpose of your report. That purpose is to help keep babies safe in hospital in the future. You will only achieve that purpose by identifying shortcomings, failures in safeguarding, oversight and culture, and by making recommendations where it is necessary to do so. Those recommendations will, of course, be influenced by the facts as you find them to be. We agree with Mr Skelton KC that there is a risk recommendations lose force when they are dissociated from facts.

The convictions of Letby resulted in this public inquiry being ordered. Unsurprisingly, the Inquiry legal team addressed the issues and questions raised in the Terms of Reference upon the basis of her guilt. As a matter of fact, Letby stands convicted of multiple murders and attempted murders. We submit that it would have been wrong in law to have approached this Inquiry in any other way. Throughout we have observed the requirement for the need to act with fairness towards all parties, not least Letby's victims and their families.

It is recognised by all Core Participants that sudden unexpected death in infancy protocols were not followed, and basic principles and practice of

safeguarding were overlooked. We heard from Dr Garstang, a clinical associate professor of child protection at the School of Nursing, who gave evidence on safeguarding and the child death review process, that NHS England had not yet agreed to funding for the RCPCH to update the Kennedy guidance. We heard yesterday from NHS England and the RCPCH that a commitment has now been made in respect of funding for that work.

There is clearly work to be done in 2025 to ensure that all those working in the NHS understand their duties and responsibilities towards babies in hospital, and that deliberate harm being caused on their ward or in their hospital is always a possibility.

We agree with the submissions made by Ms Fiona Scolding KC yesterday that the culture of safeguarding within education and schools appears far more developed than the culture within the NHS when it comes to evaluating any risks posed to children or babies from staff.

It is significant that where it was relevant to do so, all of the Core Participants in their submissions agree that the police should have been called earlier to investigate suspicions and concerns about Letby, and the increase in sudden and unexpected neonatal deaths at the Countess of Chester. Furthermore, there is general

consensus that a safeguarding culture within the hospital and more widely did not adequately address the possibility of deliberate harm being caused by a member of staff.

The Families' teams and most of the Core Participants have given great assistance to the Inquiry on the important topic of recommendations. You were clear, my Lady, that existence of this Inquiry should not prevent any organisation from understanding internal investigations or implementing any changes aimed at improving safeguarding and culture. For example, we received evidence during the Inquiry about the Nursing and Midwifery Council's reviews of its own internal processes and the role of its Employer Link Service. NHS England, meanwhile, have undertaken a review on the control of insulin.

In all of the circumstances, whether or not there is a prospect of a referral by the CCRC to the Court of Appeal or any successful appeal by Letby, we submit there is no need to pause this Inquiry in the terms requested. It is not unfair to the former executives for you to complete your task. My Lady, you will arrive at your conclusions and judge all of the witnesses by what they knew and did at the time, and not with the benefit of hindsight. Where you are able and consider

it necessary to make recommendations which will contribute to keeping babies safe in hospital in the future, we submit that there is an obligation to do so.

On matters beyond the pause application, there is some suggestion in the submissions of the former executives that the narrative of the Inquiry was to accept the doctors' accusations of bullying against them without the necessary scrutiny required. That is rejected. Both doctors and senior managers faced difficult and challenging questions, and it is the answers that were given which you will assess.

As the submissions of the Family Groups demonstrate in particular, omissions or actions by both doctors and senior managers were scrutinised. All of the witnesses from whom we heard evidence were sent detailed requests for evidence by the Inquiry legal team. They were in most cases provided with extensive documentation, including previous accounts they had given, in order to assist their recollection of events. They had seen every document they were referred to in the witness box in advance. Where witnesses were represented, their own counsel were able to ask questions of the witness at the end, in order to pick up issues as they saw fit. Some witnesses were more reflective than others about the challenges that arose

at the time in the hospital and how they responded. Most accepted they should or could have acted differently. The significance of their reflections, my Lady, and how they expressed them is ultimately a matter for you.

In its opening last September, the Inquiry legal team set out details of the written evidence received and many of the questions or issues to be addressed by the witnesses. The role of the Inquiry legal team was to test the evidence of all of the witnesses who gave oral evidence, particularly where documents and contemporaneous records were inconsistent with what was being said, and where there were conflicting accounts between witnesses. As Chair of this Inquiry (and having listened to every witness), my Lady, it is for you alone to assess the totality of the evidence and the role of each witness in the events as they unfolded.

When writing your report, where you decide that any person or organisation should be criticised for any reason, they will have the opportunity to respond to a confidential warning letter in the summer outlining potential criticisms to be made. You will consider each response to any warning letter before you finally determine what comments or criticisms you make in a published report.

It is also important to make clear about our process that Core Participant legal teams have had access to a vast amount of underlying documents on Relativity. Core Participants were able to identify documents that they considered to be of relevance and documents that they believe should be explored in oral evidence.

The closing submissions refer to materials adduced in evidence and which are published on the website. They also refer in some cases (the CQC, for example) to materials disclosed to Core Participants as part of the Inquiry's investigation but which have not been adduced in oral evidence. Often, that cohort of material includes information that is sensitive and irrelevant. Realistically, it is neither proportionate nor necessary to spend further time and cost publishing these documents on the website.

The Inquiry witness process relies on extensive collaboration between all of the legal representatives, and the Inquiry has benefited and is grateful for the assistance of all counsel and solicitors with this. The Inquiry received 364 written statements, 18 statements in respect of Part A of the Terms of Reference, 250 statements in respect of Part B, and 96 statements in respect of Part C.

The oral hearings began on 10 September 2024, and concluded on 17 January 2025. A final witness gave evidence on 24 February 2025 (as it was more appropriate to hear the evidence of this witness after employment proceedings had completed).

All Core Participant legal teams were invited to comment on a provisional witness list and identify any further witnesses they wished you, my Lady, to call. Some Core Participants did identify further witnesses to be called, and witnesses were added.

The Inquiry heard oral evidence from 134 witnesses. As with all public inquiries, and pursuant to a Rule 10 process under The Inquiry Rules, what witnesses were to be asked about involved a review, week by week, and collaboration between legal teams. Where Core Participant advocates applied for permission to question any witness themselves, this was agreed by Counsel to the Inquiry in every case. My Lady, you were not asked to adjudicate on any such application.

In addition to the questions asked directly by the Core Participant advocates, Core Participants can and did submit a number of questions, topics or documents that they sought Counsel to the Inquiry to explore or ask a witness about on their behalf.

In conclusion, my Lady, the Inquiry legal process

has worked as it should and has been a fair and collaborative one. Counsel and Solicitor to the Inquiry would like to acknowledge that from the Core Participant teams.

Finally, we submit that you should not accede to the request to pause in your report writing or warning letter process. Letby's convictions result from a full and lengthy judicial process. Delaying report writing and your consideration of recommendations would not be fair to the Families where they have given evidence to you and are motivated to prevent the suffering of others in the future. It would not be fair to organisational Core Participants where they seek to improve the culture and safety of babies in hospital.

And contrary to the assertion made, we submit it is not unfair to the former executives either. They will be judged by what they did and said at the time, and not the benefit of hindsight.

The matter of the timing or publication of your report and/or sections of your report, of course, remain a matter that you should and are able to keep under review.

Those are our submissions, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Langdale.

So that concludes all the submissions and counsel's response. We'll adjourn now. I'm going to be sitting at 12 o'clock tomorrow to give some closing remarks and, if appropriate, I'll give you my decision on the application, but you'll be told about that some time tomorrow morning, but whatever form the hearing takes, I don't foresee that it will take more than an hour for those of who you have to plan your lives.

So thank you all very much for the submissions today and yesterday and I'll see you tomorrow.

(4.13 pm)

(The Inquiry adjourned until 12.00 pm on Wednesday, 19 March 2025)

I N D E X