

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

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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

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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

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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 taken 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

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1 position.

2 It has been suggested that Mr Chambers actively  
3 sought to stall and obstruct the police being called.

4 This is not accepted by him, nor is it supported by the  
5 evidence of the other senior managers. Their concern  
6 was that they went to the police at the right time when  
7 the reason for increased mortality had some clarity  
8 around it and could be fully articulated. They wanted  
9 to be in a position to assure the police that other  
10 factors had been more thoroughly investigated and  
11 eliminated as potential explanations. Furthermore, they  
12 had been given clear advice from Stephen Cross that  
13 calling in the police would have significant  
14 consequences for the hospital and, therefore, the  
15 Families that it served.

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

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

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

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

5 The Countess of Chester --

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

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

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

18 **MS BLACKWELL:** Yes.

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

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

25 The Countess of Chester Hospital has submitted in

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

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

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

25 "Mr Chambers was very concerned about the

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

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

10 She also said:

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

13 And:

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

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

25 The consultants were repeatedly described and

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

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

9 **MS BLACKWELL:** Yes, my Lady.

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

15 **MS BLACKWELL:** Yes.

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

19 **MS BLACKWELL:** Yes.

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

22 **MS BLACKWELL:** Yes.

23 **LADY JUSTICE THIRLWALL:** So the questions were about that.

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

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

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

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

14 **MS BLACKWELL:** Yes.

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

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

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

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

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

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

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

8 **MS BLACKWELL:** Yes.

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

11 **MS BLACKWELL:** It is.

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

14 **MS BLACKWELL:** Yes, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

19 Second, hindsight bias and exceptionality.

20 **LADY JUSTICE THIRLWALL:** But that's part of

21 Dr Spiegelhalter's evidence, isn't it?

22 **MS BLACKWELL:** Yes.

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

25 **MS BLACKWELL:** It should have alerted, yes.

15

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

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

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

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

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1 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

10 Equally, what might appear more obvious over  
 11 nine years after the final death and after three and  
 12 a half years of police investigation, a ten-month  
 13 criminal trial and retrial and the Inquiry's own  
 14 18-month investigation was simply not obvious at the  
 15 time. Hindsight bias may well have unfairly founded  
 16 much of the criticism of those who were operating in the  
 17 real-world context of the hospital at the time. It is  
 18 easy with the benefit of hindsight to identify features  
 19 of each child's collapse or death which were  
 20 significant. These were far less obvious, perhaps, in  
 21 real time, in isolation, in the context of a neonatal  
 22 unit treating and caring for babies in great need of  
 23 medical care. The Inquiry must ensure, we submit, that  
 24 hindsight bias does not permeate into its conclusions  
 25 and its report.

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1 any member of the senior management staff that there was  
 2 a concern that a member of staff was deliberately  
 3 harming babies. If having heard the evidence the  
 4 Inquiry finds that a clinician or clinicians harboured  
 5 real concerns that Letby was deliberately harming babies  
 6 prior to the death of Child P at the end of June of  
 7 2016, fundamental questions for your Ladyship to resolve  
 8 will be: why it was these individuals did not clearly  
 9 and unambiguously report these concerns either to the  
 10 police or anyone else; why they did not act on their  
 11 concerns, given their professional duties and codes of  
 12 conduct; why relations between senior managers and some  
 13 clinicians became strained in the latter part of 2016  
 14 and 2017 when there had been no previous history of  
 15 difficulty.

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

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

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

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

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

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

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

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

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

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

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

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

24 "The baby dislodged the breathing tube."

25 During his evidence at the first criminal trial he

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

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

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

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

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

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

23

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

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

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

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

22

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

5 **MS BLACKWELL:** No.

6 **LADY JUSTICE THIRLWALL:** So these are different --

7 **MS BLACKWELL:** Some of the nursing witnesses, yes.

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

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

12 **MS BLACKWELL:** All right.

13 **LADY JUSTICE THIRLWALL:** Yes.

14 **MS BLACKWELL:** Thank you, my Lady.

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

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

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

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

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

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

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

25

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

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

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

27

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

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

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

25 The fact that the thematic review was convened

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

8 Whilst it has been asserted by Dr Brearey that he  
 9 sought an urgent meeting with Mr Harvey on  
 10 15 February 2016 following the thematic review meeting,  
 11 there is no documentary evidence to support this, nor  
 12 does Mr Harvey recall this, nor would this be in any way  
 13 consistent with the tenor of subsequent emails from  
 14 Dr Brearey of which the Inquiry is in possession, nor  
 15 did Dr Brearey make any attempts to speak to Mr Harvey  
 16 in person or indeed any other members of the senior  
 17 management team following the meeting.

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

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

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

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

16 The thematic review was sent to Ms Kelly on  
17 21 March. Some three weeks passed between the receipt  
18 of the report and a follow-up email from Ms Powell  
19 asking for Ms Kelly's thoughts. There should have not  
20 been such a delay.

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

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

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

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

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

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

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

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

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

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

13 **MS BLACKWELL:** She did.

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

16 **MS BLACKWELL:** Yes.

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

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

25 **LADY JUSTICE THIRLWALL:** But she says in terms:

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

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

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

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

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

22 **MS BLACKWELL:** At the thematic review meeting on 11 May of  
23 2016 there were a number of possible factors discussed  
24 to explain the increase in mortality.  
25 If Dr Brearey held the suspicion at that meeting

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

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

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

13 **MS BLACKWELL:** Yes.

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

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

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

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

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

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

22 **MS BLACKWELL:** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 my Lady that they had no concerns regarding Letby.

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

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

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

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

25 The senior managers have emphatically refuted the

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

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

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

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

25 **MS BLACKWELL:** It should have been shared when it landed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **MS BLACKWELL:** No.

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

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

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

21 **MS BLACKWELL:** Yes.

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

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1 website.

2 **MS BLACKWELL:** Of course, it's quite so that the witness  
3 statements were uploaded to the system.

4 **LADY JUSTICE THIRLWALL:** Yes, so there was no misleading of  
5 anybody about anything that the nurses had had to say;  
6 is that right?

7 **MS BLACKWELL:** Yes.

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

9 Now to the application --

10 **MS BLACKWELL:** Yes.

11 **LADY JUSTICE THIRLWALL:** -- or to the letter.

12 **MS BLACKWELL:** Yes.

13 My Lady, the senior managers wrote to the  
14 Secretary of State for Health and Social Care and to  
15 your Ladyship on 21 February of this year requesting  
16 that the Inquiry either be suspended under section 13 or  
17 paused under section 17.

18 My Lady, section 13 of the Inquiries Act of 2005  
19 provides the Minister with a power to suspend the  
20 Inquiry at any time if it appears to him to be necessary  
21 to allow the completion of any investigation relating to  
22 any of the matters to which the Inquiry relates or  
23 the determination of criminal proceedings arising out of  
24 any of those matters.

25 Sub-paragraph (2) confirms that the power may be  
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1 way in which the Inquiry accomplishes its aims, fulfils  
2 its Terms of Reference.

3 And "conduct" is the manner in which the Inquiry  
4 is managed.

5 As my Lady is well aware, the Terms of Reference  
6 have as its introduction the convictions and sentence of  
7 Letby and confirms that the offences took place at the  
8 Countess of Chester Hospitals. Those are, therefore, we  
9 respectfully submit, the bedrock, the foundation of the  
10 Terms of Reference.

11 The Terms of Reference are then split into three  
12 areas of investigation (a) the experiences of the  
13 parents at the Countess of Chester Hospital of the  
14 babies named on the indictment, (c) the effectiveness of  
15 NHS management and governance structures and keeping  
16 babies safe, and (b) the conduct of those working at the  
17 hospital with regard to the actions of Letby in terms of  
18 whether suspicion should have been raised earlier, the  
19 responses to concerns raised and whether the Trusts  
20 culture, management and governance structures and  
21 processes contributed to the failure to protect babies  
22 from Letby.

23 But the Terms of Reference go on and confirm that  
24 the Inquiry will in operate within the legal framework  
25 of the Inquiries Act, that the procedure and conduct of  
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1 exercised whether or not the investigation or

2 proceedings have begun, and subsection (3) confirms that  
3 before exercising that power, the Minister must consult  
4 the Chair.

5 Section 17 of the Act --

6 **LADY JUSTICE THIRLWALL:** And you've written to the Minister  
7 as well, haven't you?

8 **MS BLACKWELL:** Yes, we have, yes.

9 **LADY JUSTICE THIRLWALL:** Yes. So section 17.

10 **MS BLACKWELL:** Section 17 deals with the duty of the Chair  
11 in relation to the Inquiry's evidence and procedure, and  
12 confirms that:

13 "... the procedure and conduct of an inquiry are  
14 to be such as the [Chair] of the Inquiry may direct."

15 And in relation to subsection (3):

16 "... as to the procedure or conduct of an inquiry,  
17 the [Chair] must act with fairness and with regard also  
18 to the need to avoid any unnecessary cost ..."

19 Section 43 of the Act provides definitions in  
20 relation to some of the words used within the course of  
21 the Act. It offers no further explanation or assistance  
22 in relation to procedure or conduct, and so it is our  
23 respectful submission that those two words should have  
24 their ordinary meaning applied.

25 The "procedure", then, is the way or particular  
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1 the Inquiry will be conducted by the Inquiry Chair,  
2 therefore echoing what it is in section 17, that the  
3 Terms of Reference are decided by the Secretary of  
4 State, that the order in which the issues are to be  
5 considered at the time that the Terms of Reference were  
6 drafted had not been decided but the priority was to  
7 conduct a thorough inquiry as swiftly as possible.

8 And the final paragraph of the Terms of Reference  
9 confirmed that the Inquiry Chair will provide a final  
10 report and, if appropriate, interim reports to the  
11 Secretary of State as soon as is practically possible.  
12 When that is practically possible it proves to be  
13 a matter for the Chair in her conduct of the procedure  
14 and conduct of the Inquiry.

15 The request for the suspension under the power of  
16 section 13 or the pause under my Lady's duty of  
17 section 17 --

18 **LADY JUSTICE THIRLWALL:** Which is it so far as  
19 I'm concerned?

20 **MS BLACKWELL:** -- so far as you're concerned, my Lady, the  
21 pause is under section 17, the duty to act with fairness  
22 and to avoid unnecessary cost -- was made pending the  
23 outcome of the CCRC's consideration of an application  
24 made by Letby in respect of her criminal convictions.

25 We understood at the time of writing from what had  
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1 been publicly stated and has now been confirmed in the  
2 letter received by the Inquiry yesterday from  
3 Ms Mortimer at Bhandal Law, Letby's solicitors, that the  
4 application relates to all of her convictions and it was  
5 received by the CCRC on 3 February of this year.

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

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

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

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

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1 panel --

2 **MS BLACKWELL:** Yes.

3 **LADY JUSTICE THIRLWALL:** -- have said --

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

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

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

19 **LADY JUSTICE THIRLWALL:** So what would the unfairness --

20 **MS BLACKWELL:** Well, my Lady.

21 **LADY JUSTICE THIRLWALL:** -- the potential unfairness --

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

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

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

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

25 **LADY JUSTICE THIRLWALL:** Sorry, seven of the experts on the  
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1 of Letby, so the midwives, the nurses, the doctors, the  
2 managers, the senior managers.

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

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

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

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

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

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

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

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

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

18 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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1 I had the power to do so --

2 **MS BLACKWELL:** Yes.

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

5 **MS BLACKWELL:** Quite so.

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

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

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

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

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

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

12 **MS BLACKWELL:** Yes.

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

16 **MS BLACKWELL:** Yes.

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

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

23 **LADY JUSTICE THIRLWALL:** Oh, I see.

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

25 **LADY JUSTICE THIRLWALL:** So if otherwise I would pause if

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

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

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

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

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

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

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

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

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1 **LADY JUSTICE THIRLWALL:** Do you want to say anything else  
2 about cost?  
3 **MS BLACKWELL:** Yes. I have addressed my Lady about the  
4 ongoing cost of --  
5 **LADY JUSTICE THIRLWALL:** Yes, because effectively the hard  
6 yards have been done and the costs --  
7 **MS BLACKWELL:** Yes.  
8 **LADY JUSTICE THIRLWALL:** -- have been spent.  
9 **MS BLACKWELL:** That's right, but --  
10 **LADY JUSTICE THIRLWALL:** The hard yards for everybody else.  
11 I am not saying --  
12 **MS BLACKWELL:** Quite so.  
13 **LADY JUSTICE THIRLWALL:** -- there aren't some more to come.  
14 **MS BLACKWELL:** Yes. There is still work, of course, for  
15 my Lady's Inquiry legal team to complete. The warning  
16 letter process, which I've referred to as being  
17 protracted and possibly costly, we don't know, but also  
18 the drafting of the report and the costs that are  
19 incurred in that procedure too.  
20 **LADY JUSTICE THIRLWALL:** But I infer from what you're saying  
21 that one could do A and C and the cost argument would  
22 not prevail but B we shouldn't do because --  
23 **MS BLACKWELL:** Significant --  
24 **LADY JUSTICE THIRLWALL:** -- it's the fairness argument.  
25 **MS BLACKWELL:** Yes.

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

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

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

25 My Lady, those are our submissions unless I --

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1 **LADY JUSTICE THIRLWALL:** Yes, all right.  
2 Thank you. We'll take the break now and we'll  
3 start again at quarter to 12.

4 **(11.21 am)**

**(A short break)**

6 **(11.44 am)**

7 **LADY JUSTICE THIRLWALL:** Mr Skelton.

**Closing submissions by MR SKELTON**

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

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

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

25 This is not a mandate for alarmism or

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

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

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

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

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

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

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

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

21 First, the consultants who first became concerned  
22 about Letby initially doubted their own judgment and  
23 didn't at that early stage consider they had enough  
24 information to be sure that she had attacked children.

25 They may have even hoped that other information would

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

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

11 At the time of Child D's death, Dr Brearey, the  
12 lead neonatal consultant, and Eirian Powell, the unit's  
13 manager and a senior nurse, had already identified that  
14 Letby was present for all three deaths. In their oral  
15 evidence to this Inquiry, Dr Brearey said that by the  
16 time he met Ms Powell to discuss the three deaths on  
17 2 July 2015, he had a concern that someone might be  
18 harming babies. Ms Powell said that when she discussed  
19 the possibility that a member of staff had harmed the  
20 babies with her nursing colleagues, this was just after  
21 June 2015, and then, as she put it, "all the time", and  
22 those colleagues were Yvonne Griffiths, Yvonne Farmer  
23 and Ann Murphy.

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

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

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

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

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

25 As Professor Mary Dixon-Woods explained early on

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

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

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

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

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

20 Excuse me.

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

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

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

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

13 Finally, one of the most significant concerns on  
14 the part of those raising the concerns or suspicions in  
15 2015 and 2016 was that they would find themselves  
16 criticised, ostracised and censured as a result. This  
17 could have been by way of accusations by colleagues and  
18 managers that they were wrong and were scapegoating and  
19 victimising Letby. It could also have been by way of  
20 formal counter-accusations that the facts were being  
21 misrepresented, that Letby was being bullied and that  
22 medical staff were covering up their own substandard  
23 care, with possibility that these matters could have  
24 escalated to disciplinary proceedings internally at the  
25 hospital, or externally at the GMC and NMC.

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1 murder and the risk of recurrence outweighed all other  
2 considerations.

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

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

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

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

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

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

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

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

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

25 Lastly, in June 2016, even after the deaths of  
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1 outlined.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 consultants to list their suspicions.

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

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

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

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

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

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

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1 and complex situation for the staff in the neonatal  
2 unit.

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

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

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

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

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

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

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

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

25 The clear inference that must be drawn from the

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

7 "All emails cease forthwith."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 They were not told about the thematic review.

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

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1 notification in 2017 evolved inexorably into a formal  
2 murder investigation, it is logical and reasonable to  
3 conclude that a similar course would have been followed  
4 based on similar information at any time in 2015 and  
5 2016.

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

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

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

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

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1 Dr McPartland.

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

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

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

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

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

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

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

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

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

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

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

19 **LADY JUSTICE THIRLWALL:** Mr Skelton, thank you.

20 I understand short, clear, all of which is very  
21 persuasive, but I just wonder how such a document copes  
22 when people can't believe it and want, as it were, to  
23 see it with their own eyes. Are you submitting, perhaps  
24 you are, that you need to make that explicit --

25 **MR SKELTON:** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

4 From the Families' perspective, the only fair and  
5 sensible course is for you to complete your work and  
6 submit your report based on the established facts of the  
7 criminal convictions and the many additional facts that  
8 you have carefully adduced over the last seven months.  
9 These provide a comprehensive picture of individual,  
10 collective and systemic failures to respond  
11 appropriately to Letby's suspected offending between  
12 2015 and 2017. Otherwise, the Families, the  
13 Core Participants, the NHS and the public will be  
14 waiting indefinitely for your assessment of what went  
15 wrong at the hospital, and the recommendations that you  
16 need to make for the immediate improvement of patient  
17 safety in the NHS.

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

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

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

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

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

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

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

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

13 So the balance is firmly in favour of proceeding.

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

25 My Lady, finally, as was said in the written

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

11 Thank you.

12 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.

13 Mr Baker.

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

16 **MR BAKER:** Yes.

17 **Closing submissions by MR BAKER**

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

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

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

25 **MR BAKER:** -- and I don't propose to read those out in their  
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1 have sat together through two trials, two failed appeals  
 2 and this Inquiry, and they've done that with one common  
 3 goal. Firstly, to discover the truth and achieve  
 4 justice for their children but also to make sure that  
 5 others don't have to experience the same harm that they  
 6 did.

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

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

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

3 **LADY JUSTICE THIRLWALL:** Certainly.

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

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

21 Almost all of the submissions made before you  
 22 refer to the dignity of the Families in these  
 23 proceedings and they have undoubtedly been very  
 24 dignified in the way that they've approached this, but  
 25 we should not overlook their courage and bravery. They  
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1 Whatever side of the debate people are on, people  
 2 should remember that the dead and harmed are not public  
 3 property to be dissected on television or on the  
 4 Internet.

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

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

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

21 The Families would hope that the one thing that  
 22 should unite everyone who reads the evidence given  
 23 before this Inquiry is a sense that the NHS should do  
 24 better when faced with these issues. The Families'  
 25 submissions highlight that the evidence before the  
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1 Inquiry demonstrates a number of things.  
 2 There were poor systems for investigating unusual  
 3 deaths.  
 4 There was a failure to reach or to react to  
 5 unusual blood tests.  
 6 There was a failure of safeguarding structures,  
 7 a failure to listen to concerns when raised and  
 8 a deliberate cover-up.  
 9 There was a suppression of evidence, a lack of  
 10 candour with Families, and then the persecution of  
 11 whistleblowers.  
 12 The message coming through the evidence is that  
 13 there was a total and absolute failure of culture at the  
 14 Countess of Chester Hospital, and on the part of  
 15 individuals a total failure to meet the basic standards  
 16 to be expected of senior, powerful and well-paid NHS  
 17 executives.  
 18 The volume of the noise surrounding this Inquiry  
 19 should not be allowed to distract from the message at  
 20 its heart. The failure of basic patient safety  
 21 mechanisms within NHS trusts cannot be allowed to  
 22 continue in this way. Many features of this case are  
 23 common and have been repeated through multiple inquiries  
 24 and investigations into healthcare disasters. If they  
 25 are not addressed they will continue to cause harm to

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

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

7 **LADY JUSTICE THIRLWALL:** Yes, certainly.

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

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

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

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

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

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1 patients and to their families by many different routes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 I agree that it would be wholly inappropriate,

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

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

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

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

25 "More specifically, in the context of this appeal,

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

5 The elephant in the room, my Lady, and the one  
6 which neither Letby nor her legal team are prepared to  
7 explain, is why she didn't call the evidence at trial.

8 The Families note that her counsel appears regularly in  
9 the media, is rarely asked a question, and when he is  
10 asked a question, refuses to answer. It is, we're  
11 afraid, a question that needs to be answered. The only  
12 reason why a defendant would choose not to call their  
13 own experts to give evidence is because they know that  
14 those experts, if tested in court, would be likely to  
15 convict them. A defendant cannot choose not to call  
16 their experts at trial and then ask for permission to  
17 roll the dice again when the gamble doesn't pay off.  
18 That is the definition, my Lady, of "expert shopping".

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

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

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

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

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

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

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

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

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

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

25 This is not a case, as I said in submissions

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

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

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

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

25 If we pause this Inquiry now and it's another  
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1 (12.53 pm)

(The luncheon adjournment)

3 (2.02 pm)

4 **LADY JUSTICE THIRLWALL:** Sorry to keep you all waiting.

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

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

25 Within the alphabetical chronology, that is from  
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1 ten years or even five years or even a year before  
2 anything can resume again, momentum will be lost.  
3 Momentum to change will be lost. The opportunity to  
4 make a difference exists now, and pausing will cause  
5 serious harm to that opportunity.

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

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

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

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

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

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1 Child G to Child P.

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

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

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

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

25 This is part of a pattern of odd and ghoulish  
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1 behaviour by Letby which troubled some of her colleagues  
2 and which is identified throughout this Inquiry. It  
3 also forms part of a picture of evidence that was there  
4 to be found if questions had been asked.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 a regular basis with their milk.  
 2 During the evening of 3 August 2015 she made her  
 3 usual journey to the neonatal unit, arriving there at  
 4 about 2100 hours. She was confident in her recollection  
 5 about the time because she was working to a feeding  
 6 schedule.

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

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

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

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

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

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

4 Mother EF gave evidence before the Inquiry that:

5 "I found out that the notes had been changed to  
 6 suit a different narrative of when Child E's bleed  
 7 started and that's why the registrar hadn't been  
 8 contacted, because he didn't know I'd been there and he  
 9 didn't know that Child E was bleeding at just before  
 10 9 o'clock."

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

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

19 Dr ZA --

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

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

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

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

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

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

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

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

25 The timing in the notes is confirmed by

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

5 Sorry, Mr Baker.

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

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

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

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

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

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

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

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

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

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1 Countess of Chester Hospital 26 years later.

2 The suggestion that we might be clouding our  
3 judgments with hindsight bias when judging the response  
4 to those insulin results is brought into sharp focus by  
5 this observation. Dismissing abnormal blood test  
6 results would have been as wrong in 1991 as it was in  
7 2015, as it would be now. No hindsight bias comes into  
8 it.

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

16 Having considered the universal revulsion to the  
17 crimes of Beverley Allitt alongside the sense of hope  
18 contained within the Clothier Report that such events  
19 should not be repeated, the Families cannot help but  
20 feel a profound sense of sadness that a little over  
21 20 years later that recommendation had been wiped out  
22 not only from the collective memory of the NHS but from  
23 those who were working within the Countess of Chester  
24 Hospital.

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

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

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

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

25 They failed to achieve the same result in the

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

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

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

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

10 (2.20 pm)

(A short break)

12 (2.34 pm)

13 **LADY JUSTICE THIRLWALL:** Mr Baker.

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

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

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

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

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

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

25 Now, although Dr ZA's decision is ultimately  
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1 a consultant responsible for the patient's care, then  
2 the opportunity for Dr ZA to attribute the result to  
3 a lab error, if that's what she did, would have been  
4 greatly reduced.

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

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

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

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

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

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

19 The laboratory passing that test result on to the  
20 hospital believed that they had discharged their duty in  
21 notifying them of the result, but took no action to  
22 ensure that there was a direct dialogue between the  
23 clinical scientist and the consultant who was  
24 responsible for decision-making. Had there been  
25 a mandatory requirement that a laboratory speak with  
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1 During the latter part of 2015, a number of  
2 clinicians working within the neonatal unit began to  
3 suspect the possibility that somebody might be causing  
4 deliberate harm to babies, and the Families would submit  
5 that by the time we get to October 2015, by the point of  
6 Child I's death at the latest, there were active  
7 suspicions regarding Letby's involvement in the deaths.  
8 This should have led to effective safeguarding action,  
9 but did not.

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

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

24 Firstly, the Inquiry will recall the evidence of  
25 Dr Gilby and her concern on being taken through the  
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1 records by Dr Brearey that the collapses were highly  
2 unusual and to her eyes suspicious. She felt that one  
3 of those incidents in isolation would have concerned  
4 her.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The evidence suggests that whether or not they had  
23 been communicated in clear terms before, the meeting on  
24 11 May 2016 involved a discussion surrounding Letby's  
25 potential involvement in the collapses and deaths. The

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 reprehensible behaviour if it had been his plan.  
 2 In attempting to deny that note, my Lady, he  
 3 showed himself not only to be reprehensible but also to  
 4 be dishonest. The submissions, we would say, as  
 5 Mr Skelton has said, on behalf of the senior executives  
 6 for this Trust enter into the realms of fantasy.

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

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

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

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

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

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

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

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

25 In his submissions at paragraph 281, Mr Kennedy KC

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

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

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

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

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

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

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

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

17 The first is the interactions with the Families.

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

25 That Ian Harvey's reply to the press enquiry had

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1 been disingenuous was immediately obvious, but still  
 2 nothing he would accept. He said:  
 3 "This was a report that we had asked for and  
 4 invited from The Royal College. At the time of  
 5 requesting the review and in the interests of  
 6 transparency we were open with our board, our governors,  
 7 our staff, patients and a wide range of stakeholders  
 8 including the local media. We received a final report  
 9 in December 2016 and it is due to be published next  
 10 week. We have carried out additional independent  
 11 reviews as requested as part offer this process.  
 12 Medical Director at The Countess of Chester Ian Harvey  
 13 said: 'We have done all we can to keep parents informed  
 14 and our clinical teams will be contacting them again  
 15 ahead of the review being published ...'"

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

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

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

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

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

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

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

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

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

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

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

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

3 After meeting with Sian Williams on 6 February,  
 4 Mother C wrote to Ian Harvey by letter dated  
 5 7 February 2017. She set out for him in the clearest  
 6 terms just what the impact had been from the Trust's  
 7 disgracefully poor efforts to inform or update her in  
 8 relation to the emergence of concerns about the NNU and  
 9 the progression of the investigations. She immediately  
 10 recognised and set out the facts that he and the other  
 11 executives were seeking to conceal and suppress, by  
 12 saying:

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

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

25 The approach to Mother C was essentially

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1 patronising, hoping that she would not have the  
2 intelligence to see through the features missing from  
3 the redacted report and ask further questions.  
4 It is the context of Mother C's reaction to the  
5 RCPCH report that makes Ian Harvey's subsequent  
6 correspondence and meeting conduct so egregious. His  
7 first strategy was to delay. When Mother C received no  
8 reply to her letter, she telephoned the hospital on 13  
9 and 14 February without success, eventually successfully  
10 obtaining an appointment to meet Ian Harvey a week later  
11 on 20 February 2017.

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

21 Mother C set out her recall of the meeting:  
22 "Ian Harvey apologised to us for poor  
23 communication. He advised that some small areas that  
24 could be improved upon had been noted in the review of  
25 Child C's care, but nothing of concern ... there was

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1 which omitted references to that issue.

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

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

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

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

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

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

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

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1 out the reports.

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

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

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

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

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

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

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

24 This might be thought to be something of  
25 an understatement. Alison Kelly was prepared to concede  
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1 Since there was no pleasing PR-appropriate answer  
2 available, the problem was not disclosed.

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

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

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

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

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

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

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

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

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

24 In that answer there was a direct echo of  
25 a managerial culture and tone set by Mr Tony Chambers.  
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1 were presenting good news rather than problems".

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

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

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

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

23 Which is about going to the police. And she said:  
24 "Yes.

25 **"Question:** Based on concerns about the  
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1 reputations of either themselves or the Trust,  
2 is that a problem?"

3 And she said:

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

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

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

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

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1 clear here it cannot keep happening.

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

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

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

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

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

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

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

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

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

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

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

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

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

9 "Thank you."

10 Mother and Father J said:

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

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

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

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

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

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

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

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

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

17 She said:

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

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

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

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

22 My Lady, unless I can assist any further.

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

25 Ms Langdale, it occurs to me we could probably  
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1 explain section 13, and that a suspension may be, for  
2 example, to ensure that an inquiry does not prejudice  
3 a criminal investigation. Section 13 says that the  
4 Minister may, at any time by notice to the Inquiry  
5 Chair, suspend the Inquiry for such period as appears to  
6 the Minister to be necessary to allow for (a) the  
7 completion of an investigation into any of the matters  
8 to which the Inquiry relates or (b) the determination of  
9 any civil or criminal proceedings arising from those  
10 matters.

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

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

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

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

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

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1 take a break now and then take your submissions.

2 **MS LANGDALE:** Is 15 minutes acceptable, my Lady? To have  
3 a break for 15 minutes?

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

6 (3.30 pm)

7 (A short break)

8 (3.45 pm)

9 Closing submissions by MS LANGDALE

10 **LADY JUSTICE THIRLWALL:** Ms Langdale.

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

21 As a starting point there is, we submit,  
22 an important difference between a power to pause and  
23 a power to suspend a statutory inquiry. The power to  
24 suspend an inquiry is vested in the Minister, not the  
25 Inquiry Chair. The explanatory notes to the 2005 Act  
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1 "(d) the period of suspension is until the day  
2 specified in the notice or until further notice is given  
3 by the Minister.

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

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

16 Applying the ordinary principles of statutory  
17 interpretation as set out in R (Project for the  
18 Registration of Children as British Citizens) v  
19 Secretary of State for the Home Department [2023] AC  
20 255, Lord Stephens concluded, at paragraph 82, in  
21 agreement with the High Court and the Court of Appeal  
22 that:

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

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

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

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

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

23 With that legal context in mind, an application to  
24 pause has been made by the former executives team under  
25 section 17(3) of The Inquiries Act. Section 17 provides  
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1 deaths, and unexplained collapses, namely poor clinical  
2 management care and natural causes. The Inquiry will,  
3 therefore, be acting in breach of the duty to act fairly  
4 to individuals and witnesses, and if there is another  
5 explanation about how the babies can be harmed it would  
6 be wrong to ignore it.

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

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

20 We note at the outset that the request for you to  
21 pause before writing and completing your report is  
22 currently made for an indefinite period of time. There  
23 is some force you may think, my Lady, in the point made  
24 by Mr Baker KC that in practice the request made by the  
25 former executives is for a suspension.  
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1 that the procedure and conduct of the inquiry are such  
2 as the Chair may direct, and that:

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

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

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

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

21 Thirdly, not to pause the Inquiry will create  
22 a "real risk" that you are not acting with fairness  
23 and/or avoiding any unnecessary cost because rather than  
24 proceeding on the basis of guilt, there is, I quote,  
25 "a real likelihood" of alternative explanation for these  
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1 Given the express power granted to the Minister  
2 pursuant to section 13 is subject to such a high bar  
3 when suspending an inquiry, we agree with the written  
4 and oral submissions of Ms Jenni Richards KC and  
5 Mr Andrew Kennedy KC that a decision by the Chair of  
6 an inquiry to pause under section 17 should be similarly  
7 constrained.

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

17 Sir David Davis MP wrote to the Inquiry on  
18 28 February 2025. He did not refer to section 17 but  
19 asked that, and I quote:

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

24 There is currently no appeal outstanding. If the  
25 Criminal Cases Review Commission exercises its power to  
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1 refer the case to the Court of Appeal, an appeal would  
2 be commenced in respect of any conviction in accordance  
3 with the Criminal Appeal Act 1995, section 9(2).

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

11 Sir David Davis also wrote to the Inquiry in  
12 August 2024. He raised concerns then about the  
13 convictions and expressed the view that the Terms of  
14 Reference should be broadened so as to not depend on the  
15 presumption that Letby's convictions were safe.

16 Sir David Davis said that the deaths may not have been  
17 caused by murder but rather, firstly, the result of  
18 a systemic failure in a unit that was overstretched and  
19 underfunded. Secondly, by bad medical management of  
20 vulnerable neonatal babies on the unit.

21 Sir David Davis wrote:

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

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

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

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

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

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

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

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

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

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

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

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

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

6 "At this stage it is not possible to determine how  
7 long it will take to review the application.

8 A significant volume of complicated evidence was  
9 presented to the court in Ms Letby's trials."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 In conclusion, my Lady, the Inquiry legal process

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

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

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

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

23 Those are our submissions, my Lady.

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

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

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

11 **(4.13 pm)**

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

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