THE THIRLWALL INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF
THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

A INTRODUCTION

1 We return to what we said at the start of the Inquiry. CoCH's thoughts remain with the parents of the babies that died and those that were harmed. We appreciate how difficult it must have been to hear some of the evidence given to the Inquiry. Opportunities missed, actions delayed or a reluctance to take important decisions will be of particular concern to the families. CoCH continues to keep in mind the profound suffering and terrible loss that the families have suffered. In this document we identify failings on the part of the Trust and of individuals employed or engaged by the Trust at that time. For those failings we apologise unreservedly.

(1) Approach

2 The Trust has endeavoured to work with the Inquiry Team in a collaborative manner. It hopes that these endeavours have assisted the Inquiry to obtain an understanding of what went wrong, when and why. The Trust remains committed to assist the Inquiry in any way it can.

3 These submissions are intended to set out the Trust's position on the central issues that the Inquiry has investigated. We have addressed much of this chronologically setting out where the Trust accepts failings and where it suggests that there have been failings on the part of others. We then seek to group some of these failings in section D entitled "Generic Themes"; our submissions in this section are brief, more in the form of conclusions, so as to avoid repetition of material addressed earlier. Given the stance taken in opening by the Former Executives, we devote section F to a response to their position, building on any relevant observations in the preceding sections.

4 We conclude this section by pointing out what is, sadly, obvious. Some witnesses (particularly the families) will have lived and breathed the events of 2015/16 each and every day that has followed. For others, their involvement will have been more intermittent and for some giving

evidence to the Inquiry this may have been the first time they have had to speak openly about those events. The impact of the passage of time on recollections will be variable.

5 It may be particularly difficult for those being asked to recall events for the first time. For those who have been closely involved (including those who gave evidence at Letby's trial) the requirement repeatedly to recall past events carries its own risks. Where possible, assessment of witness evidence against the content of the contemporaneous documents will be an important safeguard.

6 The Inquiry will also have in mind the risk of viewing past events through the lens of current thinking and with knowledge of what has transpired since 2015/16 in terms of the Police investigation into Letby's actions and her subsequent trial. This is particularly important to bear in mind when comparing what was known about causes of death in 2015/16 and what is now known following a lengthy, detailed and comprehensive Police investigation which exposed the care provided to neonates at CoCH to an unprecedented level of scrutiny. Any failings in the care provided should be understood in that context.

(2) Structure

7 The structure of these submissions is as follows:

- Section A: Introduction
- Section B: Background
- Section C: Events of 2015 to 2017
- Section D: Generic themes
- Section E: Submissions in relation to individual witnesses
- Section F: Response to stance of Former Executives
- Section G: Changes
- Section H: Recommendations
- Section I: Response to Chair’s note of 4 February 2025
- Section J: Submissions on postponement

8 We have bookmarked these sections and subsections within them for ease of navigation. We will provide a Word and pdf version of these submissions in the hope that the bookmarks can be preserved when these submissions are shared with other CPs.

(3) Naming conventions

9 We have endeavoured to follow the conventions that the Inquiry has used during its oral hearings. Hence, we identify documents by INQ number and, where appropriate, page number [INQxxxxxxx_yyyy]. Where we refer to witness statements, we use the INQ number of the statement followed by the paragraph number [INQxxxxxxx §yy]. For transcript references we

adopt the direction in the Chair's note on closing statements: therefore, [witness name/week number/day number/page number/line number].

10 We use the expression "the Trust" and "CoCH" interchangeably. The use of one expression over the other carries no significance. We refer to the Former Executives either individually by name or collectively as the Executive Team when addressing the events of 2015/16.

B BACKGROUND

11 The history of the Countess of Chester Hospital (CoCH) has been set out in the documents and statements that CoCH has submitted to the Inquiry; see Jane Tomkinson's witness statements [INQ0017158, INQ0017159, INQ0017160]. Whilst oral evidence was not heard from Ms Tomkinson on this topic, it is covered in her first statement [INQ0017158 §§5-15].

12 Dr Brearey was the neonatal lead clinician in 2015/16 and continued in this post until July 2020. In his statement he provides a helpful description of the structure, staffing and operation of the Neonatal Unit (NNU) [INQ0103104 §§17-29]. As the Inquiry is aware, the NNU operated as a Level 2 unit until the voluntary downgrading in July 2016. Despite a belief that the downgrade was a temporary measure, the NNU has not been returned to Level 2 status. The Trust acknowledges that redesignation as a Level 2 unit may not be a concern for the Inquiry. Insofar as it is an issue that the Inquiry wishes to address, concerns about the redesignation process were touched on by Dr Brearey in his witness statement [INQ0103104 §§489-490] and by Jane Tomkinson in her oral evidence to the Inquiry [Tomkinson/week15/13Jan/91/4-95/7].

13 As the Inquiry is aware there have been changes to the NNU since the events of 2015/16 - organisational, operational and physical changes. We address these further below in section G "Changes".

C THE EVENTS OF 2015 TO 2017

14 CoCH has reflected at length on the terrible events of June 2015 to June 2016, its response over that time, and its actions thereafter. It recognises that it is of the upmost importance to the families of Letby's victims that it identifies and acknowledges its failings and learns the appropriate lessons in response. Accordingly, this first section outlines the Trust's position as to what went wrong. It is structured chronologically and addresses themes as they arise.

(1) June and July 2015

15 Child A was murdered on 8 June 2015. His twin sister Child B was attacked two days later. The following week, on 14 June, Child C was murdered. Eight days later, Letby murdered Child D.

16 As would be expected, those deaths were a source of concern and alarm amongst staff on the NNU at CoCH. The principal actions taken in response were as follows:

17 the deaths were reported on the Datix incident reporting system [INQ0000016, INQ0000111, INQ0000766]. The Datix forms for Child A and Child C were escalated to the Director of Nursing, Alison Kelly [INQ0000016_0005], INQ0000111_0005]:

(a) the deaths were referred to the coroner [INQ0002042_0004, INQ0002047_0003, INQ0002045_0004] and post-mortems arranged [INQ0002042_0140, INQ0000108_0152, INQ0002045_0831];
(b) each mother's care was subject to an obstetric secondary review [INQ0008799, INQ0003556, INQ0003299];
(c) the deaths were referred to the Child Death Overview Panel ('CDOP') [INQ0001942, INQ0001950, INQ0012220]; and
(d) the deaths were discussed at morbidity and mortality meetings [INQ0003294, INQ0005449, INQ0003297].

18 On 18 June 2015, a meeting of the Women and Children's Care Governance Board ('WCCGB') noted the death of Child A [INQ0004235]. These minutes were received by Alison Kelly.

19 On 22 June 2015, Dr Stephen Brearey and Eirian Powell met to discuss the death of Child D [INQ0003110]. It was noted that: (i) all the deaths had occurred in the same room on the neonatal ward; (ii) all microbiology results were negative to date; (iii) Child A's initial post mortem result had not revealed a definitive cause of death; (iv) in the case of Child D, nosocomial infection was unlikely; and (v) one nurse was on shift for all three deaths, although she was not the responsible nurse for Child D. An action plan was developed with a view to investigating the deaths of Child A, Child C and Child D.

20 The deaths were the subject of further email correspondence between the paediatric consultants the following day [INQ0025743]. It is apparent from that email that there was concern amongst both the consultant body and the registrars about the events of the preceding two weeks. It was noted that a strange change in colour had been observed in Child A, Child B and Child D at the time of their collapse, although this was absent in the case of Child C. On 24 June 2015, Child A was discussed at a perinatal morbidity and mortality meeting [INQ0003294].

21 On 29 June 2015, the neonatal deaths were noted at a serious incident panel attended by members of the Executive Team. The deaths had been highlighted to both Ian Harvey and Alison Kelly in email correspondence three days prior [INQ0008157]. That same day, a baby death was noted at an Executive Team meeting attended by Alison Kelly [INQ0003203]. These are the first records of the deaths being brought to the executives' attention. 29 June also saw a paediatric senior clinicians meeting attended by Drs Jayaram, Newby, Saladi and Gibbs, as well as Anne Murphy and Eirian Powell [INQ0036166]. The three recent deaths were noted as were the registrars' concerns regarding the same.

22 On 1 July 2015, Dr Brearey met with Debbie Peacock and Eirian Powell to review the deaths of Child A, Child C and Child D [INQ0003191]. Various areas for improvement in the care provided were identified; however, it was not felt that errors in the children's care had influenced their outcomes.

23 On 2 July 2015, a debrief and a sudden unexpected death in infancy/childhood ('SUDIC') initial strategy meeting were held in respect of Child C [INQ0103164, INQ0000108_0178]. These submissions will address issues in respect of safeguarding and SUDIC reporting in greater detail below at paragraphs 234 to 237.

24 2 July 2015 also saw a serious incident review meeting attended by Julie Fogarty, Ruth Millward, Dr Brearey, Alison Kelly, Sian Williams and Debbie Peacock. At this the deaths of Child A, Child C and Child D [INQ0003530] were considered. There is a dispute as to whether Eirian Powell attended – her evidence is that she would ordinarily have expected to attend a meeting of that nature but has no recollection of having done so [INQ0108000 §104]. At this meeting:

(a) the three deaths in June 2015 were discussed. Whilst two were ultimately felt to be explained by natural causes, the cause of death in Child D's case was unexplained [INQ0003299_0002];

(b) Dr Brearey's evidence is that the common presence of Letby was again noted. He recalls his response was to remark *not Lucy, not nice Lucy*[1] [Brearey/week10/19Nov/49/15];

[1] When giving oral evidence, Dr Brearey was questioned as to the significance of the words 'oh no' preceding this statement. Whilst he engaged with that line of questioning, the basis for the assertion that he spoke the words 'oh no' is unclear [Brearey/week10/19Nov/60/25].

(c) in turn, he recalls Alison Kelly's response to Letby's presence at the deaths as being *we will have to keep an eye on it* [Brearey/week10/19Nov/52/10]; and

(d) a decision was taken to report Child D's death to STEIS on the basis that there may have been a delay in recognising signs of sepsis and commencing antibiotics [INQ0103104 §117].

25 After this meeting:

(a) later on 2 July 2015, Alison Kelly emailed Dr Brearey noting that the cases had been looked at in detail and that there were some areas which required further review [INQ0003625];

(b) on 20 July, the Quality, Safety and Patient Experience Committee ('QSPEC') met. The minutes are silent on the three neonatal deaths in June [INQ0003211];

(c) on 23 July, Alison Kelly emailed Ruth Millward outlining the importance of considering the neonatal deaths carefully and expressing an intention to raise the issue with the Executive Team on 5 August and at the QSPEC meeting in September [INQ0005591];

(d) on 29 July, the deaths of Child C and Child D were discussed at a neonatal morbidity and mortality meeting [INQ0003297]; and

(e) on 30 July, a meeting of the Women and Children's Care Governance Board was held. An ongoing neonatal death review is noted but otherwise the minutes are silent as to neonatal deaths and fail to acknowledge the death of Child D since the previous meeting [INQ0004240].

26 Pausing there, CoCH recognises the following failings or omissions in its immediate response to the deaths of Child A, Child C and Child D and the collapse of Child B.

27 First, there was variable practice in the use of both 'hot' and 'cold' debriefs after deaths.[2] No 'hot' debrief was held in respect of Child A [INQ0107962 §195] and it is unclear if one was undertaken in respect of Child C or Child D. A 'cold' debrief was held in respect of Child C [INQ0000108_0027] but not until two weeks after his death. One appears to have been planned in respect of Child A but it is unclear if it took place [INQ0103164_0002]. It is unclear if one took place in relation to Child D. One was planned for 6 July [INQ0103164_0002]; however, Dr Newby could not recall if it did in fact take place [Newby/week4/3Oct/19/8]. The Inquiry has heard evidence of the difficulties in arranging debriefs due to shift work meaning staff are away from the hospital or there is a need to fulfil their clinical duties if they are present [INQ0102740 §116]. Whilst the primary purpose of debriefs is one of pastoral care, and they are not intended as a mechanism either for clinical governance or by which to interrogate the circumstances of a death [McGuigan/week5/8Oct/79/6, Brearey/week10/19Nov/28/10], it would nevertheless have been preferable for them to have been held consistently after deaths. As to the holding of debriefs

[2] A 'hot' debrief describes a group discussion immediately following a resuscitation whereas a 'cold' debrief may occur some days later. Their purpose was described by Dr McGuigan as twofold: (i) to support the staff involved; (ii) to share immediate feedback and learning [McGuigan/week5/8Oct/78/22].

following a successful resuscitation, there appears to have been no consistent practice as of 2015. Whilst CoCH does not believe it was an outlier in this regard [McGuigan/week5/8Oct/79/20], it is logical that had they been undertaken they would have conferred some benefit.

28 Second, the deaths were reviewed by the neonatal lead undertaking paper-based reviews of the medical records. Whilst CoCH submits that was a reasonable approach, it would have been preferable to have had greater involvement from the consultants and registrars involved in the care of the children. One consequence was that there was no first-hand account of the deaths at the serious incident review meeting of 2 July 2015. Further, the 'strange' rash observed on Child A, Child B and Child D was not apparent from the entries in the medical records. The significance of its unusual features went unrecognised by clinicians at the time, and it was subsequently felt to be consistent with the children's pathologies [Brearey/week10/19Nov/33/5]. That analysis may have contributed to the description of the rash not being shared with the pathologist in advance of the postmortem of Child A [INQ0002042_0130]. CoCH notes, however, that although that information was relayed in respect of Child D [INQ0002045_0834], it does not appear to have assisted in determining the cause of death. The importance of the rashes would only be recognised a year later in June 2016 [INQ0107962 §199].

29 Third, whilst there was an initial awareness of Child B's collapse and an appreciation that it occurred in the context of the deaths of Child A, Child C and Child D [Brearey/week10/19Nov/35/11, INQ0025743], over time the focus of the Trust's response became the deaths, and the significance of Child B's collapse was not appreciated.

30 Finally, there were several failings in the systems of clinical governance:

(a) in retrospect, there may have been benefit in discussing Child C and Child D alongside Child A at the perinatal mortality meeting on 24 June 2015. However, CoCH submits that the decision not to do so needs to be seen in the context of a desire to afford adequate time for the discussion of each child, the efforts to arrange a further opportunity to discuss Child C and Child D at the neonatal morbidity and mortality meeting on 29 July 2015, and an understanding at the time that the deaths had come about separately and were due to natural causes [Brearey/week10/19Nov/37/20];

(b) the WCCGB meeting of 18 June 2015 noted the death of Child A [INQ0004235], yet no follow up actions resulted. There is no evidence that Child C and Child D were discussed at the WCCGB on 30 July 2015 when it would have been appropriate to do so [INQ0004240]. It would also have been appropriate to bring the outcomes of the 2 July 2015 serious incident meeting and Dr Brearey's case reviews to that meeting;

(c) the three deaths do not appear to have been discussed at the QSPEC meeting of 20 July 2015;

(d) insofar as Alison Kelly intended to raise the issue of neonatal deaths at the executive directors group meeting on 5 August 2015 [INQ0005591], there is no evidence that this

happened. Nor were they discussed at the QSPEC meeting on 21 September as she intended; and

(e) having reported Child D's death to STEIS, provision should have been made to discuss Child D at the QSPEC meeting of 21 September 2015 [INQ0004243]. Notwithstanding that failure, CoCH notes that the STEIS report was brought to the attention of the Executive Team at a meeting of the executive directors group attended by Tony Chambers, Ian Harvey and Sue Hodkinson on 9 September 2015 [INQ0003200]. It is unclear how this was followed up if at all.

31 CoCH wishes this first section to focus on an acknowledgement of its failings. It is however convenient at this point to consider whether the criticisms made by some [INQ0101332 §260] [Powis/week15/17Jan/108/21] that it would have been appropriate to report the cluster of deaths in June 2015 as a serious incident is justified. For the reasons that follow, CoCH submits that it is not:

(a) the expectations for the reporting of serious incidents as of June 2015 are set out in the NHS Serious Incident Framework dated 27 March 2015 [INQ0009236]. As was noted by Counsel to the Inquiry, that document states at page 13: '*Serious Incidents are events in healthcare where the potential for learning is so great or the consequences to patients, families and carers, staff or organisations are so significant that they warrant using additional resources to mount a comprehensive response'.* The document continues (at page 14): *'Serious Incidents in the NHS include acts and/or omissions occurring as part of NHS funded healthcare that result in unexpected or avoidable death'.* Footnote 8 adds that serious incidents are: *'Caused or contributed to by weaknesses in care, service delivery including lapse, acts and/or omission as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice*';

(b) as observed by Counsel to the Inquiry [Powis/week15/17Jan/105/13], the natural reading of those words is that a serious incident is an act or omission in the care provided which contributes to an unexpected or avoidable death;

(c) further, the guidance envisages that there may be scenarios in which it is unclear whether an act or omission contributed to a serious outcome. In such circumstances, the healthcare provider is required to '*discuss openly, to investigate proportionately and to let the investigation decide*'. Nothing in those words implies a requirement for unexpected deaths in which it is unclear whether an act or omission contributed to be routinely reported as serious incidents. Conversely, the natural reading is that a trust is required to discuss the event, investigate it proportionately and then respond appropriately on the basis of its findings;

(d) applying that guidance to the circumstances at CoCH in June 2015: (i) as of 2 July 2015, the deaths of Child A, Child C and Child D had been investigated by Dr Brearey and

discussed openly at a serious incident review meeting attended by a body of appropriate individuals; (ii) that investigation had not identified any acts or omissions in the care provided to Child A and Child C which were felt to have contributed to the deaths; and (iii) conversely, the investigation for Child D had given rise to concerns that a delay in the administration of antibiotics might have contributed to his death;

(e) it follows that having conducted its investigation, the decision by the Trust to report only Child D's death as a serious incident was reasonable. Adopting a lower threshold would essentially require all unexplained deaths to be reported as serious incidents. That is inconsistent with the guidance to '*investigate proportionately and to let the investigation decide*' and the overriding position that '*Serious Incidents are events in healthcare where the potential for learning is so great…they warrant using additional resources to mount a comprehensive response'.*

(2) August and September 2015

32 Child E was murdered on 4 August 2015. He was considered high risk for necrotising enterocolitis ('NEC') and deteriorated rapidly in the context of gastrointestinal bleeding and red-purple abdominal discolouration [INQ0099097 §§34 to 36]. His death was reported on the Datix system [INQ0002659], on an SBAR form [INQ0002659_0003] which was discussed at a serious incident panel attended by both Ian Harvey and Alison Kelly on 13 August 2015 [INQ00002659_0004] and was referred to CDOP [INQ0012016]. A review of Child E's death was later undertaken by Dr Brearey [INQ0003296].

33 In her written and oral evidence, Child E's paediatric consultant Dr ZA acknowledged the following [ZA/week5/7Oct/23/19 to 26/8]:

(a) her impression of Child E's cause of death, namely NEC, was wrong;

(b) she felt at the time that Child E's normal abdominal x-ray was consistent with NEC severe enough to account for his death, something she now recognises was incorrect;

(c) that in the context of the deaths of Child A, Child C and Child D in June 2015, she was insufficiently curious as to the cause of Child E's death; and

(d) in consequence of the above, she considered a postmortem examination to be unnecessary for Child E. Whilst that view was explained to be guided in part by a desire to avoid causing Child E's parents even greater distress, it was mistaken.

34 CoCH accepts that it is unclear whether Child E was discussed at a morbidity and mortality meeting [INQ0003288, INQ0005628, INQ0005630]. Those documents tend to suggest there was insufficient time to discuss Child E at the neonatal mortality meeting on 26 November 2015 and that it was intended to discuss his death at a subsequent meeting. If Child E's death was not discussed at a morbidity and mortality meeting, that was a failure. If the death was discussed but

was not documented, the opportunity to note the circumstances of the death and learn appropriate lessons and recognise any trends was lost.

35 Child F collapsed in the early hours of 5 August 2015. He was profoundly hypoglycaemic and so a hypoglycaemia screen was ordered. The medical records note that his insulin level was 4657 and his c-peptide <169. Those results were misinterpreted, and their significance went unrecognised. Had the significance of these results been identified, it would have established that Child F had either accidentally been administered inappropriate insulin or had been deliberately harmed.

36 CoCH's witnesses have described the failure to identify and appropriately act on Child F (and Child L's) insulin/c-peptide results as a collective failure of the paediatricians. The Trust's reflections are as follows:

(a) given the time it takes for insulin/c-peptide results to be returned, repeating the bloods would have conferred limited benefit. By the time the results were available, days had passed from Child F's poisoning and Child F had been treated. Accordingly, it would not have been possible to reproduce the results from 5 August 2015 by repeating the tests some days later;

(b) it follows that the treating doctors would have ultimately been required to either reject the results as erroneous or accept them as accurate. Dr ZA's evidence was that '*it is relatively common for samples to give inaccurate results as the blood cells are broken down (haemolysis) or clotted together. It happens most commonly with urea and electrolyte tests or full blood count tests. I felt that the most likely explanation for the results was some sort of inaccuracy with the test… I did consider that insulin could have been delivered deliberately but this seemed absurd and ridiculously unlikely so the tests being wrong seemed the only possible explanation*' [INQ0099097 §§47 and 48];

(c) that account suggests that both institutional and individual memories of the recommendation of the Clothier Inquiry that there be heightened awareness in all those caring for children of the possibility of intentional harm when a patient unexpectedly deteriorates is poor. In part, that may reflect the passage of time since the crimes of Beverley Allitt and the apparent absence of specific training addressing the risk to patients from deliberate acts of harm by staff in the modern medical curriculum [Jayaram/week9/13Nov/16/5]. Many of the junior doctors at the time could not recall those events. Nevertheless, the Trust's senior staff accepted they were familiar with the actions of Beverley Allitt and the more recent events at Stepping Hill Hospital, yet that appears insufficient to have given rise to suspicions of Letby in the early chronology of events;

(d) normal practice was that the responsibility for acting upon results lay with the clinical team looking after the patient and not the laboratory. Given the better knowledge of the patient's condition afforded to the former, that is in CoCH's view reasonable; and

(e) whilst the system by which concerning results are telephoned through to the ward seems to have been effective, it is unclear if the clinicians receiving the information benefitted from

an alert or any other assistance in interpreting such results [INQ0098712 §11]. This compounded a lack of familiarity and understanding of insulin/c-peptide interpretation, even amongst senior doctors [INQ0103104 §149].

37 On 7 September 2015, Letby attempted to murder Child G. She would seek to do so again on 27 September 2015. Letby was tried on a further charge of attempting to murder Child G in relation to an incident on 21 September 2015, as well as in relation to two attacks on Child H. These episodes, and the collapse of Child F, were not recognised as suspicious by clinicians at the time. The Trust will address this and issues in respect of collapses generally at paragraphs 241 to 254 below. The Trust accepts however that the focus on deaths, both informally in the minds of the consultants and formally by way of mortality reviews, was to the detriment of its ability to adequately scrutinise morbidity. In part, that reflects the pressures on staff as illustrated by numerous emails sent outside of normal working hours.

38 On 16 September 2015, the deaths of Child A, Child C and Child D were discussed at a meeting of the Cheshire and Merseyside Clinical Effectiveness Group ('CEG'). Dr Brearey recalls informally mentioning the recent deaths at CoCH, including that of Child E [INQ0103104 §166]. The purpose of discussing the deaths at the CEG however was to disseminate learning across units in the region [INQ0103104 §195]. It was not a forum which was intended to perform detailed investigations of the deaths or to fulfil a role in either the Trust's or the regional network's clinical governance.

(3) October 2015

39 Dr Brearey undertook a review into Child E's death in October 2015 [INQ0003296]. That review concluded that Child E likely died of perforated bowel secondary to NEC and that it was unlikely that changes in his management would have altered the outcome. Again, CoCH accepts that that betrays the limitations of paper-based mortality reviews. CoCH also accepts that it would have been helpful for this review (and others) to have been informed by closer involvement of the children's families. It however recognises Dr Brearey's evidence that clinical pressures and time constraints mean that this would not be ordinary practice, either at CoCH or elsewhere [Brearey/week10/19Nov/56/16].

40 On 22 October 2015 a meeting of the WCCGB made reference to three unexpected deaths. The minutes were received by Alison Kelly as executive lead [INQ0003223].

41 Child I was murdered by Letby on 23 October 2015. She had been the subject of several transfers between Liverpool Women's Hospital, the Countess of Chester Hospital and Arrowe Park Hospital. At CoCH she had deteriorated on numerous occasions, something which had given the clinicians treating her the impression she was of fragile health [INQ0102740 §78]. Letby was charged with attacking her and causing her collapse on four occasions. Her death was subject to

a Datix report [INQ0000457], referral to the coroner [INQ0002043_0003], a postmortem [INQ0002043_0037], and the CDOP process [INQ0001945]. She was discussed at the neonatal morbidity and mortality meeting on 26 November 2015 [INQ0003288]. On 31 October, Dr Brearey conducted a review of her care [INQ0003286]. A debrief was held on 9 November 2015 [INQ0000429_1543].

42 Dr Brearey's evidence is that he would have spoken to Eirian Powell on 23 October 2015 about the death of Child I and the association between Letby's presence and the five deaths since June. That account is entirely consistent both with the evidence of others [Griffiths/week6/16Oct/135/14] and with Eirian Powell's email to Dr Brearey at 17.25 hours on 23 October which appears to reference prior knowledge of events [INQ0003106]. Attached to that email was a document produced by Ms Powell identifying Letby's presence at the deaths of Child A, Child C, Child D and Child E [INQ0003189]. There is, in that email, an apparent acceptance of the need for Eirian Powell to escalate the events surrounding Child I to senior nurses within the Trust. It appears there was a failure to do so.

43 On 26 October 2015, Alison Kelly, Ian Harvey, Sian Williams and Ruth Millward attended an SUI meeting. Items for consideration included an NNU case review in respect of Child S and a list of potential claims against the Trust which included reference to the death of Child D [INQ0003614, INQ0008194, INQ0008195]. By this time, the deaths of Child A, Child C, and Child E had been reported on SBAR forms which were forwarded to Alison Kelly and, in the case of Child E, Ian Harvey. Alison Kelly had attended the serious incident review panel of 2 July 2015. CoCH submits that by this date, the increasing mortality on the neonatal ward must have been well known to Alison Kelly and that this should have informed her response to later events.

44 On 27 October 2015, Eirian Powell emailed Dr Brearey [INQ0003107]. That email makes two discrete points. First, Ms Powell gives her and Debbie Peacock's view that they *did not feel there was a connection*. In light of Dr Brearey's evidence as to his conversation with Ms Powell on 23 October 2015, the email of 17.25 on 23 October, and the attachment detailing the nurses on duty for each of the deaths since June, references to a *connection* are likely to be to an association between Letby and the deaths. Second, it can be seen that Ms Powell's view is to reject the possibility of any connection and to instead propose that a table including *all the doctors that was (sic) involved with the deceased patients on the unit* is produced to *ensure all avenues have been addressed*.

45 CoCH accepts that there is no evidence that Eirian Powell specifically raised Child I's death, or Dr Brearey's observed *connection* between Letby and the deaths of Child A, Child C, Child D, Child E or Child I, with Sian Williams or Alison Kelly as implied by her email of 23 October [INQ0003106]. Instead, by the following Monday, Ms Powell's response appears to have been to downplay Dr Brearey's concerns and to explore other explanations for the deaths [INQ0003107].

The significance of the association between Letby and the deaths identified by Dr Brearey appears to have been lost.

46 These submissions will consider the evolving knowledge of the paediatricians between June 2015 and February 2016 in greater detail below. Nevertheless, it is clear that the death of Child I represented a significant change in the level of concern of certain members of the paediatric team as to the cause of the increased mortality since June. Dr Brearey's evidence was that Child I's death represented *a significant moment that raised my level of concern quite considerably* as to the prospect of deliberate harm [Brearey/week10/19Nov/71/15], albeit that he also *had a duty to consider other things* [Brearey/week10/19Nov/74/18]. Dr Jayaram's evidence was that on returning to work in November 2015 he became concerned for the first time that Letby could somehow be causing inadvertent or even deliberate harm, although those concerns were tempered by uncertainty as to whether such worries were *genuine*, *difficulties with thinking the unthinkable*, an awareness of the risk of confirmation bias and *seeing things which weren't there* [Jayaram/week9/13Nov/34/22]. Dr Newby recalled speaking to Drs Gibbs and Brearey about Letby's presence at the deaths following the death of Child I, but also a recognition amongst them that there was a small pool of nursing staff who were frequently on duty [Newby/week4/3Oct/33/4]. It is also the case that, in the mind of the neonatal lead, those incipient concerns had been drawn to the attention of executives by this time [INQ0103104 §173].

47 The Trust accepts that, at the end of October 2015 when concerns were first openly articulated as to the possibility of deliberate harm, it would have been appropriate for CoCH to exclude Letby pending its own investigations. We do not consider the decision of Dr Brearey (and indeed Eirian Powell) to investigate the deaths themselves at this time to be unreasonable. In the vast majority of cases, concerns around deaths will ultimately have a clinical explanation which can be established by local investigation by those qualified to undertake it.

48 Had those investigations not satisfied the concerns raised, i.e. by providing clinical explanations for the events, then the only body with the skill set and powers to exclude criminality was the Police. The Trust considers that it is an unanswerable hypothetical as to whether any investigations by the Trust at that time, set against an understanding that the deaths had plausible natural explanations and that Letby's presence was potentially explained by a small number of nurses working frequent shifts, would have resulted in referral to the Police. Nevertheless, the concerns raised, even if underdeveloped and incipient, ought to have been treated with the upmost seriousness.

(4) November 2015 to the 'thematic review'

49 Child J desaturated on 27 November 2015. Letby was charged with her attempted murder.

50 November 2015 also saw an obstetric review of stillbirth and neonatal deaths at CoCH in 2015 undertaken by Dr Sara Brigham [INQ0003589]. CoCH accepts that there were limitations to that review:

(a) whilst the review was titled 'Review of neonatal deaths and stillbirths at Countess of Chester Hospital — January 2015 to November 2015', it examined matters from an obstetric perspective and focused almost exclusively on the care provided to mothers. The neonatal care thus went uninterrogated save for the reviews being undertaken as each death arose. The deaths had not, by November 2015, been considered together as a group from a paediatric point of view since 2 July that year;
(b) as neonatal lead, Dr Brearey did not contribute to it. Nor did any other paediatrician; and
(c) notwithstanding those limitations, there is some evidence that the review was interpreted as having examined the neonatal aspects of care when in fact it had not [Fogarty/week6/15Oct/112/25, Hopwood/week12/3Dec/165/15].

51 CoCH accepts that the paediatricians should have contributed to the November 2015 review. Instead, the investigations proceeded in parallel and in isolation, with the obstetric review contained in Dr Brigham's report whilst Dr Brearey made efforts to have an external reviewer from Liverpool Women's Hospital assist him with his own investigations. That may have reflected the separation of paediatrics from obstetrics in the Trust's divisional structure at that time. Whilst CoCH submits that it would have been obvious to any informed reader of the review that it considered issues from only an obstetric perspective, the Trust accepts that there was a potential for the focus of the report to be misunderstood and therefore for the report to falsely reassure. This may have especially been the case for those who lacked a clinical background.

52 On 16 November 2015 Dr Brigham's report was referenced at a meeting of QSPEC [INQ0004268]. The minutes record: '*Ms Fogarty informed members that a meeting to look at the recent still births in the Trust had taken place to see if there were any themes. Members asked for a copy of the report to be received for assurance*'. On 2 December 2015, Alison Kelly emailed Julie Fogarty requesting a copy of the November review so that it could be reviewed at the QSPEC meeting in December [INQ0003220]. Ian Harvey was copied into this email. Regardless of the origin of the handwritten text at the top of that page [Kelly/week11/25Nov/221/7], it is clear that at the very least, Ms Kelly must by this time have been aware of the higher than expected number of neonatal deaths and that the obstetricians had reviewed their role in the mothers' care [INQ0107704 §187, Kelly/week11/25Nov/267/18]. It is axiomatic that Ms Kelly's intention in copying Mr Harvey into this email was to make him aware of the same.

53 On 14 December, Dr Brigham's review was received at a meeting of QSPEC attended by Sue Hodkinson and Alison Kelly [INQ0003204]. CoCH makes the following observations of that meeting:

(a) first, the minutes note that Ms Kelly thanked the team for the assurance that the report had provided to the committee. Whilst that may have been true in respect of potential obstetric causes for the increased mortality, the scope of the review was such that it could provide no assurance in respect of neonatal care. The evidence suggests that the executives, in particular Ms Kelly, were aware that the Brigham review had only considered the issue of neonatal deaths from an obstetric perspective and that a separate neonatal investigation was therefore either necessary or planned [INQ0107704 §191, Kelly/week11/25Nov/267/18, Harvey/week11/28Nov/118/1];

(b) notwithstanding that QSPEC was yet to consider any review of the neonatal care, the matter was remitted back to the WCCGB for future monitoring and implementation of the action plan. It was received there on 18 December 2015 [INQ0004371]. There was no plan in place for QSPEC to have any oversight of investigations into the deaths from a neonatal perspective or, insofar as it was understood that the same was planned, to follow up the results of that review. CoCH accepts that was a failing - having been subject to executive oversight at QSPEC, the rise in neonatal deaths should have remained the responsibility of that committee until both the neonatal and obstetric teams had completed their reviews and sufficient assurance had been received. That failure was accepted in oral evidence by Mr Harvey [Harvey/week11/28Nov/119/21];

(c) had the thematic review been considered at QSPEC, the issues which arose between February and May 2016 in respect of its timely escalation and the appropriateness of the Trust's response may have been avoided. Receiving the report at QSPEC would also have provided for oversight by the Trust Chair and non-executive directors at an earlier stage; and

(d) the minutes of that meeting explicitly record that there had been an increase in neonatal deaths. It follows that Alison Kelly's oral evidence that '*I don't think we fully appreciated until we had the thematic review that there was an increase in neonatal deaths*' [Kelly/week11/25Nov/269/2-4] simply cannot stand. As of 14 December 2015, it was known that there had been an increase in neonatal deaths, this had been reported to QSPEC, obstetric explanations had been excluded, and a neonatal review was either necessary or pending.

54 Dr Brearey's evidence is that it was after Child I's death that he first considered an external review of the neonatal deaths at CoCH in 2015 [INQ0103104 §173]. In part, this appears to be related to his developing concerns about Letby's association with the deaths and a view that an external perspective would provide both an objective assessment of those concerns and the Trust's response to the rise in neonatal mortality [Brearey/week10/19Nov/108/13]. Concern was also developing in the mind of Dr Gibbs by the end of 2015 or beginning of 2016 [Gibbs/week4/1Oct/81/8].

55 On 14 January 2016, the minutes of the WCCGB make reference to the Inquest of Child A, the death of Child D and Dr Brigham's review of neonatal deaths [INQ0004293]. Four days later, the minutes of the January QSPEC meeting are silent on the issue of neonatal mortality [INQ0004296]. As above, CoCH accepts that oversight of the investigations into the rising neonatal mortality rate should have remained with QSPEC.

56 Eirian Powell updated the table describing which staff were on duty at the time of each neonatal death on 19 January 2016 [INQ0003277]. Letby's presence remained a consistent feature. Two days later, there was a meeting of the Cheshire and Merseyside CEG at which the death of Child I was discussed [INQ0005559]. Following this, Dr Brearey approached Dr Nim Subhedar about the prospect of him acting as an external panel member for the planned review of neonatal deaths [INQ0005643].

57 On 25 January 2016, Dr Jo Davies emailed Ian Harvey stating '*We have had an increase in stillbirth and neonatal death for 2015. Therefor (sic) additional review was undertaken — see attached report*' [INQ0003575]. This was in response to a request by Ian Harvey for information in advance of the CQC inspection scheduled for February 2016. The existence of Dr Brigham's report, and that it was commissioned in response to increased neonatal mortality in 2015, was already known to Mr Harvey following Alison Kelly's email of 2 December 2015 and the QSPEC meeting of 14 December 2015, the minutes of which he reviewed [INQ0107653 §84]. It follows that by the end of January 2016 at the latest, he too must have been aware of the rising neonatal mortality.

(5) February, March and April 2016 and the thematic review

58 On 8 February 2016, a thematic review of neonatal deaths in 2015 and 2016 was undertaken by Drs Brearey, V and Subhedar, as well as Eirian Powell, Anne Murphy, Debbie Peacock and Laura Eagles. The initial draft was circulated late in the evening of 8 February to those who had attended the meeting earlier that day [INQ0102405, INQ0003217].

59 The evidence is that at some point Dr Subhedar was made aware of Dr Brearey's concerns about an association between the deaths and a member of staff, probably from a conversation between them shortly after the meeting [Subhedar/week10/20Nov/26/8]. Regardless of the timing of that conversation, Dr Subhedar's knowledge of Dr Brearey's concerns influenced him to suggest an amendment to the draft thematic review to emphasise an aspect he felt important, namely that the deaths were unexpected and unexplained [Subhedar/week10/20Nov/25/19, INQ0102405]. In response, Dr Brearey changed the draft report, reordering the themes on page 7 and making explicit references to the sudden and unexpected nature of the babies' deteriorations, that there was no clear cause for them, and highlighting that the arrests had predominantly occurred between midnight and 4am [INQ0006817].

60 On 15 February, Dr Brearey sent to Ian Harvey, at Ian Harvey's request, the draft version of the thematic review [INQ0003140]. Whilst this did not contain the updated themes, it nevertheless identified the increasing neonatal mortality in 2015, timing of the deaths, absence of satisfactory explanations for many, and the association with Letby. That email was forwarded to Alison Kelly that afternoon. Alison Kelly's evidence is that she expects the attachment would have been included [INQ0107704 §207]. Three days earlier, Alison Kelly had been forwarded Dr Davis' email [INQ0003575] identifying an increase in stillbirth and neonatal deaths for 2015 and referencing the November obstetric review undertaken in response.

61 Dr Brearey disseminated the final version of the thematic review on 2 March 2016 [INQ0003114, INQ0003251]. This contained the updated themes suggested by Dr Subhedar. Clearly, both Dr Brearey and Dr Subhedar felt the wording in the final report was sufficient to highlight those concerns [Subhedar/week10/20Nov/35/22, Brearey/week10/19Nov/114/16]. CoCH accepts that the concerns then held by Dr Brearey could have been expressed more clearly – the association between Letby and the deaths was at this point prominent in his mind and had not been assuaged by the findings of the thematic review. Notwithstanding that, the language used in the thematic review was sufficient to put any attentive reader on notice that: (i) there had been a significant increase in neonatal deaths; (ii) those deaths were unexpected and unexplained; (iii) no clear medical cause for them had been identified; and (iv) the same member of staff had been present at each death. In her oral evidence, Ms Kelly accepted that the thematic review did not provide adequate explanations for the causes of death of the babies concerned [Kelly/week11/25Nov/276/1].

62 CoCH submits that Dr Brearey's hesitancy to make more explicit his concerns in a report intended for wider dissemination across the Trust was reasonable [Brearey/week10/19Nov/117/17]. The Trust accepts that there appears to have been a reticence amongst staff to vocalise concerns in documents and fora which were not confidential, or which were likely to result in wider dissemination of those concerns. The Trust addresses this in greater depth below at paragraphs 258 to 263.

63 Regardless, the thematic review had highlighted issues which ought to have prompted the greatest concern in those who received it. Insofar as the language may have been conservative in reflecting the concerns then held by some, CoCH submits that it should be viewed in the context of several other actions being undertaken in parallel:

(a) at the time the report was finalised, Dr Brearey made direct efforts to pursue the issue with Eirian Powell. The same day as he disseminated the final thematic review, he emailed her stating *I think we still need to talk about Lucy* [INQ0003114];
(b) the first action identified in the thematic review was for Dr Brearey and Eirian Powell to review all cases with the intention of identifying any medical or nursing association with the

deaths. Arguably that had already been done. In any event, it was completed by 17 March 2016 and the report then forwarded directly to Alison Kelly;

(c) insofar as the deaths had been overlooked or ignored by Alison Kelly up to that point, Eirian Powell's email of 17 March was explicit. It identified: (i) a neonatal mortality which had more than doubled; (ii) a *commonality* between the deaths and a single nurse; and (iii) the absence of any satisfactory explanation for the deaths. A request was made for a meeting with the Trust's senior leadership at which the thematic review's content could be discussed openly [INQ0003558, Brearey/week10/19Nov/117/15]. Those issues were self-evidently ones which demanded an urgent response; and

(d) Dr Brearey's evidence is that he had already sent emails to Ian Harvey requesting an urgent meeting in the fortnight from 8 February 2016 [INQ0103104 §201, Brearey/week10/19Nov/104/3 and 114/24]. Whilst he accepts that he has not been able to locate those emails, there is evidence that he identified his concern at being unable to do so contemporaneously [INQ0014610].

64 Having had the thematic review sent directly to them on 21 March 2016 [INQ0003558], no response was forthcoming from either Alison Kelly or Ian Harvey. On 14 April 2016, Eirian Powell chased Alison Kelly for a response [INQ0003089]. Again, no response was received. On 15 April 2016, a further table of staff members present was produced by Eirian Powell [INQ0006951]. On any reading, this table appears to be an effort to downplay concerns about Letby and encourage alternative explanations, in particular an association with members of the medical team.

65 Notwithstanding that the thematic review had been sent to both the Medical Director and Director of Nursing three weeks prior, the meeting of QSPEC on 18 April 2016 was silent on the issue of neonatal deaths. Nor was it received at the May QSPEC meeting as it appears was intended by Alison Kelly [INQ0003121].

66 April 2016 also saw the following:

(a) Child L collapsed on 9 April. Letby was found guilty of his attempted murder. His blood tests from that day were consistent with him having been administered inappropriate exogenous insulin. Whilst the results were documented in the medical records [INQ0001169_0021], they appear to have been misinterpreted by junior doctors over the following days [INQ0001169_0025-0027] and went either unchecked or else that misinterpretation went unrectified by the consultant;

(b) Child M also collapsed on 9 April. Letby was found guilty of his attempted murder. The significance of his collapse went unrecognised;

(c) Letby was moved off night shifts and on to day shifts. CoCH submits that the evidence suggests this was done for reasons of pastoral care and to observe her performance [Powell/week6/17Oct/123/15, Powell/week6/17Oct/127/8, Murphy/week7/21Oct/78/7, Rees/week7/21Oct/124/24, Farmer/week6/16Oct/51/20]. The evidence does not clearly

establish that this was because of concerns that she was deliberately harming babies in her care. Were that to be the case that would have been an entirely inappropriate response;

(d) at the same time, Letby was required to undertake reflective practice in relation to a drug error [INQ0008961_0049]. It does not appear that her supervisors considered the possibility of a connection between this error and the concerns about her association with the deaths. Indeed, it appears to have been treated in the same way as previous incidents in 2013, namely as a medication error of the sort which may from time to time occur and which represented a learning need rather than a more serious concern. That approach was inappropriate given the concerns about her association with the deaths, and her supervisors thereafter continued to represent to senior leaders that there were no concerns as to her performance; and

(e) an increasingly defensive approach towards concerns about Letby's presence at the deaths was developing. This would adversely impact the response into May and June of 2016.

(6) Early May 2016 to end of June 2016

67 Alison Kelly and Ian Harvey eventually met with Dr Brearey on 11 May 2016. The meeting on 11 May 2016 presented an opportunity to take action in response to the concerns about Letby. No positive action was taken, and she was allowed to continue to care for babies. Irrespective of whether or not Dr Brearey requested a meeting with Ian Harvey in February, there was an unacceptable delay in arranging the meeting that eventually took place on 11 May. On 17 March 2016 Ms Powell had asked for a meeting *to discuss how to move forward* and summarised the findings of high mortality and the commonality of a nurse (Letby) and a doctor [INQ0003089_0002]. She followed this up on 14 April and on 5 May when she sought an urgent meeting *primarily for reassurance and to ensure that we have covered all the relevant actions* [INQ0003115_0001]. Even if the concerns about Letby could have been expressed more forcefully, Ms Powell was clearly alerting Alison Kelly to her concerns and requesting guidance and leadership.

68 It is unfortunate that Dr Brearey was not included in the earlier meeting on 5 May 2016. Given that it was his email to Alison Kelly the preceding day that precipitated this meeting [INQ0003138_0002] it is unclear why he was not included, and he should have been. Alison Kelly was aware that Dr Brearey was the CoCH lead on the thematic review. Dr Brearey was entitled to feel let down that Ms Powell had not invited him to the meeting [Brearey/week10/19Nov/125/11]. The risk Dr Brearey's non-inclusion created was that of a bias in Letby's favour as illustrated by (i) Alison Kelly informing Ian Harvey that she was *currently reassured* [INQ0003087] and (ii) the "Neonatal Unit review 2015-16" that Ms Powell created following the meeting [INQ0003243].

69 Although Dr Brearey received this document before the meeting on 11 May 2016, he did not have a chance to read it until after the meeting. It is clear from the totality of the evidence that Dr

Brearey presented the thematic review to the meeting (see Alison Kelly's handwritten note [INQ0015537_0002] and Ian Harvey's evidence about the terms *sudden* and *unexpected* [Harvey/week11/28Nov/128/18]). Therefore, whether they had read and digested the thematic review in February, March or April, Ian Harvey and Alison Kelly cannot have been unaware of the concern about the association of Letby with the increase in mortality. Dr Brearey also explained that his concerns were shared by his colleagues.

70 Ms Powell's defence of Letby is important and its significance cannot have been properly appreciated by Ian Harvey and Alison Kelly; if Letby was being presented as a competent nurse (irrespective of whether this was in fact accurate given previous concerns about competence) who was associated with a substantial number of deaths, this was itself a matter of concern. Ms Powell accepted that she was *vociferous* and *vocal* in her support of Letby and that she should have been more reflective [Powell/week6/17Oct/134/11-135/1].

71 The response of both Ian Harvey and Alison Kelly has been to suggest that the thematic review had identified wider concerns about the quality of care being delivered in the NNU; [Kelly/week11/25Nov/115/14] & [Harvey/week11/29Nov/153/13 – 154/10]. This is neither fair nor accurate. The thematic review made clear that neither delayed cord clamping/hypothermia, Ranitidine use, or placement of umbilical venous catheters (UVC) provided an explanation for the increased mortality. Moreover, the thematic review highlighted that some of the deaths had followed sudden and unexpected deteriorations and that no clear cause of death had been identified at post mortem.

72 For reasons which she was unable to explain in her oral evidence, despite being the Trust's Safeguarding Lead, Alison Kelly did not view the information in the thematic review as raising safeguarding issues.[3] She accepted that on 11 May *maybe I should have done* but went on to explain that she had received assurances from her senior nursing team [Kelly/week11/25Nov/9/15-25]. This underscores the dangers of a one-sided approach to information gathering. Her purported justification that *it was more about clinical concerns and practice and potential competency issues* does not withstand analysis when considered with what she was being told about Letby's competence by Ms Powell [Kelly/week11/25Nov/10/24].

73 Given their positions within the Executive Team (including Alison Kelly's position as Trust Safeguarding Lead) Dr Brearey was entitled to expect some *fairly solid guidance* from Ian Harvey and Alison Kelly from the meeting on 11 May [Brearey/week10/19Nov/130/14]. He did not receive that guidance or assistance probably because the meeting was dominated by Ms Powell's defence of Letby. The criticism of Dr Brearey for failing to prepare an equivalent document to that prepared by Ms Powell is misplaced; as he explained his "best points document" was the thematic

[3] CTI explored with Alison Kelly the implications of this being seen as a safeguarding concern; Kelly/week11/25Nov/5/4 onwards.

review. Alison Kelly and Ian Harvey should have appreciated that Dr Brearey and Ms Powell had differing views about Letby and should not have allowed the issue simply to be deferred. The obligation upon them was to take control and demonstrate leadership.[4]

74 By this point, concerns as to deliberate harm by a member of staff were being clearly vocalised. The Trust had exhausted the clinical investigations which fell within its own skill set. Those investigations had been conducted by the paediatricians as those best placed to establish if there were natural or medical causes. There was nothing that further internal investigations could offer. Accordingly, CoCH submits that at this point, the appropriate leadership response was to refer the matter to the Police. That this had not happened in March that year was a failing of the Executive Team to respond to Dr Brearey and Ms Powell's concerns in a timely manner.

75 Dr Brearey describes feeling anxious and confused following the meeting [INQ0103104 §232] and regretting writing the email of 16 May 2016 [Brearey/week10/19Nov/212/11].

76 Child N was attacked by Letby on 3 June 2016. Dr Brearey accepted that he did not discuss his concerns about Child N with Ms Powell. CoCH accepts that the notification system outlined in Dr Brearey's email of 16 May 2016 did not operate and Child N's deterioration was not reviewed *as soon as practicable* as it should have been.

(7) End of June 2016

77 Child O died at 17.47 on 23 June 2016. Dr Brearey accepted that he should have taken action that evening rather than wait until the following day [Brearey/week10/19Nov/89/9]. No action was taken to make the NNU safe. Letby was not removed from the NNU. CoCH acknowledges that these were serious omissions.

78 When Dr Jayaram met with Ms Townsend on 24 June it is likely that Dr Jayaram mentioned Letby by name and that he and Dr Brearey and others were uncomfortable about Letby being on the NNU. Ms Townsend understood that there was a risk *that there was going to be further harm to babies on the NNU*. Whether or not Ms Rees is correct that Dr Jayaram was not forthcoming with what his clinical concerns were, she told the Police that she understood that *both [Dr Brearey and Dr Jayaram] thought Lucy was purposefully harming babies on the neonatal unit* [INQ0014005].

79 Child P died at 16.00 on 24 June 2016.

80 CoCH acknowledges that there is a conflict of evidence concerning the circumstances of discussions that day between Dr Brearey and Karen Rees (i.e. when, where and whether in

[4] There is a later note dated 13 July which may reference this meeting in which it is recorded *Mt with IH AK Eirian Steve B Eirian says not problem Steve B says there is a problem* [INQ0003365_0002].

person or on the telephone). What, however, appears to be common ground is that there was a discussion on the telephone on the evening of 24 June. It is also common ground Dr Brearey asked for Letby to be moved off the NNU. Whether this was expressed in as forceful terms as Dr Brearey suggests *you are happy to take responsibility if anything were to happen on the following day* [Brearey/week10/19Nov/93/19] is an issue that the Inquiry may not feel it is necessary to resolve.

81 Karen Rees's state of knowledge was explored in her oral evidence; she had received the thematic review with Letby's name in red and, on her evidence, had been told by Karen Townsend that Dr Jayaram and Dr Brearey were concerned that Letby may be purposefully harming babies [Rees/week7/21Oct/147/10-25]. She told the Inquiry that on reflection she should have called safeguarding [Rees/week7/21Oct/150/19].

82 CoCH's position is that, insofar as it had not been done earlier, Letby should have been removed from the NNU on 24 June in accordance with Dr Brearey's request. This was a serious failing and with the benefit of hindsight the failure to do this is illustrative of the attitude of the Executive Team towards the paediatricians and their concerns more generally.

83 For reasons which are not clear the meetings that took place at the beginning of the week commencing 27 June 2016 did not involve all those who had contributions to make. Dr Brearey asked if Alison Kelly and Ian Harvey could join the senior paediatricians' meeting at 12.00 on Monday 27 June to discuss the deaths of children O and P [INQ0003142_0002]. Alison Kelly's response was that she would discuss this with Ian Harvey. As it transpired neither attended the 12.00 meeting. Separately, there was a meeting which appears to have taken place at 16.30 attended by Alison Kelly, Ian Harvey and some of the senior nursing team [INQ003275_0001, INQ0015537_0004].

84 Karen Rees was correct to concede that the absence of the paediatricians from the meeting at 16.30 on 27 June gave the impression of an *"us and them" category* and was *divisive* [Rees/week7/21Oct/151/17 & 152/24].

85 Ian Harvey's recollection of his discussion with Dr Jayaram at or following the 10.00 Babygrow meeting that *there were no concerns with regard to Letby* [Harvey/week11/28Nov/152/9] cannot be right. This is wholly improbable given what Dr Jayaram told Karen Townsend [Jayaram/week9/13Nov/55/1-10] and the nature of the discussions during the 12.00 paediatricians' meeting. Dr Jayaram had told Karen Townsend on 24 June that the consultants were very concerned about Letby being on the NNU and they were not comfortable with her working unsupervised. Karen Townsend's recollection of what she was told is more explicit: *Dr Jayaram went on to suggest that he and Dr Stephen Brearey were very concerned for the two remaining triplets and there were concerns with clinical practice and an individual who may be*

deliberately harming babies on the NNU [INQ0102354 §41]. This is consistent with what Karen Rees recalls being told by Karen Townsend [INQ0102038 §28] and with what Alison Kelly recalls being told by Karen Rees [Kelly/week11/25Nov/121/25].

86 Dr Brearey's evidence is that all the paediatricians and members of the nursing team present at the meeting at 12.00 on 27 June agreed that Letby must be removed from a clinical setting.[5] He told Ian Harvey this following the meeting as is confirmed by Ian Harvey's email to Alison Kelly at 13.06 on 27 June [INQ0005727] and reiterated the position in an email the next day [INQ0005749_0003].

87 In contrast, Ian Harvey's evidence was that at the Babygrow meeting Eirian Powell was adamant that there were no concerns [Harvey/week11/28Nov/152/22]. Irrespective of whether Eirian Powell had or had not changed her views between the Babygrow meeting and the 12.00 meeting, Ian Harvey and Alison Kelly were aware when they met with her and Anne Murphy at 16.30 that (i) Drs Brearey and Jayaram believed Letby was intentionally harming babies and (ii) the paediatricians as a group wanted Letby removed from the NNU. Despite this, the meeting concluded that Letby should not be removed from the NNU and should *remain on days for support* [INQ0003275_0001].

88 Viewed with the benefit of hindsight these separate meetings tend to reinforce the impression of a division between the doctors and the nurses. This is surprising given the totality of the evidence given to the Inquiry about relationships between the doctors and nurses on the NNU and about the culture generally. The Inquiry may want to consider whether this in fact reflects an attitude amongst the Executive Team of favouring the views of the nurse managers over those of the paediatricians.

89 CoCH's position is that Ian Harvey and Alison Kelly should not have taken the decision to keep Letby on the NNU without any direct input from the paediatricians. This failure to consult those who were presenting serious concerns about Letby and who were the subject matter experts is a recurring theme in the management by the Executive Team and in particular Ian Harvey, Alison Kelly and Tony Chambers. The strength of feeling of the paediatricians is apparent from Dr Brearey's emails to Karen Townsend at 15.29 on 28 June *Just to confirm then, Ian and Alison are happy for LL to work on NNU in the same capacity as last week despite the paediatric consultant body expressing our concerns that this may not be safe and that we would prefer her not to have further patient contact?* and 08.50 on 29 June *To make decisions against the wishes and concerns of the clinicians involved without discussing it with any of us first for a week seems a little odd and disrespectful* [INQ0005749_0001-0002].

[5] See also [Dr Gibbs/week4/1Oct/112/10], Dr Jayaram [INQ0107962_0061/421], [Saladi/week4/3Oct/87/6].

90 Not removing Letby from the NNU on 27 June 2016 was a serious and culpable failing on the part of the Executive Team.

91 The possibility of an invited review by the RCPCH was raised on 27 June. The merits of this decision are considered at paragraphs 117 to 127 below.

92 Mr Harvey's first contact with the RCPCH was on the morning of 28 June. Also, on 28 June Dr Brearey emailed Ms Townsend (copied to Mr Harvey and Ms Kelly) *There has been a watchful waiting approach since our last meeting with Ian and Alison in March. However, since the episodes and deaths last week there was a consensus at the senior paediatricians meeting that we felt that on the basis of ensuring patient safety on NNU this member of staff should not have any further patient contact on NNU … Hence, it would be helpful to meet sooner rather than later, with nursing and medical colleagues together* [INQ0005749_0003].

93 Ms Kelly accepted that the events of this week of June 2016 should have triggered a safeguarding conversation [Kelly/week11/25Nov/14/24]. As the week progressed, she was provided with additional information that can and should have further highlighted this issue: she was told that there were concerns about sudden and unexpected deteriorations; that the pattern of deaths occurring at night had stopped when Letby was moved to days; and that babies had not responded to resuscitation as had been expected [Kelly/week11/25Nov/16/16-18/4].

94 Dr Brearey's request for a meeting appears to have generated an offer of a meeting with Mr Harvey and Ms Kelly on 1 July. That there was to be a delay of three days demonstrated a concerning lack of urgency as Dr Brearey was to point out.

95 Dr Saladi described sleepless nights following the senior paediatricians' meeting before sending an email at 08.16 on 29 June calling for help from outside agencies and specifically the Police [INQ0003112_0004]. It is apparent from Alison Kelly's email to Ian Harvey at 08.29 that day that she and Sian Williams had also discussed the Police, and Sian Williams was to speak to Stephen Cross before the meeting of the Executive Team at 10.00. Ian Harvey's response by email at 08.31 was that *The police having been raised, I think that we will have to*. Alison Kelly's reply shortly after *Thanks, yes I would agree re Police* [INQ0047571_0001].[6]

96 Ian Harvey acknowledged that his email that *All emails cease forthwith* was *completely wrong* [Harvey/week11/28Nov/159/19]. He also accepted that Dr Jayaram was probably correct that they had had a discussion on the morning of 29 June which had resulted in Dr Jayaram's email at 10.24 that *The Trust are contacting the police soon, once some information gathering has taken*

[6] Although Alison Kelly's email appears to be timed at 07.31 it is reasonable to conclude that it followed Ian Harvey's email of 08.31 and that therefore the clock on her computer was out by one hour.

place, which is why Ian [Harvey] asked for the chit chat to stop for now [INQ0107962 §435] [INQ0003112_0001].

97 Stephen Cross' note of a discussion with Mr Harvey at 08.15 on 29 June concerning the *Neonatal issue* references *Email this am from further consultant* and *ADVICE Police need to be involved now* (emphasis in original) [INQ0003360]. In evidence Ian Harvey told the Inquiry that the *first three lines of [Stephen Cross'] notes are in reference to me taking Dr Saladi's email to him to discuss with him* [Harvey/week11/28Nov/158/4]. Although Ian Harvey's evidence was that *our recollection differs. I do not recall Mr Cross, at any point at that time recommending we went to the police*, Stephen Cross' handwritten note is unequivocal, particularly his underlining of *now*. Even though Stephen Cross was unable to give evidence to the Inquiry and therefore his recollection was not tested, it is difficult to explain why he would have made this note if it did not represent the content of the discussion he had with Ian Harvey and the advice that he had given. The Inquiry should reject Ian Harvey's evidence.

98 This gives rise to the important question: why, if Alison Kelly, Ian Harvey and Stephen Cross (along with Drs Semple, Jayaram, Brearey and Saladi)[7] were all of the view that the Police needed to be involved did it take until May 2017 for contact to be made with Cheshire Police?

99 Ian Harvey's justification for not going to the Police appears to be that there needed to be a discussion amongst the executives and that there was a lack of specificity in the paediatricians' concerns (particularly those voiced by Drs Brearey and Jayaram).[8] In his evidence he said *at no point did they say in their view she was murdering them* [Harvey/week11/28Nov/160/18]. First, this is to miss the point and second this is wrong.

100 The paediatricians repeatedly told the Executive Team that they were concerned about Letby's association with the deaths; at the meeting on 29 June at 17.10 Dr Brearey explained that seven out of nine deaths had occurred between midnight and 04.00 and that after Letby had been moved from nights there had been no deaths. Dr Jayaram raised the possibility of air embolism. Even if Dr Jayaram was *talking about the possibility of accidental as well as possible deliberate* [Harvey/week11/28Nov/161/7] Ian Harvey could not safely conclude it was the former rather than the latter; particularly so, when he was being reassured by Eirian Powell that there were no competency concerns about Letby.

101 The information that Alison Kelly received about Karen Townsend's conversation with Dr Jayaram was that he was concerned that Letby was deliberately harming babies. Whilst the word "murder" may not have been used, as CTI pointed out to a number of witnesses, the infliction of deliberate harm that results in death is murder.

[7] See Stephen Cross' witness statement [INQ0107707 §49]
[8] See the Opening Statement on behalf of the Former Board Members [§14].

102 The Executive Team (now including Mr Chambers) met with the paediatricians and others including Stephen Cross at 17.10 on 29 June [INQ0003371]. Mr Chambers accepted that the paediatricians were looking to him for leadership and that he was presented with the expert conclusions of the paediatricians. He also accepted he *had no reason to believe that there was no rational basis for what they were saying* [Chambers/week11/27Nov/20/6].

103 Judging by the general tenor of Mr Chambers' oral evidence and what was to happen after this meeting, the recollection of Drs Brearey and Jayaram about Mr Chambers' approach at either this meeting or the meeting the following day is probably correct: Dr Brearey formed the impression that Mr Chambers thought the paediatricians were raising concerns to hide their own failings. Dr Jayaram recalled that Mr Chambers said that the concerns about deliberate harm would be a convenient explanation for the paediatricians and that there must be something else [INQ0107962 §465]. It is apparent from Mr Cross' note that Mr Chambers wished to investigate further before involving the Police and was open to the idea that "are we missing something". When Dr Brearey raised the possibility of moving Letby from the NNU he was told by the Executive Team that she could not be excluded. In evidence Mr Chambers was unable to explain why Letby could not be excluded [Chambers/week11/27Nov/27/15]. The result was that Letby worked the following day.

104 The resistance to removing Letby from the NNU continued. Ms Kelly's note of the Executive Team's meeting includes *SB to explain to AK why he feels nurse should be removed* [INQ0015537_0007]. Dr Brearey put the issue in stark terms in the meeting between the paediatricians, obstetricians and executives *Does not matter what level with concerns about a member of staff. Can reduce cots, HDU, gestation but still not safe because of staffing* [INQ0003362_0001]. Alison Kelly's putative question to Dr Brearey framed the question the wrong way: patient safety demanded that the question posed was "why AK feels it is safe to keep the nurse on the unit". This tendency to frame the question the wrong way permeated the executives' approach moving forwards, by way of illustration their interpretation of the RCPCH report and the question of Letby's return to the unit.

105 The failure to remove Letby from the NNU following the death of Child O has not and cannot be satisfactorily explained. Although many had an opportunity to act, responsibility for this failure must ultimately lie with the Executive Team.

106 With Letby on annual leave from 1 July the plan was for a review to be undertaken within two weeks. As Dr Brearey explained with Letby off the NNU *we were in a position of safety and there was some breathing space to get a collective view on this and agreement on it*. [Brearey/week10/19Nov/139/14].

107 Later on 30 June Ms Kelly emailed Ann Ford (CQC) to follow up an earlier telephone conversation. We address this at paragraph 273 below.

(8) Unit Downgrade

108 On 7 July 2016 the Trust took the decision to downgrade the NNU from level 2 to level 1. That decision preceded the Trust's own investigations into the causes of the increased mortality. It was an action which was consistent with a belief amongst the Executive Team that the cause of the deaths were clinical or systemic factors. As we observed in our Opening Note, the Trust's communication surrounding the decision to downgrade was poor.

(9) Silver command

109 Silver Command was set up between 6 and 8 July. The names of those involved are listed in [INQ0003174_0001&_0003]. The striking features of the Silver Command exercise are:

(a) first, the almost total exclusion of the consultant paediatricians. Only Dr Gibbs played a role. He was tasked with highlighting any babies transferred out of NNU where the need for transfer was due to something unusual or unexpected. As Dr Gibbs explained this was a subset of all of the babies that had collapsed, and the exercise would not capture those babies who had collapsed but not been transferred [Gibbs/week4/1Oct/145/1]. Therefore, the very large majority of the babies considered by the Inquiry would not have been captured by the review undertaken by Dr Gibbs with Anne Martyn (McGlade). We are unable to explain why the involvement of the paediatric team was confined to addressing an issue that was at best peripheral;

(b) second, the focus was on trying to find an explanation for the increase in mortality. Reviewing rolling mortality data, activity and acuity did nothing to address or answer the paediatricians' concerns that Letby had deliberately harmed babies. This was rightly described by CTI as *entirely misconceived* [Harvey/week10/28Nov/169/20]. This approach was to contaminate the internal review that Mr Harvey undertook, the exercise of agreeing the terms of reference for the RCPCH invited review and the interpretation of the results of that review and of the later review by Dr Hawdon. It ultimately led to the Trust Board being misled on 10 January 2017;

(c) third, it largely repeated exercises that had already been undertaken. Sian Williams was tasked with looking at rotas, an exercise that had already been performed by Eirian Powell for the thematic review (and before). Staff competencies were reviewed even though so far as Letby was concerned no one was challenging her competence, and, indeed, the nurse managers expressed absolute confidence in her competence;

(d) fourth, having undertaken the rota review with Julie Fogarty, Ms Williams came to the view that the Police should be contacted. When she suggested this to Ms Kelly the response that she received was that the Trust needed to do its own investigation first [INQ0101320

§§57-58]. Ms Kelly's evidence was that she did not recall the detail of this conversation [Kelly/week11/25Nov/139/3].

110 Irrespective of whether the exercise was *entirely misconceived,* the paper prepared by Alison Kelly and Ruth Millward did not provide an explanation for the increase in mortality. The text of the paper recognised that the increase could not be attributed to *common cause variation* (i.e. chance), and that neither activity nor acuity were more than contributory factors [INQ0001888].

(10) 13 & 14 July

111 Dr Gibbs' recollection was that at the meeting on 13 July the graphs from the Kelly/Millward review were presented as slides. The text was not presented [Gibbs/week4/1Oct/150/15]. His impression was that the Executive Team believed that the graphs could explain the increase in the death rate. Although in his view this did not explain the unusual nature of the deaths, as it had been agreed that the RCPCH would review the neonatal service, he concluded that it was best to wait for that review to take place. Dr Jayaram has a similar recollection of the meeting and of the Executive Team's interpretation of the slides [Jayaram/week9/13Nov/113/4]. This would be consistent with Mr Cross' handwritten notes of the earlier meeting which record Mr Chambers as saying *Tempted to think Unit doing too much? System set up to fail? … Coping culture Escalation issue. Is it competency of nurse* [INQ0003365_0003].

112 Mr Harvey presented the findings of the internal review to the Extraordinary Board of Directors meeting on 14 July. We understand that the slides presented to the meeting did not include the text of the Kelly/Millward review [INQ0002837]. Sir Duncan Nichol recalled that *our attention had been drawn in the earlier part of the meeting to the possibility that there were multiple factors that could be bearing on why the children had died, including the Chambers presented the internal review* [Nichol/week12/2Dec/59/4].

113 Mr Wilkie was surprised that the proposal from the Executive Team was that Letby should remain on the NNU on a supervised basis. He spoke to Alison Kelly the following day. He recalled that his impression was *Alison's overriding concern seemed to be the impact that removal from the unit would have on the individual* [Wilkie/week12/2Dec/177/3].

(11) Managing Letby's return & redeployment

114 In accordance with the decisions taken at the meeting with the paediatricians on 13 July and the Extraordinary Board of Directors meeting on 14 July it was proposed that on her return from annual leave Letby's practice would be supervised. It is apparent from the notes of the meeting on 13 July that the paediatricians had reservations about this. Mr Cross' note records *[Dr Gibbs] Main worry is Nurse X ∴ must be totally supervised* and *[Dr ZA] Cast iron assurance – total*

supervision. Sian Williams was recorded as flagging up that this would affect staffing levels [INQ0003365_0008].

115 There was a lack of transparency and honesty in the decision to place Letby on supervised practice. On 14 July she was told that all staff, including her, who had been identified in the internal review as being more regularly involved in the care of the babies concerned would undergo a period of supervised practice. She was also told that she would be the first nurse to undergo this process [INQ0003147]. On 18 July she was told that she was to be deployed to the complaints team because there were insufficient staff to provide supervision. This lack of transparency was an important feature in Letby's decision to follow the Trust's grievance procedure. The appropriate response would have been to commence a disciplinary investigation and suspend Letby pending its conclusion.

116 The Trust accepts that given the concerns about Letby the decision to redeploy her to Ruth Millward's team was wrong. Ruth Millward explained that she offered this redeployment believing that it would be a short-term measure.

(12) The decision to undertake the RCPCH review

117 The decision to commission the Royal College of Paediatrics and Child Health ('RCPCH') review was flawed. The Trust accepts that the appropriate response to events at the end of June 2016, insofar as it had not been undertaken before, would have been to notify the Police.

118 In addition to that general failing, CoCH acknowledges specific failings in the process by which the RCPCH were commissioned to review the NNU in July 2016.

119 First, the decision to commission an external review appears to have arisen from a meeting of the executives and paediatric nursing staff on 27 June 2016 [INQ0003275]. The wisdom of that meeting has been considered above at paragraphs 83 to 91. One consequence was that the review was likely conceived without considering whether it was in fact capable of resolving the concerns of the paediatricians which it was intended to address.

120 Second, insofar as the doctors endorsed the plan, that endorsement came with significant caveats:

(a) it was repeatedly made clear that they held concerns that the review was incapable of resolving their concerns, was not a substitute for immediate steps to resolve the patient safety risk, and had the potential to delay matters without adding to the understanding of events [INQ0003116_0002, INQ0003362_0003-0004, INQ0003238_0005];

(b) Dr McCormack expressed his view was that it was unfair to ask the RCPCH to undertake a forensic review, that their review would identify only minor issues, and that the Police would do a better job [INQ0003362_0004]; and

(c) Dr Brearey remained concerned as of 13 July 2016 but was minded to follow his colleagues in accepting the proposed review and not to refer to the Police at that time [INQ0003365_0009].

121 Third, the doctors' endorsement has to be seen in the context of what they had been told or understood at the time:

(a) there was an expectation that if the review failed to find any other cause for the deaths the Police would be contacted [Jayaram/week9/13Nov/253/9];

(b) they had been told that the review would be in depth, when in fact it could only ever be a service review [Jayaram/week9/13Nov/211/24];

(c) there was an acknowledgement amongst the paediatricians that their suspicions were unproven;

(d) Letby had been removed from the unit and so the immediate patient safety risk had been mitigated [Jayaram/week9/13Nov/212/20]; and

(e) they had been told there was insufficient evidence to go to the Police and that were the Police to be involved this would result in the NNU being closed as a crime scene [McCormack/week5/8Oct/66/20, Jayaram/week9/13Nov/213/10].

122 In the circumstances, CoCH submits that the Inquiry should be slow to criticise the paediatricians for accepting the plan to commission the review from the RCPCH.

123 Fourth, it is clear that the terms of reference for the review which Ian Harvey ultimately agreed with the RCPCH were deficient [INQ0009597_0004]. This was accepted by Ian Harvey in his oral evidence [Harvey/week11/28Nov/198/20]. Notably, the terms of reference agreed were incapable of investigating and excluding criminality, as indeed were the RCPCH generally [Harvey/week11/28Nov/201/5].

124 Finally, those terms were inevitably interpreted through the lens of the information provided to the RCPCH about the Trust's concerns. CoCH submits that that information was misleading and tended to direct the college away from the paediatrician's concerns:

(a) for reasons which remain unclear, the word '*apparently'* was inserted into the terms of reference when describing the increase in deaths [Kelly/week11/25Nov/166/19]; and

(b) concerns were played down by senior management in their communications with the RCPCH [Eardley/week6/7Nov/41/18]. Sue Eardley's evidence was that framing impacted on her views as to the seriousness of the allegations [Eardley/week6/7Nov/142/6]. It was not intimated that it was a serious allegation which was being taken seriously by the medical

director [Eardley/week6/7Nov/142/10]. Similarly, Allison Kelly came across as supportive of Letby and dismissive of the allegations against her [Eardley/week6/7Nov/142/20].

125 What was communicated to Ms Eardley stands in sharp contrast not only to the developed concerns of the paediatricians, but also the assurances given in parallel by Ian Harvey to allay the observations of the Board of Directors. Notably, Ros Fallon had inquired *if there was a direct correlation, would they uncover this*, whilst Sir Duncan Nichol has asked *whether the review team will be briefed on the explicit concerns* [INQ0003238_0008 and _0009]. Both were assured by Ian Harvey that those concerns were being stressed to the review team.

126 Had Sue Eardley been told of the paediatricians concerns in the terms they were conveyed to the review team by Drs Brearey and Jayaram on 1 September [INQ0014604_0006-0016],[9] it may be that she would have concluded that *this is not something that the RCPCH should becoming involved in.* The failure to engage the paediatricians in the process of commissioning and scoping the RCPCH review was, it follows, a serious omission.

127 As a consequence of those failings, CoCH agrees with the proposition put by Mr Skelton KC that the Trust would become locked into a process of investigation which was incapable of answering the question which needed to be confronted [Jayaram/week9/13Nov/251/4].

(13) RCPCH review

128 Insofar it was not already apparent to them, the limitations of the RCPCH review were made clear to Ian Harvey and Alison Kelly on the second day of the review [INQ0014605_0006]. This was reiterated in the RCPCH letter of 5 September that spelt out that what was required was a detailed forensic casenote review of all the deaths by two independent people. In his evidence Ian Harvey sought to confound or confuse this issue: his references to there being no indication to abort the review or it still being a worthwhile exercise did little to assist the Inquiry [Harvey/week11/29Nov/2/16 and 4/15]. The Inquiry may want to consider whether this is consistent with the impression formed by Ms Eardley of the attitude of the senior team:

(a) Of Mr Harvey *I think if he had thought it was a serious allegation he would have called the police sooner*.
(b) Of Ms Kelly *She was particularly supportive of Lucy Letby and in my recollection quite dismissive of the allegation.*
(c) Of Mr Chambers *My recollection of that conversation is not so strong but there appeared to be consistent response from the management team, that it was something the doctors were raising but not something they were taking particularly seriously in terms of evidence beyond that correlation of the -- of the rotas.*

[9] Drs Brearey and Jayaram discussed the possibility of foul play, mechanisms by which Letby could have caused harm [air embolism], the failure to respond to appropriate resuscitation and the prospect of police involvement.

(14) Dr Hawdon's review

129 Mr Harvey's letter of instruction to Dr Hawdon of 5 October 2016 copied the relevant passages from the recommendations in the RCPCH letter of 5 September. His earlier email to Dr Hawdon of 8 September had omitted the word "forensic" in the request for a detailed casenote review. Nor did it reference the need to examine post-mortem findings with a view to identifying a cause of death or investigating those who had had access to the unit from four hours before each death.

130 Dr Hawdon was entitled to feel misled by Ian Harvey. She should have been told in advance that the paediatricians were suspicious of a member of staff. The first time that she became aware of those concerns was when she received Ian Harvey's email dated 14 February 2017 [INQ0014376_0002] [Hawdon/week9/12Nov/35/14]. If Ian Harvey had told her that review was to exclude homicide, she would have told him that a casenote review was not the level of forensic review that was needed [Hawdon/week9/12Nov/51/16]. She was correct when she told the Inquiry that the only appropriate response was to call the Police or go through the safeguarding process (which would have engaged the Police) [Hawdon/week9/12Nov/72/2].

131 Dr Hawdon was told by Ian Harvey that parental consent had been obtained [INQ0003123_0001]. There is no evidence that parental consent had been obtained. It should have been. It was Ian Harvey's responsibility to ensure that parental consent had been obtained. He accepted that if parental consent was not obtained this was *a significant error on my part* [Harvey/week11/29Nov/25/4]. This was an important aspect of the communication failures that we identified in our Opening Note.

132 In answer to the suggestion that both Drs Hawdon and McPartland were misled, Ian Harvey's evidence was that he commissioned both reviews in good faith [Harvey/week11/29Nov/46/1]. Whilst this may be correct the central and crucial information which neither was given was that the paediatricians suspected intentional harm. Ian Harvey's response appears to be that he was influenced by the way the RCPCH had phrased their recommendations and the reference to *gut feeling* when describing the basis for the paediatricians' concerns. Neither response withstands any form of analysis: the primary RCPCH recommendation was for a detailed forensic casenote review and the fact that the paediatricians' concerns about an unequivocal rise in mortality may have been based upon a *gut feeling* did not make those concerns any less valid. As Ian Harvey was at pains to make clear, he respected Dr Brearey and did not doubt that his concerns were genuine [Harvey/week11/28Nov/90/18].

133 The covering letter dated 29 October 2016 sent with Dr Hawdon's review made clear (as did the review itself), the limited exercise that she had undertaken. She explained that she had not undertaken a full systematic chronological review for each case, nor had she had access to the coroner's post-mortems and she was not in a position to investigate those who had had access

to the unit from four hours before each death [INQ0003358]. Dr Hawdon's report recommended a "broader forensic review of the cases in category 2 above [at that stage five cases] as after independent clinical review these deaths remain unexpected and unexplained" [INQ0003172_0045].

134 For reasons which have not been adequately explained, Dr Hawdon's report was not released to the paediatricians until February 2017.

135 It is difficult to conceive how either the RCPCH report or Dr Hawdon's review could be regarded as reassuring in the face of concerns expressed by the paediatricians that Letby was deliberately harming babies.

(15) Grievance

136 The recommendation made by the RCPCH communicated in the letter of 5 September 2016 was for an investigation into the allegation that had been made against Letby [INQ0003120_0002]. Mr Harvey and Ms Kelly were aware from 1 September at the latest that the RCPCH would not be investigating the allegation.

137 On 7 September Letby submitted her grievance [INQ0002879_0003]. This followed Mr Milea's letter to Ms Rees informing her that he believed that Letby had grounds to action a grievance [INQ0003171].

138 When Sue Hodkinson presented the options document to the Executive Team on 8 September she recommended option 4 "Re-integrate back within NNU without ITU/HDU duties whilst competencies reviewed (e.g. 3 months)" [INQ0004660_0001]. Notwithstanding the contents of the RCPCH letter and that Ms Hodkinson's options document included reference to "Disciplinary investigation undertaken", it is not clear from the evidence or from the contemporaneous material that active consideration was given (as it should have been) to a disciplinary investigation into the concerns about Letby. It is apparent from Mr Milea's letter to Karen Rees that his advice to Letby concerning the possibility of a grievance was heavily influenced by the failure to actively investigate Letby's actions.

139 Ian Harvey did not understand the grievance to be about how the doctors had behaved. He understood it was about how Letby had been managed off the unit [Harvey/week11/29Nov/55/13]. Ian Harvey regretted that he did not say anything to Dr Green to the effect *"I did not understand [the behaviour of the consultants] was part of this process*" [Harvey/week11/29Nov/69/14].

140 However, from as early as 8 September there were references to the behaviour of the consultants:

(a) Mr Cross' note of the meeting on 8 September mentioned "Potential deal with [Dr Brearey]. What about other consultants?" [INQ0006265];
(b) Ms Hodkinson's note the following day referenced the inappropriate behaviour of Dr Jayaram and an obstetrician, presumably Mr McCormack [INQ0015640_0040].

141 Moreover, on 26 October 2016 Ms Hodkinson reassured Letby that she would raise the issue of comments that had been made about her within the grievance hearing [INQ0008964_0082]. It is clear that Ms Hodkinson's belief was that there were two aspects to the grievance: the transparency of the information that had been provided to Letby and how she was being spoken about by clinicians [Hodkinson/week11/26Nov/112/2]. This was not consistent with Dr Green's instructions which reflected Letby's grievance document and did not include issues about the behaviour of others [INQ0002879_0069].

142 It is clear from the grievance interviews that witnesses were inappropriately invited to offer their views on the consultant's behaviours which transpired in most cases to be based upon multiple hearsay. Alison Kelly's interview is illustrative of this and presented a picture that was (at best):

(a) incomplete and misleading as regards any conclusions about Letby in the RCPCH report and the circumstances in which she had been redeployed to Ruth Millward's team;
(b) less than impartial insofar as she accused the consultants of *fuelling the situation* and whether she believed that there was a basis for investigating Letby's actions. Those who were the subject of criticism were entitled to expect the senior management team to approach an issue as serious as this with an open mind.

143 CoCH accepts that there were shortcomings in the grievance process:

(a) Dr Green's investigation report should not have included reference to the consultants not being open and honest with the Executive Team and this should not have formed part of Ms Weatherley's conclusion when (i) neither Dr Brearey nor Dr Jayaram were asked about this [Green/week8/6Nov/216/1] and (ii) this was not part of Letby's grievance. Dr Green acknowledged that *This is probably one of the key parts of the document that I look back on now with some regret maybe* [Green/week8/6Nov/229/24];
(b) the process of writing and rewriting the report was not sufficiently transparent;
(c) some of what was said during the process was ill advised or intemperate. Dr Green was *embarrassed* by his statement that "I was disgusted by [Dr Brearey and Dr Jayaram's] behaviour. It's likely that they had lied" [INQ0003155_0017] [Green/week8/6Nov/237/11];
(d) the outcome of the process which required Drs Brearey and Jayaram to go through a process of mediation was fairly described by CTI as *absurd* [Green/week8/6Nov/238/5].

144 Dr Green was correct to conclude and concede that *perhaps I should not have been asked to do that grievance; perhaps it should have been someone external to the Trust* as there were other

things going on at the time that he was not sure that he was equipped to deal with [Green/week8/6Nov/244/12]. It was also the view of Alison Kelly that it would have been better if the investigator had been entirely independent of the Trust and for the person adjudicating to be neither a doctor nor a nurse [Kelly/week11/25Nov/180/1].

145 Most significantly had the allegations against Letby been properly investigated she may not have had the basis to bring a grievance at all; certainly, on Mr Milea's analysis an important reason for bringing the grievance was that the Trust had failed to investigate the allegations properly against Letby. Alternatively, given the ongoing reviews the grievance should, as Ian Harvey suggested, have been halted [Harvey/week11/29Nov/95/12]. Most importantly, the grievance process should not have been allowed to be side tracked into considering issues relating to the behaviour of clinicians when this formed no part of the grievance as formulated in Letby's grievance letter.

(16) Relationships between the paediatricians and executives from July to September 2016

146 Prior to the end of June 2016, the response of CoCH's Executive Team to concerns about Letby was characterised by delay, indecision, and an apparent inability or unwillingness to acknowledge the seriousness of the concerns being raised. Whilst those features persisted, CoCH observes that from the end of June the response of the Executive Team increasingly became coloured by scepticism towards the Trust's paediatricians and a defensive attitude towards Letby. Over time, that scepticism developed into outright hostility. This is evident from:

(a) The failure to include the paediatricians in discussions on 27 June.
(b) Ian Harvey's *all emails cease forthwith* [INQ0003112_0002].
(c) Mr Chambers' comment to Dr Jayaram that "*I can see how that would be a convenient explanation for you but surely there must be something else*"
(d) By 14 July 2016, Mr Chambers was of the view that there was a *systemic problem* in paediatrics and that the *culture in obstetrics/paeds is broke* [INQ0004327].
(e) Six days later he was considering whether there was a need for a *change in leadership* in paediatrics [INQ0007197_0134]. Given that, save for Eirian Powell, the Inquiry has heard near uniform accounts by witnesses of a good culture on the neonatal ward prior to the spring of 2016, Mr Chambers' conclusion is surprising;
(f) How the grievance procedure was managed and its outcomes.

147 In parallel, the paediatricians were excluded from the response to either the RCPCH or Hawdon reports. Notwithstanding their requests to see it [INQ0107962 §590], the RCPCH report was shared only briefly with Dr Brearey, Dr Jayaram and Anne Murphy on 10 November 2016 [INQ0103104 §327]. The other paediatricians were provided only with a redacted version on 3 February 2017. That was despite Ian Harvey being free to share the review with whoever he saw fit subject to minor data protection considerations [Harvey/week11/29Nov/71/18]. The effect of that decision was threefold. First, as accepted by Mr Harvey in evidence, it was on any analysis

unlikely to support good working relationships between the paediatricians and executives [Harvey/week11/29Nov/188/3]. Second, insofar as there were any patient safety concerns in the report, it created a patient safety risk by depriving the paediatricians of the opportunity to remedy them. Third, it removed the opportunity for the paediatricians' expertise to be utilised in interpreting the report's findings. It is hard to understand the reasoning which underpinned the decision not to share those reports with the doctors to whom they related in a timely, open and transparent manner, and failing to do so was also almost inevitably going to produce suspicion and mistrust between the paediatricians and the executives.

148 The effect of those actions was that between June 2016 and the autumn of that year, the paediatric consultant body felt increasingly isolated as a group, was suffering poor morale, and was developing legitimate concerns about the intentions of senior managers. Those concerns were articulated to Tony Chambers by Dr Jayaram in a lengthy email dated 20 September 2016 [INQ0003133]. This included an observation that many decisions were being taken without the involvement of the consultants concerned and a fear that their relationship with senior managers was *breaking down*.

149 Dr Jayaram's email raised serious concerns in a measured way. It expressed fear as to the state of the relationship between the paediatric consultants and executives. In places, Dr Jayaram reflects on his own actions and those of Dr Brearey and their possible contribution to the situation. Tony Chambers' response to that email amounted to six lines. It failed to acknowledge most of the concerns or to suggest any remedy. Tellingly, he forwarded his response to Ian Harvey sharing his view on the correspondence: '*A not very warm email from Ravi and a slightly warmer response from me*'. It is unclear on what basis he felt he could describe his own response as *warm*. At a time that required leadership in the most difficult of circumstances, Mr Chambers took no meaningful action to address Dr Jayaram's concerns or any steps to repair those strained relationships.

150 We suggest that the tone of Mr Chambers' response resonates with his "tone deaf" response to the paediatricians 26 questions in 2018 that necessitated the intervention of Sir Duncan Nichol and Dr Gilby who described the response as "tone deaf" [INQ0101076 §108].

(17) Meeting of 24 November 2016

151 On 24 November 2016, Dr Brearey was required to attend a meeting, the purpose of which was to ensure that he knew he was not to share the content of the RCPCH review prior to it being disseminated by the executives [INQ0003094]. That approach was, in and of itself, flawed. The request not to share it was however a simple matter which could easily have been attended to via email or upon Dr Brearey's return from leave.

152 What happened next is demonstrative of the attitude being taken towards the paediatric consultants by the Executive Team by the autumn of 2016. Despite it being known that he was on leave [INQ0005304], Dr Brearey was required to attend a meeting at one day's notice with both Ian Harvey and the Executive Director of People and Organisational Development, Sue Hodkinson. Ian Harvey was unable to offer any satisfactory explanation as to why Ms Hodkinson's presence at that meeting was necessary [Harvey/week11/29Nov/72/25]. In oral evidence, both he and Ms Hodkinson described the letter which followed on 13 December 2016 recording both the meeting and the *direct management instruction* not to discuss the report as *heavy handed* [Harvey/week11/29Nov/73/10 Hodkinson/week11/26Nov/201/22].

153 If that interpretation is accepted, it reveals serious deficiencies in Mr Harvey and Ms Hodkinson's management skills. Tellingly however, Ms Hodkinson had no choice but to accept in oral evidence that having a witness (coincidentally, the organisation's most senior human resources official) attend a meeting at which a direct management instruction was given (one later recorded in writing) would, had Dr Brearey breached that instruction, have provided a basis for disciplinary action against him. It is reasonable to infer that as an experienced HR professional [Hodkinson/week11/29Nov/6/8] Ms Hodkinson knew that at the time. There is no evidence to suggest she took steps to dissuade Mr Harvey from the approach taken at the meeting of 24 November or in his subsequent correspondence.

154 One explanation for the meeting of 24 November is that it was as Dr Brearey put it *a blatant attempt to intimidate me*. Even if he is mistaken and it was merely *heavy handed* management, the effect was the same. The significance was not lost on Dr Brearey [INQ0103104 §335].

(18) Meetings with Letby

155 Letby and her parents met with Mr Chambers, Mr Harvey, Ms Kelly, Ms Hodkinson and others on 22 December 2016 [INQ0002912], with Mr Chambers, Ms Kelly and others on 10 January 2017 [INQ0003471], and with Mr Chambers, Mr Harvey, Ms Kelly, Ms Hodkinson and others on 6 February 2017 [INQ0014279]. In addition, Letby met with Ms Hodkinson with or without Ms Kelly on multiple further occasions [INQ0003471].

156 This level of direct contact between Letby and her parents and the Executive Team was not appropriate. Ms Hodkinson described it as very unusual to have a meeting with the parents of a staff member [Hodkinson/week11/26Nov/116/11]. The notes of the meetings demonstrate that control had been ceded to Letby and her family so that, for instance, she was able to stipulate the names of those from whom she wished to receive an apology. The contrast with the treatment of the consultant paediatricians and the extent to which they were kept informed of the progress of the RCPCH invited review and Dr Hawdon's review is striking.

157 Some of what was said by the Executive Team during these meeting was ill judged. This was explored with Mr Chambers in his oral evidence [Chambers/week11/27Nov/101/1]. Whilst he accepted that with the benefit of hindsight, he did not handle these meetings well [Chambers/week11/27Nov/117/10], what he said at the time makes it clear that his view (and this appears to mirror the view of the wider Executive Team) was that the various reviews had *vindicated* Letby [INQ0014279_0005]. Mr Chambers accepted that insofar as his reference to vindication related to the reviews that had been carried out this was not accurate as the RCPCH had not investigated Letby and Dr Hawdon's review had not vindicated her, albeit he added the caveat *but it didn't point at an unnatural causes* [Chambers/week11/27Nov/118/25].

(19) Board of Directors meeting on 10 January 2017

158 At the meeting on 10 January 2017 the Board was asked to approve Letby's return to the NNU in accordance with a plan that had been agreed at the meeting of the Executive Team with Sir Duncan Nichol on 30 December 2016 [INQ0004299_0003]. The approval was sought on the basis that the reviews that had been undertaken had found no evidence of a single person's culpability.

159 Mr Harvey and Mr Chambers have sought to characterise the RCPCH report and the Hawdon review as reassuring. Mr Harvey explained that *The reviews hadn't been specifically commissioned to look for a crime. But I suppose we had anticipated that, in the event that there had been a malicious act, that there would have been evidence found in the course of those reviews* [Harvey/week11/28Nov/203/20]. Mr Chambers applied a similar caveat. The error that both, but particularly Ian Harvey, made was in the framing of the question that was posed: rather than asking does the RCPCH report or Dr Hawdon's review exclude the possibility that Letby was responsible for these deaths, he posed the question does the RCPCH report or Dr Hawdon's review establish that Letby was responsible for the deaths.

160 It is clear that, as Mr Harvey accepted, neither the RCPCH report nor the Hawdon review could exclude the possibility that the babies had been deliberately harmed. In the document that he prepared for the Board of Directors meeting on 10 January 2017 Mr Harvey wrote "the review having found no evidence of a single person's culpability" [INQ0003239_0002]. At the meeting itself Mr Harvey is recorded as having told the Board *The case reviews very much reinforce what is in the review, it comes down to issues of leadership, escalation, timely intervention and does not highlight any single individual* [INQ0003237].

161 Mr Chambers told the Board *There was an unsubstantiated explanation that there was a causal link to an individual, this is not the case and the issues were around leadership and timely clinical interventions and that There is an unsubstantiated claim that the issue was down to one individual's actions and behaviours*.

162 These statements were both inaccurate and misleading. Mr Harvey accepted as much but suggested that the wider (and un-minuted) discussions during the Board meeting *highlighted the gaps* and that the *full picture … came up in the conversation around the report* [Harvey/week11/29Nov/186/13-187/5].

163 Sir Duncan Nichol's evidence is unequivocal:

> *"I believe that the board was misled in December 2016 when it received a report on the outcome of the external, independent case reviews. We were told explicitly that there was no criminal activity pointing to any one individual, when in truth the investigating neonatologist had stated that she had not had the time to complete the necessary in-depth case reviews." Then you tell us at paragraph 159: "I did not have the date to hand when talking to the BBC. The report I referred to the board receiving was Ian Harvey's report to the extraordinary meeting on 10 January."*
>
> *…*
>
> *What I thought at the time was that I was misled because I was not informed that Dr Hawdon had not had the capacity to do the job that she had been asked to do in the depth that was required. I thought that was essential information that was not made available to either myself or the board and that was the only reference that I -- I intended to make to being misled.*
>
> *Q. Because you didn't know that she couldn't take on what the RCPCH had suggested?*
>
> *A. She couldn't take on what I think Mr Harvey had asked her to do.*
>
> *Q. Right. But you saw, did you, anything that Dr Hawdon had written. Did you see for yourself?*
>
> *A. I saw -- I saw the some summaries of, of cases. But I -- I didn't -- I didn't see anything else.*
>
> *Q. So do you think you were misled or not? When we look at the 10 January meeting particularly, I am not talking about the details of the review, were you or do you think you got their views, Mr Harvey and Mr Chambers' views?*
>
> *A. I think a critical piece of information of the kind that I have just mentioned, namely that the reviewer, Dr Hawdon, didn't have the capacity to do the review in the required depth, for us not to be -- for me not to be told about that was misleading* [Nichol/week12/2Dec/78/1-79/22].

164 Mr Wilkie's evidence tends to contradict the proposition that in non-minuted parts of the meeting a fuller and more accurate picture was presented to the Board *But on that date at that board meeting, the whole outcome of the Royal College report was framed in a way that the inference that I drew was that basically Letby had been exonerated, right* [Wilkie/week12/2Dec/182/13].

165 The only proper conclusion is that the Board was misled on 10 January 2017. The Board was not given the 5 September 2016 letter from the RCPCH to Mr Harvey, or the "full' RCPCH report or the Hawdon review. The Inquiry may wish to consider whether providing a redacted RCPCH report only at the Board meeting and retrieving it at the conclusion of the meeting was designed to limit the Board's opportunity to read it in detail. Certainly, this is likely to have been the impact.

166 The conclusion that the Board was misled is reinforced by:

(a) the terms of Mr Harvey's letter to the families of 8 February 2017 which fails to mention that Dr Hawdon had not been able to undertake the *thorough review* that the RCPCH had recommended:

> *In the report, it describes no single cause or factor to explain the increase we have seen in our mortality numbers …*
>
> *You will see in the report one of the recommendations includes a thorough review of the specific care and treatment each baby received* [INQ0012619_0003]

(b) the briefing sent to the media on 8 February 2017:

> *In the report, there is no single cause or factor identified to explain the increase we have seen in our mortality numbers. The review makes a total of 24 recommendations across a range of areas including compliance with standards, staffing, competencies, leadership, team working and culture. We are already working to implement these recommendations.*
>
> *One of the recommendations included conducting a further thorough independent review of each neonatal death between January 2015 and 2016 to determine any factors which could have changed the outcomes. While this has now been completed as a matter of priority, it has led to the review taking longer than originally anticipated.* [INQ0006049].

167 Even if it is correct that the Board was provided with misleading information on 10 January 2017, the Trust nevertheless accepts that the Board did not hold the executives to account as it should have done:

(a) The Board could and should have ensured that there was sufficient time to read the RCPCH report and that they had received an unredacted version.

(b) The Board too readily accepted Mr Harvey's interpretation of the reports of the RCPCH and Dr Hawdon when it could or should have sought assistance from the paediatricians who were the Trust's subject matter experts.

168 Sir Duncan Nichol acknowledged that he could have asked to see Dr Hawdon's full report, albeit he was unable to say how this may have influenced the outcome of the collective board discussion.

169 Mr Wilkie's conclusion, in retrospect, was that the safety mechanism that a NED was intended to provide did not work effectively, although he caveated this by saying that it is not unreasonable for a NED to accept credible views provided by the executives [Wilkie/week12/2Dec/190/9].

(20) Meeting of 26 January 2017

170 On 26 January 2017 there was a meeting attended by the consultant paediatricians,[10] Karen Rees, Rachel Hopwood, Dr Sean Tighe, Stephen Cross, Tony Chambers, Ian Harvey, Alison Kelly and Sue Hodkinson. It is important to note the following features of that meeting as recorded in the minutes [INQ0003523]:

171 the meeting commenced with an account of Mr Harvey's interpretation of the RCPCH report. Save insofar as Drs Brearey and Jayaram had had brief sight of it, none of the other consultants had seen it and therefore Mr Harvey's interpretation of it did not benefit from their expertise. That was accepted as a failing by Tony Chambers and Ian Harvey [Chambers/week11/27Nov/99/9, Harvey/week11/29Nov/188/14];

(a) there was an assertion by Mr Chambers that the Trust's speak out safely processes had been *professionally managed*;
(b) following this, Mr Chambers felt it necessary to explain that *emotions were running high at the time. Things have been said and done that were below the values and standards of the Trust*. He continued to discuss the actions arising from the grievance. The minutes record that the *grievance had indicated that there had been victimisation of the nurse*;
(c) Karen Rees then proceeded to read out a statement by Letby describing her suffering in consequence of the consultant's actions [INQ0012080];
(d) Ian Harvey said *there is a need to draw a line under the Lucy issue*;
(e) Mr Chambers reiterated the requirement to *draw a line* whilst at the same time adding that there needed to be an apology from the consultants and that this would be followed by mediation; and
(f) the consultants were asked to support the Board's recommendation and Letby's return to work.

172 It is helpful to consider the content of the minutes set against the account of the meeting provided by Mr Chambers in his oral evidence. He described that he was *expecting… a discussion…* but that *in the meeting, it just felt odd that there was no dialogue and no conversation* [Chambers/week11/27Nov/148/17]. Mr Chambers described the meeting as *very tense* and that he *didn't really understand why* [Chambers/week11/27Nov/149/23]. He went on to describe it as *an odd meeting… the consultants didn't seem to be able to engage fully…* [Chambers/week11/28Nov/38/10].

173 That account ostensibly describes a meeting which: (i) was intended by Mr Chambers as a collaborative discussion of the issues around neonatal mortality; and (ii) was far more tense than he had anticipated. It is a position which, in CoCH's submission, does not withstand scrutiny:

[10] The minutes record the presence of Drs Jayaram, Brearey, Saladi, V, McGuigan and Gibbs

(a) first, Mr Chambers' ambition for a *discussion* with the paediatricians stands in stark contrast to the account of how the meeting developed as illustrated by its minutes. The meeting was led by Mr Chambers and Mr Harvey and addressed the topics which they intended to be discussed in the order they chose to discuss them. Those topics were, in order: (i) Mr Harvey's interpretation of the RCPCH report (uninformed by comments from the paediatricians); (ii) Letby's grievance and the *behaviours* of the paediatricians; and (iii) Letby's account of the impact of events on her;

(b) second, there can be no suggestion that the meeting proceeded in a manner which was unintended by the Executive Team. Its structure and the topics covered were entirely consistent with the handwritten agenda planned by them in advance [INQ0007194_0063];

(c) third, for a meeting which Mr Chambers intended as a *discussion*, there is a curious absence of any invitation for contributions from the paediatricians. At no point do the minutes suggest any effort by Mr Chambers or Mr Harvey to invite a discussion with the paediatricians as to the issues at hand. All parties accept that the paediatricians contributed little. It is correct to characterise the meeting as a *didactic* one in which Mr Chambers and Mr Harvey provided their views to the paediatricians. That this was a genuine attempt to canvas the paediatricians' views is difficult to accept;

(d) fourth, Mr Chambers' stated desire for the meeting appears to be inconsistent with his own evidence as to the approach he anticipated being required, namely that he would need to take a *strong line* [Chambers/week11/28Nov/38/3];

(e) fifth, it is difficult to understand how Mr Chambers could genuinely believe that, set against the backdrop of events to date, the tone of the meeting was ever likely to be the productive discussion he apparently anticipated;

(f) sixth, the decision not to share the RCPCH or Hawdon reports is simply incompatible with an intention to engage the paediatricians in a productive discussion of issues relating to mortality on the NNU;

(g) seventh, it is unclear what purpose reading Letby's letter could serve other than as an admonishment of the paediatricians; and

(h) finally, Mr Havey's decision to invite the BMA representative, Dr Tighe [INQ0102067 §8], can only betray that executives felt this was a meeting at which the paediatricians would benefit from union representation. Dr Jayaram's understandable immediate response to Dr Tighe's invitation was that it *Begs the question. Why?* [INQ0107964_0062].

174 Turning now to the paediatricians' evidence:

(a) Dr Brearey's evidence is that he was surprised by the tone and presence of non-executive directors, notwithstanding that he had been warned that Tony Chambers and other executives were after a *decapitation* by David Semple [INQ0103104 §336]. That conversation is also recalled by Dr V [INQ0102068 §174]. It was the *worst and most shocking meeting* of Dr Brearey's NHS career [INQ0103104 §347];

(b) Dr Jayaram's evidence is *I remember at the time being shocked. We had still not seen the reports and had no awareness that potential disciplinary issues might be raised (especially after Mr Harvey had said in the email the day before it was not a disciplinary issue). I wanted to speak up but we had agreed not to respond until we as a group had had a chance to discuss what had been said. I found Mr Chambers' words threatening and intimidating especially given that neither he nor Ian Harvey had actually detailed the evidence to which they had referred and so I was not in a position to question them at this stage. I felt as if he was bullying my colleagues and I into accepting what he was telling us* [INQ0107962 §§604 and 605];

(c) As to the conclusion of the meeting, Dr McGuigan recalls '*The part that stuck with me very clearly from that meeting is what happened next. Tony Chambers looked up at the paediatricians, and my recollection of his words were, 'I'm drawing a line under this, do not cross that line". He did not expand further on what this meant, but my understanding of his words was clear. He wanted this to end, and there would be consequences if individuals tried to take this further. In the context of the email invitation, my understanding was that there would be disciplinary consequences for individuals who continued to raise concerns about Letby.*' [INQ0101097 §20];

175 The evidence of the other paediatricians is entirely consistent with those accounts. They describe some or all of the following [INQ0102068 §§172 to 176, INQ0102740 §96, INQ0102064 §55, INQ0101097 §§12 to 25]: (i) that Mr Harvey summarised the findings of the RCPCH, which they were told were negative; (ii) reference was made to victimisation of Letby and/or negative behaviours, possibly with allusions to them having fallen below GMC standards [INQ0107962 §601, INQ0102067 §5]; (iii) Karen Rees read out Letby's statement; and (iv) the consultants were told of the need to apologise to Letby and to draw a line under events, alongside a threat of consequences if that was not adhered to. All invariably describe the tone of the meeting as aggressive or intimidating, and Mr Chambers as angry and threatening. Whilst he was invited by Ian Harvey, Dr Tighe's account is similarly consistent, noting the *dictatorial and intimidating* tone, the implied threat of consequences if the paediatricians did not do as requested, and that the discussion was *very one sided and the paediatricians had limited opportunity to comment* INQ0102067 §§8 and 9, Tighe/week5/8Oct/197/9].

176 CoCH submits that the consistent accounts of the meeting on 26 January provided by the doctors present are likely to be accurate. The account provided by the executives, and by Mr Chambers in particular, is difficult to accept. In the context of the executives' relationship with the paediatric consultants at the time, the arrangements for the meeting and the way it was conducted, Mr Chambers' surprise at how the meeting developed shows either a serious lack of insight and understanding of the issues as of January 2017 or is simply disingenuous.

177 Three days after the meeting of 26 January 2017, Dr Tighe felt the need to write to Dr Jayaram [INQ0003489]. It is clear that what he had observed at the meeting on 26 January had caused him considerable concern. His conclusion was that if further investigations could not allay the consultants' concerns that serious crimes had been committed, referral to the Police or coroner was required. On 30 January 2017, the paediatricians wrote to the executives outlining their ongoing concerns, requesting sight of the RCPCH and Hawdon reviews and asking for the executives' *help in assisting us to restore confidence in our neonatal service* [INQ0003095]. No response to that letter was received.

(21) Early February 2017

178 Four months after Ian Harvey had received the report from the RCPCH, it was shared with the paediatricians on 3 February 2017. Dr Hawdon's report was provided on 7 February. It was immediately apparent to the paediatricians that (i) the findings did not explain the deaths; (ii) the interpretation given to them at the meeting of 26 January was incorrect [INQ0103104 §§354 to 365, INQ0102740 §97, INQ0107962 §160]; (iii) Ian Harvey's account of the reports provided on 26 January had failed to acknowledge the significant positives identified by the RCPCH; and, (iv) the reports failed to resolve (or even address) their concerns about Letby's association with the deaths.

179 On 9 February 2017, Drs Brearey and Jayaram met with Ian Harvey. Their WhatsApp messages reveal the ongoing discrepancy between the paediatricians' and Mr Harvey's interpretations of the RCPCH report [INQ0103168_0007]. The following day, the consultants wrote again outlining their concerns that the reports had not provided a satisfactory explanation for the deaths and collapses on the NNU and providing reasons for that view [INQ0003117]. That same day, Dr Subhedar emailed Ian Harvey setting out the deficiencies in Dr Hawdon's report, the absence of an explanation for the cause of death in seven children and the importance of a 'broader forensic review' of those deaths. He also included this observation on the RCPCH report [INQ0103192]:

> *I would like to make one further observation in relation to the RCPCH report and recommendations. Many of the recommendations relating to the governance arrangements around neonatal deaths are valid and sensible, but again extend beyond the NNU at CoCH. The unit in Chester is by no means an outlier either in terms of processes around mortality reviews or consultant presence and supervision on the NNU. The CoCH team's commitment to the Network's Steering Group and Clinical Effectiveness Group is exemplary and, in my view, demonstrates a commitment to improving the safety and quality of the neonatal care they provide*.

180 Whilst CoCH submits that the same should have been apparent simply from careful reading of the RCPCH and Hawdon reviews, by the time of the executive meeting on 14 February Ian Harvey had been explicitly told:

(a) that the reports which had been commissioned did not explain many of the deaths and that further forensic review of those deaths was required;
(b) that was the view not only of the Trust's consultants, but Dr Subhedar and Dr Hawdon; and
(c) that the RCPCH had undertaken only a service review, the conclusions of which would be applicable to many NNUs.

181 Moreover, if the reality was that the strained relationship between the executives and the paediatricians compromised the executives' reliance upon input from the paediatricians, this advice was coming from an independent third party, the local neonatal lead.

182 The executives' response to the paediatricians' letter of 10 February, as recorded in the minutes of their meeting on 14 February, demonstrates quite how rigid their thinking had become [INQ0003379]:

(a) Ian Harvey's response was that he *wondered what they were plotting*. That language was explored with both Mr Chambers [Chambers/week11/27Nov/160/23] and Mr Harvey [Harvey/week11/29Nov/93/5] in oral evidence. Neither provided a satisfactory explanation for it. Allusion to a plot by the paediatricians can also be detected in Mr Harvey's subsequent comment: *met Steve and Ravi end of last wk, no indication this L (letter) was coming, probably more going on bet(ween) them*;
(b) Mr Chambers is recorded as saying *moving goalposts – how they died/challenge to PM results*. Such a comment betrays an alarming ignorance of the issues he was required to confront. Far from moving the goal posts, how the children died and whether the post-mortem results explained the deaths was absolutely fundamental to the question which had been facing the executives since June 2016; and
(c) the paediatricians' concern that the RCPCH report failed to properly address the fact that Drs Brearey and Jayaram had told the reviewers of their suspicions that a member of staff was deliberately harming patients is described as them *picking on bits re: stuff not in report*.

183 Furthermore:

(a) when discussing paragraph 1 of the consultant's letter dated 10 February (which explained that the RCPCH review did not identify a cause for the increased mortality and that the paediatricians' concerns as voiced to the reviewers did not feature in the report) Tony Chambers concludes *presumably bec(ause) no substance in the Lucy issue*. That interpretation is extraordinary in circumstances where:
    (i) the *Lucy issue* was a concern that Letby was murdering babies in her care;
    (ii) on any fair reading the RCPCH report did nothing to dismiss those concerns;
    (iii) the college had written to Ian Harvey on 5 September stating *a detailed forensic casenote review of each of the deaths since July 2015 should be undertaken, ideally*

using at least two senior doctors with expertise in neonatology/pathology in order to determine all the factors around the deaths [INQ0003120] and that had not been actioned;

(iv) Ian Harvey was being told by both Dr Hawdon and Dr Subhedar that up to seven of the deaths had no obvious explanation; and

(v) Dr Subhedar had told Ian Harvey that insofar as the RCPCH report had identified any failings, similar failings may be found on many units;

(b) rather than acknowledging the paediatricians' concerns (which were by this point echoed by Dr Subhedar), the executives' interpretation of their motivation for writing on 10 February was that *docs don't like outcome to date + so L (letter), not surprised by L(letter) but disappointed*…;

(c) ironically, the doctors are described as having a *collective mindset* and being *locked in*;

(d) the actions arising from the meeting include: '*what is role of GMC? What is role of Sean Tighe?...*'. Mr Chambers then continues: '*reply to each doc (individually)… treat all docs same not (?tho) Steve B + Ravi … individual L's (letters) – need to feel heat'*; and

(e) the discussion moves on to the need to finalise the plan for Letby's return to the unit. Alison Kelly observes '*phone call from Mother C and Child A's family – getting exercised. Want answers!... risk for more media if not dealt with asap for families*'.

184 CoCH submits that the order in which matters were considered by the executives on 14 February and the duration for which they were considered is illustrative of the executives' priorities. By this time, the Executive Team appears unable to see the paediatricians' concerns for what they were, namely the genuinely held and well-founded concerns of reasonable people. Instead, the executives appear to have concluded that it was the paediatricians, in particular Drs Brearey and Jayaram, who were the problem, and that consideration would need to be given as to how best to deal with them.

(22) 15 February 2017 meeting with Mr Rheinberg

185 Neither Mr Rheinberg nor Mr Moore have a recollection of being told about concerns that a nurse was deliberately harming babies. Ian Harvey's evidence was that *I recall that either Mr Cross or I, in passing the paediatricians' letter across to Mr Rheinberg explained the background to that letter and the paediatricians' concerns* [Harvey/week11/29Nov/117/17]. Neither Mr Moore's email to Superintendent Duggan [INQ0002048_0110] nor Mr Rheinberg's contemporaneous note [INQ0002048_0102] mention concerns that a member of staff could be responsible for the deaths. Had this been mentioned, Mr Moore's question in point 6 of Mr Rheinberg's note would not make sense: it would be readily apparent that paediatricians were seeking inquests because they were concerned that a member of staff could be responsible for the deaths. Moreover, it is unlikely that Mr Rheinberg would have recorded Mr Moore's question if the paediatricians' concerns had been mentioned earlier in the meeting (at a time when Mr Moore was not present) and it is inconceivable that the attendance note would read in the way it does had those concerns been presented to Mr

Rheinberg. Finally, as Mr Rheinberg explained in answer to Mr Skelton KC's questions had he been told of the paediatricians' concerns he would have contacted the Police [Rheinberg/week12/6Dec/77/2].

186 When it was suggested to him that there may have been mention of concerns that a member of staff may be responsible for some of the deaths Mr Moore responded: *There was no mention whatsoever of anything of that kind. If there had been, the outcome of this meeting would have been very different, I assure you. Mr Rheinberg is a very experienced, diligent and thorough Coroner and I have no doubt that he would have contacted the police probably before Mr Harvey and Mr Cross had left the room* [Moore/week12/4Dec/136/22].

187 It is likely that Mr Rheinberg's evidence is accurate when he states that *To be clear at no time during my tenure as senior coroner for Cheshire, either during the meetings of 8th and 15th February 2017 or by any communication from the Countess of Chester Hospital or by any other means was I made aware of any suspicions or concerns relating to the involvement of a nurse in relation to any deaths of babies at the hospital*. *The first time that I heard of the possible involvement of Lucy Letby in the deaths was from news broadcasts following the arrest of Lucy Letby* [INQ0017842 §100].

188 It must also follow that Mr Harvey's recollection that either he or Mr Cross explained the background to the paediatricians' concerns cannot be correct. Similarly, if his statement to Drs Brearey, Jayaram and Subhedar on 27 March 2017 that *We have shared the review, JH review and a copy of your letter and specifically called out the teams' concerns* was intended to convey that Mr Rheinberg had been told of the paediatricians' concerns, this too cannot be correct [INQ0003150_0005].

(23) 16 February 2017

189 Mr Chambers replied to the paediatricians' letter of 10 February two days after the Executive Team met on 14 February [INQ0003159]. His responses had three principal themes: (i) that the paediatricians' request for their concerns to be relayed to the coroner had been actioned; (ii) that the Trust's investigations to date had been sufficient; and (iii) the need for them to apologise to Letby.

190 In her oral evidence, Ms Hodkinson sought to imply that there was never a genuine intention to return Letby to work on the NNU [Hodkinson/week11/26Nov/81/5]. That was one of several occasions on which members of the Executive Team invited the Inquiry to conclude that what was written in letters signed by them or recorded in the minutes of their meetings was, in fact, never

their serious or settled intention.[11] Insofar as it addresses the executives' intent to return Letby to work, Mr Chambers' letter of 16 February is explicit [INQ0003159]: *you agreed that it was appropriate for you to send a letter of apology to Nurse Letby. It would therefore be most helpful for me to understand how and when you are doing this as action is now being taken to return her to the unit at the earliest possible time* (emphasis added). We consider this issue further in section F below.

191 As to the request for an apology, the unreality of the situation which the paediatricians by this time found themselves in is illustrated by the fact that as of the date of Mr Chambers letter, they had still not had sight of the grievance outcome and so were ignorant of what they were being asked to apologise for [INQ0103104 §386].

192 These same weeks in February 2017 saw the Trust's named doctor for safeguarding, Dr Howyada Isaac, draft a letter addressed to Alison Kelly outlining her concerns as to the safety of babies on the neonatal unit. Her evidence was that she decided not to send that letter due to a *culture of fear* in the hospital at the time [Isaac/week10/18Nov/221/3].

(24) Meetings of 23 and 28 February 2017

193 Dr Gibbs met Ian Harvey on 23 February 2017 at Ian Harvey's request. Whilst the meeting was ostensibly to discuss Dr Gibbs' review of children who had been transferred out of CoCH, Dr Gibbs' email to Dr Jayaram on 24 February makes clear that *although he'd said this was to discuss 'my' review of non-fatal collapses, this was only covered in passing* [INQ0014268].

194 It is unnecessary to repeat the content of that email save to note that, again, Dr Gibbs reiterated the concerns of the consultant body to Mr Harvey, in particular the concerning features of the deaths, Letby's consistent presence, that the reviews commissioned by the Trust so far had been of no assistance in resolving those concerns, and the need for an external forensic review. At its conclusion, Dr Gibbs makes the observation that, in his view, Mr Harvey's conduct towards Dr Brearey had *humiliated* him.

195 Five days later, on 28 February 2017, Ian Harvey would hear all the same information again, this time from Drs Brearey, Jayaram, Gibbs and Subhedar. The minutes of 6 March circulated by Dr Brearey record the discussion [INQ0003395_0002]. Ian Harvey was told by Dr Subhedar that the observed excess neonatal mortality at CoCH could not be explained merely as a consequence of medical or nursing workforce deficits or increased activity and occupancy levels.

[11] See also Mr Chambers' evidence as to his plans to manage Drs Brearey and Jayaram as of 12 May 2017, covered below at paragraphs 264 to 266, or Ms Kelly's analysis of her comment *she should go back* on 16 March 2017 [INQ0003344_0003, Kelly/week11/25Nov/207/5 to 207/20]

(25) March 2017

196 The following day, the paediatricians wrote to Tony Chambers [INQ0006816]. It is convenient here to consider a recurrent feature of the evidence of Tony Chambers, namely that the paediatricians were hostile to the suggestion in the RCPCH report that there were improvements to be made in the department or were otherwise seeking to frustrate the Executive Team in the implementation of those improvements. That that analysis is unfair, Tony Chambers appears to have mistaken the paediatricians' unwillingness to accept that the RCPCH report explained the excess mortality with hostility to the conclusions of the report generally.

197 In fact, the paediatricians' letter of 1 March acknowledged that there were areas for improvement identified by the RCPCH review and issues which need to be addressed both by the Trust and outside the organisation. It expressed a keenness to work with the Board to implement those recommendations. That built on earlier expressions of willingness by the paediatricians to identify any weaknesses in their service.

198 The letter went on to outline what were by now familiar themes. It described *an apparent temporal association with the unexpected and unexplained collapses and the presence of a particular member of staff at the times of these events.* It continued, *our concerns also include the unusual nature of some collapses and the responses to resuscitation efforts in a large proportion of the babies who died and in some who survived.* The letter explained, again, why the paediatricians felt the deaths had been inadequately explained. Those reasons were by this stage well known: (i) the RCPCH review was a service review which did not investigate the cause of deaths; (ii) Dr Hawdon's review had not achieved what the RCPCH had said was necessary; and (iii) activity and acuity levels did not account for the deaths.

199 That same day, Ian Harvey emailed Dr Brearey expressing the view that engaging with the mediation process may help shield him from referral to the GMC [INQ0103207].

200 On 6 March 2017, Dr Brearey circulated minutes describing the meeting of 28 February [INQ0003395]. Ian Harvey's response demonstrated a misplaced confidence in his own analysis as is apparent from the following:

(a) first, it commences with the following passage: *I felt that it was important to respond, especially since these notes — perhaps not surprisingly — have a particular slant and I am wary that if I didn't respond this might become the only version of the "truth"*. That statement imports a mistaken equivalence between Mr Harvey's *truth* and that of the neonatal experts he was corresponding with. Further, Mr Harvey's response betrays his attitude towards the paediatricians at this time. Even if Dr Brearey's minutes did contain material inaccuracies (there is no evidence they did and, moreover, they had been reviewed by everyone else present at the meeting prior to their sending [INQ0006105]), that could simply have been

corrected in Mr Harvey's response. Instead, he appears to imply an element of deliberate bias on the part of Dr Brearey.

(b) second, notwithstanding that he had been told that an increase in acuity levels did not account for the neonatal deaths by: (i) his most experienced paediatrician; (ii) his neonatal lead; (iii) the head of his children's services; and (iv) the external head of the regional neonatal network from the local tertiary centre, Mr Harvey's response (as an orthopaedic shoulder surgeon) was to tell them that they were wrong and that his interpretation was correct;

(c) lastly, his observation that he has seen no evidence to confirm Dr Subhedar's assessment of the acuity and staffing levels in other departments ignores the fact that as head of the regional neonatal network this was information which Dr Subhedar would have whilst he (Mr Harvey) would not.

201 On 16 March 2017, the Executive Team met [INQ0003344]. The minutes record the following:

(a) there was a discussion as to the state of the relationship between the Executive Team and the paediatric consultants. Amongst other matters, the minutes record the paediatricians' concerns that the board was *going down a path without understanding the deaths* and acknowledge that there were *still unexplained deaths – beyond reasonable doubt*;

(b) the consultant paediatricians are referred to as feeling *bullied and intimidated… victimised like other whistleblowers*, and that *many, 3 in particular, are looking for jobs elsewhere.* In his witness statement, Tony Chambers describes feeling *really concerned about this* [INQ0107708 §538]. Mr Chambers cannot sensibly maintain that he was ignorant of the problems in the Executive Team's relationship with the paediatricians given *inter alia* (i) Dr Jayaram's letter of 5 September 2016; (ii) his own understanding that the meeting of 26 January would require a *strong line*; and (iii) the observations of the executives on 16 February. Insofar as he was concerned about the state of that relationship, that concern did not feature prominently again in the meeting;

(c) there was only a brief discussion about comments made by Dr Jayaram to Sue Hodkinson as to his observations of Letby. CoCH addresses that issue in greater detail below at paragraphs 238 to 240. Put shortly, the Inquiry is invited by the Former Executives to conclude that Dr Jayaram's comments had a profound impact on their appreciation of events. There is little to support that analysis in the contemporaneous minutes, and every suggestion that the consultants' concerns continued to be dismissed even after Dr Jayaram's conversation with Sue Hodkinson. By way of example:

(i) Tony Chambers: *they want us to throw Lucy under a bus*;

(ii) Alison Kelly: *she (Letby) should go back*;

(iii) Tony Chambers: *Part of me says ring Police and GMC*;

(iv) Sue Hodkinson: *Ravi said* (the executives are) *focussing on employment not patient safety,* to which Alison Kelly responds *there own world (sic)* (emphasis added);

(d) the need for a *further in depth review* into the deaths was noted. That is a position which, in CoCH's submission, ought to have been recognised as wholly incompatible with the efforts being made in parallel to facilitate Letby's return to the unit.

202 In his witness statement Mr Chambers explains his comment *part of me says ring Police and GMC* in the following way *the point of calling the GMC would be to get some advice on what we should do in light of the concerns which had just been raised by Dr Jayaram* [INQ0107708 §552]. That explanation does not withstand scrutiny:

(a) the GMC would be an unusual body from which to seek assistance;
(b) Mr Chambers did not then seek such advice, notwithstanding the particularly challenging circumstances he found himself in;
(c) if he wished to do so, there was no compelling reason for him not to and nothing preventing him from doing so;
(d) the more likely explanation is that Mr Chambers was considering referral of his staff to the GMC to be an appropriate course of action as would be borne out by his conduct on 12 May.

(26) Meeting of 27 March 2017

203 Some witnesses have sought to suggest that the meeting of 27 March 2017 was arranged out of concern following Dr Jayaram's discussion with Sue Hodkinson. We address that proposition below at paragraphs 238 to 240. As to the meeting itself, the Trust makes the following observations [INQ0003150]:

(a) Dr Brearey gave his account that the hospital should not investigate this any further and that the Police should be called;
(b) in response, Tony Chambers is recorded as saying *Why are you escalating this now?* That response is surprising when set against the paediatricians ongoing and consistent expressions to the executives of their dissatisfaction with the Trust's investigations over the preceding months, and the fact that the executives had been told as early as July 2016 that the clinicians' view was that the Police were the most appropriate body to investigate;
(c) Dr Jayaram stated *we accept the Royal College review, the case note review and Jane Howden's review identified further ones… We have a collective view that this now needs to be at the level of a rota review, who, where involved, a forensic investigation*. That was not new information for the Executive Team. A forensic investigation had been consistently identified as necessary since 5 September the year before [INQ0003120];
(d) Mr Chambers' comment that *The review identified that there was no single casual factor* illustrates the executives' persisting erroneous interpretation of, and misplaced reliance upon, the investigations undertaken to that date; and

(e) thereafter, Mr Chambers challenged Dr Jayaram as to why he had not phoned the Police. It appears lost on Mr Chambers that he had personal accountability as the occupant of the organisation's most senior post, and the responsibility for acting on concerns raised to him. In response, Dr Jayaram explained that *Our career would be on the line if we contact police, it would be whistleblowing. Following BMA advice, if there is an alternative of a deeper dive, we should go for it.* Dr Brearey also correctly observed: *we were promised a thorough investigation; we were a promised college review. We hoped no great service issue as no difference to other NNUs, and we didn't see the report until February.*

(27) Dr McGuigan's conversation with Tracey Bullock

204 The analysis that the Executive Team, and Mr Chambers in particular, were considering either regulatory or employment sanctions against certain members of the paediatric consultant body is lent further weight by Dr McGuigan's account of his phone call with Tracey Bullock on 29 March 2017.

205 CoCH acknowledges that Dr McGuigan and Ms Bullock's accounts of what was said in that conversation do not entirely align. Regardless of the exact words used, Dr McGuigan's understanding from that call was that [INQ0101097 §§77 to 79]:

(a) it was informed by a discussion Ms Bullock had had with Tony Chambers;
(b) the view of the Executive Team was that there were *clinical issues on the NNU* (and) *that the paediatricians were refusing to accept these issues*. That observation is entirely consistent with the evidence of the Executive Team to the Inquiry;
(c) two particular leaders among the paediatricians were pushing alternative explanations for the deaths and arguing for a police investigation, *and that things were going to turn out badly for those two individuals*. That account would be consistent with Mr Chambers' reference to the GMC in the meeting of 16 March;
(d) Ms Bullock referenced an email written by Dr McGuigan which had been read out in a meeting earlier that week. That is consistent with Dr McGuigan's absence from the meeting of 27 March 2017 and the email providing his view being read in his absence [INQ0101313_0007]; and
(e) Ms Bullock was *calling me concerned that my reputation could be brought down alongside these individuals and… to caution me to be careful*.

206 There are features of the evidence that suggest that Dr McGuigan's evidence is correct:

(a) for whatever reason, Ms Bullock felt the need to be *very clear with Michael about being his own person* [Bullock/week14/9Jan/37/19]. On its natural reading, that was an invitation to Dr McGuigan to consider his present course of action carefully and to not align himself unthinkingly with the actions of others;

(b) Ms Bullock accepted that she told Dr McGuigan of her understanding that there were two individuals in the paediatric department at CoCH who were *leading the charge* [Bullock/week14/9Jan/44/11]. That terminology, informed by her discussions with Mr Chambers, is entirely consistent with the context of their conversation on 29 March being an account from Mr Chambers that he was having difficulties with two of his consultants;

(c) Ms Bullock had been told of a situation of the upmost seriousness at CoCH in response to which consideration was being given to calling the Police. She recalls Dr McGuigan stating *I didn't feel I was working with a bunch of people who were ignorant and had got themselves on the wrong agenda but that I had a lot of confidence with the people I was working with... That this wasn't just the opinion of two people, but everyone was concerned in a similar way... I had confidence in my colleagues and they were trying to do right thing in a difficult situation* [Bullock/week14/9Jan/41/3]. Dr McGuigan's assessment would have been important information to inform Mr Chambers' decision making. It would have been natural for her to relay that view to Mr Chambers but there is no suggestion she did so.

(28) April and May 2017

207 The paediatricians interpreted the outcome of the 27 March 2017 meeting as being that the Trust would contact the Police. The minutes record Tony Chambers as stating *We need to think about the conversation with the police* and *You need to leave with us*.

208 The evidence of the executives is that from 27 March they too considered it necessary to contact the Police [INQ0107708 §§576 to 587, INQ0107653 §§708 to 712, INQ0107713 §311, Hodkinson/week11/26Nov/156/9]. CoCH observes however that the minutes of the executives' meeting with Sir Duncan Nichol the following day record that it was a question of *not when but how do we manage Police* [INQ0014281] (emphasis added). Given what was to follow, the use of the word *manage* in the record of the conversation with Sir Duncan is noteworthy.

209 At 10.20 on 4 April 2017, there was a meeting attended by Sir Duncan Nichol, Tony Chambers, Ian Harvey, Stephen Cross and Simon Medland QC (as he was then) [INQ0003351]. The minutes are instructive as to the state of the executives' mind at this time. They record that consideration was given as to whether there was *Any mileage in speaking to consultants again*. They also note the following: *Agree we need to get to the bottom of this. If you force us to*.

210 The outcome was to arrange a meeting between the paediatricians and Mr Medland. The paediatricians understood that this was to discuss how the Police would be approached. They held that view because Mr Harvey had told them so verbally [INQ0103104 §423, INQ0006890_0243]. Further, in his email to Dr Brearey on 7 April 2017 Mr Harvey wrote [INQ0006890_0245]:

'*...none of us have been in this position before and it is about doing it in the best way possible. Therefore, we have consulted with someone experienced and active in criminal law, both as Barrister and Judge. I must stress Mr Medland's independence, I think that you will be assured of this when you meet him; it was his advice that he meet with you to fully understand, and explore, the basis for the concerns to help frame the approach since letters only convey so much.*'

211 Mr Chambers' evidence was that the purpose of instructing Mr Medland was to facilitate contacting the Police [Chambers/week11/28Nov/20/8].

212 The meeting between Mr Medland QC and the paediatricians took place on 12 April 2017 [INQ0005857]. Mr Medland's note could not be clearer as to how he saw the purpose of the meeting:

SM began by stating who he was and why he was here - been instructed by the hospital to bring an independent objective view to present situation and see if formal report to police was presently merited, in other words whether there is presently information giving rise to reasonable grounds for suspecting that a criminal offence has been committed in respect of any one of the neonatal deaths in question.

213 There then followed a discussion in which Mr Medland explained to the consultants:

(a) the negative consequences should the Police be contacted: *a condign step which was effectively a public action and would incur adverse publicity* [§6];
(b) the importance of the consultants working in unison with hospital management: *SM emphasised that it was of the first order of importance that the hospital and the consultants worked together on this issue and that positions did not become entrenched or opposed* [§9];
(c) his view that there was insufficient evidence of a crime to justify referral to the Police and that doing so would have *far reaching ramifications and should not be undertaken lightly* [§12]; and
(d) that if the individual concerned was a consultant, the individual would only want the matter *put into the hands of the police after very serious thought about the potential consequences... and where the evidence justified such a step* [§13].

214 Many of Mr Medland's observations mirror those provided previously by the Executive Team. Dr Brearey's opinion was that his views were informed by prior conversations with the Trust and the limited information he had been provided [INQ0103104 §430]. In his witness statement, Mr Chambers says that Stephen Cross' rationale document [INQ0003226] may have been referred to in the meeting with Mr Medland on April 4 and that the content of that document *broadly correlated with the Executive's position at this time* [INQ0107708 §581].

215 It would be open to the Inquiry to conclude that the intention of the executives in instructing Mr Medland was to dissuade the paediatricians from raising their concerns with the Police. We note that Ian Harvey's email to Dr Brearey the day after the paediatricians met Mr Medland makes no mention of contacting the Police nor the proposed informal discussion with DCS Wenham [INQ0006136]. It may have been Ian Harvey's hope even at this late stage that the next step would be a further review short of a Police investigation.

216 Thereafter, the Executive Team continued to downplay the paediatricians' concerns in their subsequent dealings with the Police prior to the Police meeting with the paediatricians on 15 May. Dr Brearey's observation that *IH and SC will also (be) working hard prior to the meeting to produce a number of counter arguments to our concerns* [INQ0004967]*,* and Dr Jayaram's view that important facts were *not going to be in the info Ian H/Stephen C have given to the police* [INQ0004967_0003]*,* were prescient. By way of examples:

(a) in the initial meeting with DCS Wenham and Hayley Frame attended by Drs Holt, Jayaram and Ian Harvey [INQ0005461], Mr Harvey informed them Letby was *fulltime, overtime, allocated sick and poorly babies* and that it was a *v hot unit, staff working under pressure.* Given the focus of that meeting was to consider whether there were sufficient grounds for the Police to open an investigation, it might be considered surprising that Ian Harvey brought up the *grievance HR process, recommendation of mediation and behavioural issues*;

(b) in Tony Chambers' letter dated 2 May 2017 requesting a Police investigation, he outlined that the investigation should be undertaken *with a view to excluding any unnatural causes* [INQ0102319];

(c) at the meeting on 5 May with the Police attended by Stephen Cross, Ian Harvey and Tony Chambers [INQ0003077], the Police were told *the unit was 'running hot'*[1] *and there was an increase in the number of lower birth weight babies, based on previous trends. The College review identified there were issues with communications between medical and nursing staff, incident review processes and delays in clinical escalation. Whilst the staffing was in line with surrounding units, it did not comply with the national standards.* One reason for providing that information could have been to posit to the Police an alternative explanation for the deaths. Yet by this time, Ian Harvey knew or ought to have known that those factors could not explain the deaths because he had been told so, notably by Dr Subhedar. The Executives' own note of the meeting records that the Police were told by Tony Chambers that Letby was *well regarded* and of a *witch hunt* which *led to grievance* [INQ0003348_0005]. CoCH observes that it is concerning that at the same time as the executives were showing such a lack of objectivity, the Police were stressing the reliance they would have to place on what they were told by the Trust when assessing clinical information: *If Cheshire Constabulary are involved, then it would be deemed an 'investigation'. CoCH would need to assist with clinical expertise / guidance*.

217 The executives' efforts to influence the Police investigation continued up to the meeting of 12 May 2017 between Tony Chambers, Ian Harvey, Stephen Cross and the Police [INQ0003076]. It is worth considering the text of Cheshire Police's minute in detail when considering how Tony Chambers was portraying the paediatricians at this time:

> *TC stated that there is nothing new in the email review from Dr Jayaram that has not already been shared with the Royal College of Pediatrics (sic) and Child Health and all the enquiries that have gone on. It reads in a fairly unbalanced way, and it needs to be looked at in the context of all of the information that CoCH can share with Cheshire Constabulary.*
>
> *It is disappointing that it does feel that as a group of clinicians they have not moved on despite all of the reviews and enquiries that have been completed. The concerns appear to be less the details of their allegations, but more the feeling that they have not been listened to and not had the opportunity to have an enquiry and assertive interview with an independent body.*

And then:

> *TC stated it would become a wider GMC issue as there becomes a point where a group of clinicians who are not prepared to take the recommendations of RCPCH are blocking the ability to move forward which creates a more difficult and dangerous environment for sick babies.*
>
> *TC added that the consultants have made their points, and they have been seen and not judged as sufficient to warrant a police led investigation, looking at how close it constitutes as a criminal act. There was a need to explore to ensure CoCH have not missed anything, but there is also a need to move on. It will become a GMC issue, likewise if the media are involved. This is for CoCH to manage appropriately.*

218 Six weeks passed from the date of the executives supposed intention to contact the Police before a meeting between the Police and the paediatricians was facilitated. CoCH accepts that there is force in the proposition advanced by Mr Baker KC that the executives sought at every stage to stall and obstruct the Police being called and, ultimately, sought to ruin the careers of the consultants who brought matters to their attention.

D GENERIC THEMES

(1) Communication with parents

219 The evidence which the Inquiry has received from the families emphasises the poor communication on the part of the Trust that we identified in the Trust's Opening Note at paragraphs 37 to 39. There we listed failings ranging from the absence of any contact from the Trust to the provision of information that was incomplete and/or difficult to follow. The Trust accepts that the absence of information, the provision of incomplete information or, simply, the way in which information was provided only added to the distress that the families were already experiencing. It also acknowledges the point made in evidence that family members may have important information to bring to an investigation reinforcing the need for good communication. The Trust's communication failings were wide ranging and persisting. It apologises unreservedly.

(2) Duty of Candour

220 The tensions which arise when there are suspicions of deliberate harm by a member of staff which we identified at paragraph 41 of our Opening Note were illustrated by the exchange between Mr Skelton KC and Dr Brearey [Brearey/week10/19Nov/246/11 – 248/4] and in Dr Gibbs' evidence [Gibbs/week4/1Oct/223/10].

221 Without wishing to diminish or undermine the importance of transparency and honesty we suggest that the Inquiry should be slow to criticise the paediatricians for not informing parents about their concerns about Letby's actions. Given the fact specific nature of such concerns we suggest that this issue is unlikely to be susceptible to the application of rigid guidance whether for individual professionals or organisations.

(3) Child A's inquest

222 Child A's death was reported to the coroner on 8 June 2015. A post mortem had given the cause of death as unascertained. His case was considered at a serious incident review on 2 July 2015.

223 CoCH accepts that the coroner raised the need for an SUI into Child A's death due to complications with long line and catheter insertion early in 2016. It appears that a satisfactory response to this request was not received as the coroner repeated it on 11 August 2016. The one-page serious incident panel report from July 2015 [INQ0002042_0777] was provided to the coroner who in turn provided it to Pryers' solicitors by email on 28 September 2016 with the observation *As you will see it is less than a SUI report.* In the meantime, on 19 August 2016 Josh Swash had sent the coroner three documents concerning Child A including the relevant parts of the obstetric second review and thematic review. CoCH is unable to say whether these documents were passed to Child A's family by the coroner.

224 The Trust acknowledges that the handling of the coroner's request for an SUI was poor. There was no timely response. One solution would have been to provide the coroner with the thematic review at an early stage as the passage *Agreement today that line related complication very unlikely to have caused arrest* may have provided an answer to the question he had raised earlier in the year.

225 Stephen Cross appears to have become more closely involved with the preparation for Child A's inquest from August 2016. Louis Browne KC was right to enquire whether Letby had been on duty at the time of Child A's death. His evidence was that he would have given advice about the disclosure of information to Child A's family [Browne/week12/4Dec/13/2]. It appears to have been planned that there would be a discussion between Mr Cross and Mr Browne about the fact that Letby had been confirmed as being involved in Child A's care [INQ0052593_0002]. Mr Browne did not recall such a conversation [Browne/week12/4Dec/27/19].

226 On 6 October 2016 Mr Cross wrote to the coroner to report the initial feedback from the RCPCH review which he had told Mr Moore about. He wrote *The review team have indicated that they were entirely satisfied with the care within the NNU and raised no concerns*. Although Mr Cross goes on to inform the coroner about the detailed forensic case note review, this was not an accurate summary of the initial feedback (assuming that he had seen the letter from the RCPCH to Mr Harvey dated 5 September), and was inconsistent with how the Executive Team would later represent the position to the paediatricians and to the Board. It certainly did nothing to alert the coroner to the paediatricians' concerns that had prompted the RCPCH review in the first place. He left it to Dr Jayaram to *answer any questions regarding the review* noting also that Louis Browne was *fully aware of the review* [INQ0053069].

227 CoCH would agree with Louis Browne KC and Mr Rheinberg that the primary responsibility for informing the coroner about any concerns about Letby whether in the context of an individual death or wider concerns lay with the Trust. This was not a task that could or should have been delegated to a member of the legal services' team or to a clinician because:

(a) the seriousness and sensitivity required consideration of, at least, the implications for patients and parents and the employee herself and the impact of the dissemination of such information; and,
(b) the senior management team were clearly sighted on this issue: according to Mr Cross there was a plan that Mr Harvey and Ms Kelly would review statements before Child A's inquest [INQ0107707 §85] [INQ0007197_0140].

228 There is, CoCH suggests, implicit acceptance that this was a task for the senior managers in the fact that in February 2017 Mr Harvey and Mr Cross spoke to Mr Rheinberg about this issue (albeit as discussed above there is considerable doubt as to the extent of the detail that was conveyed to the coroner).

229 Mr Rheinberg's *absolute horror* on being informed that Dr Jayaram was suspicious about Letby but did not mention this in the course of the inquest is, CoCH accepts, understandable. We also have fully in mind the evidence given to the Inquiry by Mother A&B that *It just seems to be that throughout this whole process, it's been forgotten by the Countess that we are people and they're our children* and that she was *very concerned* to learn that despite the suspicions about Letby nobody mentioned them at the Inquest [Mother A&B/week2/16Sept/25/17 and 52/7].

230 CoCH acknowledges Dr Jayaram's evidence to the Inquiry that he should have told the coroner that a member of staff may have been responsible for Child A's death. He also recognised his duty of candour given that Child A's parents were sitting close to him at the Inquest. He told the Inquiry he was *trying to sort of throw as many breadcrumbs as possible for the Coroner to pick up without explicitly saying what the suspicion was* [Jayaram/week9/13Nov/245/19]. The relevant part of the note made by the solicitors, Pryers, is:

> *Dr Jay was then brought in to try and assist with his paediatric knowledge of the circumstances in Dr S concluding with any kind of cause of death. Mr Rheinberg asked Dr Jay whether or not he had seen anything similar. Dr Jay confirmed that normally death in neonates is the end point in a course of events and normally they can be resuscitated. He confirmed that there have been similar cases of neonates dying in similar circumstances on the unit which they have not been able to explain. He confirmed that they have therefore downgraded the unit so that do not care currently for preterm babies and they have also requested an independent review and they are still awaiting the formal report. However the initial feedback from this is that nothing can be found that is wrong with any of the training, any of the practises or any of the equipment. However there is a potential issue with staffing. As far as Dr Jay is aware this report is then to go back to the Executive Board and they decide whether or not to release it to the public. Mr Rheinberg asked whether or not it would be possible for the family to receive a copy. Dr Jay said he is of the personal view that it should be made available for the public and he would have no issue with a copy of it being provided to the family, however as he pointed out it is the Executive Board's decision. He has to confirm however that the events that happened to °^ do not make any clinical sense to him at all. In relation to the cardiac conductivity, Mr Rheinberg asked whether any issues would have shown up on the monitoring. Dr Jay confirmed that this would have been the case. He said it is possible that you can have a rhythm staying the same but the heart not pumping* [INQ0107909_0008]

231 Dr Jayaram's evidence to the coroner needs to be considered in the context of the information available to him at the time as follows:

(a) Mr Cross had been involved in the pre-inquest meetings in preparation for Child A's inquest. He was fully aware of the paediatricians' concerns because he had been present at the

meetings in June and July 2016. At that time Mr Cross had said that it was the wrong thing to involve the Police [Jayaram/week9/13Nov/62/2];

(b) Mr Cross had been in correspondence with the coroner, including informing him that the RCPCH was undertaking a review of neonatal deaths. He also believed from Mr Cross' email of 6 October that the coroner had been made aware that Dr Hawdon had been instructed to undertake the review recommended by the RCPCH [INQ0107964_0024];

(c) although he had not seen the RCPCH report, Dr Jayaram had been told by Ian Harvey that the RCPCH had not identified any significant issues with clinical practice on the NNU, had made some recommendations around team working and leadership and had recommended a full forensic casenote review [Jayaram/week9/13Nov/61/15];

(d) Mr Cross' correspondence gave Dr Jayaram the impression that the paediatricians' concerns about Letby, which had prompted the RCPCH review, were *on the coroner's radar* [Jayaram/week9/13Nov/69/7], and that the coroner was *aware of the [the paediatricians'] specific concern* and that *very detailed forensic level reviews were going on* [Jayaram/week9/13Nov/65/19];

(e) he was also aware that other deaths had been reported to the coroner [Jayaram/week9/13Nov/68/17]; and,

(f) he perceived there to be *pushback* on the basis that the "*there's nothing to see here*" [Jayaram/week9/13Nov/246/2]. Although Dr Jayaram did not say from whom he was getting *pushback*, it is reasonable to infer that this was a reference to the messages he was receiving from the Executive Team.

232 Dr Saladi also gave evidence at Child A's inquest. He too did not tell the coroner about the concerns about Letby. He accepted that he should have done. When asked why not, he explained *Again I think that was probably my first, maybe first or second appearance of Inquest and I was stressed and advice we got from the solicitors was answer the questions, what is asked, don't answer what you think was asked and keep it brief and do not speculate. So if the Coroner has asked me, I would have probably said. But because it wasn't asked, because what I didn't know is what is speculation at that stage. So that's why I didn't -- I didn't -- I agree I didn't.* [Saladi/week4/3Oct/117/3]. He explained that he believed that the coroner was aware of other deaths because he and his colleagues had been reporting them to the coroner. He attributed his failure to inform the coroner down to (i) a lack of experience, (ii) that he had been advised in preparation for the inquest not to speculate and (iii) the coroner had not asked him.

233 Therefore, whilst both Drs Jayaram and Saladi acknowledged that they should have told the coroner of their individual or collective concerns, neither should have been put in the position they found themselves in, particularly in circumstances where such news would come completely out of the blue for the parents of Child A who were, as Dr Jayaram pointed out, sitting close to him in the coroner's court. The task of notifying the coroner fell to those with management responsibility. Given the sensitivity of the disclosure this was a task for members of the Executive Team and

was probably the responsibility of Mr Cross in light of his extensive dealings with the coroner. The comment in his email to the coroner that Dr Jayaram (and Mr Browne) were fully aware of the RCPCH review *and will be able to answer any questions regarding the review* was an abdication of that responsibility.

(4) SUDIC and Safeguarding

234 The clear thrust of the evidence provided by the paediatric witnesses practising in hospital settings, both from CoCH and elsewhere [McGuigan/week5/8Oct/83/23, Subhedar/week10/20Nov/67/19, Kingdon/week13/12Dec/179/17], was that they would not have considered the SUDIC process relevant to inpatient neonatal deaths in 2015/16.

235 CoCH submits that the number and experience of those witnesses should be given considerable weight in the Inquiry's assessment of whether it was normal or expected practice for deaths in hospital to be subject to the SUDIC process in 2015. In considering Dr Garstang's evidence, the Inquiry may wish to consider whether her experiences reflect her practice as a community paediatrician in a centre without a neonatal unit as noted by Dr Kingdon [Kingdon/week13/12Dec/180/4] [Garstang/week3/26Sep/146/5].

236 CoCH acknowledges that the principles of safeguarding were not considered by its staff in relation to the events of 2015/16. That failure was one repeated by the nurses, paediatricians, managers and the Trust's safeguarding lead. The widespread understanding appears to have been that safeguarding was concerned with external threats [INQ0103104 §31], [Gibbs/week4/1Oct/32/11]. That assessment was echoed by Dr Kingdon [Kingdon/week13/12Dec/200/20]. It is also arguably consistent with the wording of Working Together [INQ0014575_0091] which implies that unexpected deaths subject to the joint agency response safeguarding processes were those occurring outside hospital.

237 We have reflected on the evidence that the Inquiry has received concerning the apparent non-use (or inconsistent use) of safeguarding procedures and/or the SUDIC process following events or deaths occurring in hospital. We offer this observation acknowledging that it was not addressed in evidence: it may be that the reason safeguarding and SUDIC processes were not deemed to be engaged was because an event occurring within a hospital involving a member of its staff would be one over which the hospital would have control and could take action accordingly. By contrast, an event occurring outside hospital or involving third parties could be one over which the hospital or the clinician had no influence. Hence, the need to engage the safeguarding process to ensure that those with the ability to influence events were aware of the concerns.

(5) Dr Jayaram's disclosure to Sue Hodkinson

238 The substantive issue we address here is the contention made on behalf of the Former Executives that Dr Jayaram's disclosure to Sue Hodkinson of three concerns about Letby materially altered

or influenced their decision to involve the police. The evidence of the Former Executives on this issue includes the following:

(a) Ms Hodkinson explains in her witness statement *Had [Dr Jayaram] disclosed this information to me much earlier, I would have immediately spoken with the Executive Team, and I think it highly likely that the outcome would have been to make a Police referral.* [INQ0107713 §291].

(b) Mr Chambers told the Inquiry:

> … *as soon as new matters became known to us, as soon as new concerns or concerns that had been known for many, many years or months were shared with us, the change for -- that Lucy Letby was, she, you know -- the status quo was maintained and the exploration of escalating to the police was explored and eventually delivered.*
>
> *Q. So can I -- could you just be absolutely clear. What was the new information which tipped the balance?*
>
> *A. It was, it was, it was the -- it was the concerns that that Dr Jayaram had, had alerted to Sue, to Sue Hodkinson that led to me going to have a conversation with him* [Chambers/week11/27Nov/219/15].

(c) Mr Harvey:

> *… But -- but I feel that I have to point out that, actually, we had three opportunities that were missed where there was clear evidence of harm, that we weren't fortunate enough to have been informed about.*
>
> *Q. Yes, and you are talking about the insulin results, for example, in Child K with Dr Jayaram?*
>
> *A. I am talking about Child F, Child K and Child L.* [Harvey/week11/28Nov/196/16].

(d) Ms Kelly:

> *I think at that time we were really shocked that Dr Jayaram hadn't brought any of these concerns to us before and then all of a sudden he was saying the detail around Child K. So we were quite shocked and horrified and that is when Sue Hodkinson and Tony Chambers went to see Dr Jayaram; it wasn't me* [Kelly/week11/25Nov/207/22]

239 Dr Jayaram gave evidence about the reasons why he had not mentioned this earlier *It is the fear of not being believed, it is the fear of ridicule, it is the fear of accusations of bullying and I appreciate -- and I will say this to the parents of Child K and all the other parents -- that seems entirely selfish, just thinking about me and not the baby* [Jayaram/week9/13Nov/39/1]. He told the Inquiry that he should have had the courage to raise this issue.

240 CoCH suggests that the evidence available to the Inquiry does not support the contention advanced by or on behalf of the Former Executives:

(a) Mr Chambers and Ms Hodkinson went to see Dr Jayaram on 16 March 2017, the same day as Ms Hodkinson had conveyed his disclosure to the Executive Team. She recalls *a brief*

meeting during which we agreed to arrange a further more substantive meeting to discuss the Consultants' concerns in detail as referred to above [INQ0107713 § 293]. Mr Chambers' recollection was that he did not ask Dr Jayaram directly or explicitly about what he had told Sue Hodkinson the day before. It is surprising that an apparently crucial piece of information did not merit a longer meeting or a direct question from Mr Chambers;

(b) Mr Harvey was on annual leave on 16 March. From his statement and his oral evidence, it does not appear that either Mr Chambers, Ms Kelly or Ms Hodkinson felt it necessary to highlight Dr Jayaram's disclosure to him. Indeed, his understanding was that the purpose of the visit to the NNU had been *to discuss the concerns of the paediatricians with input from the neonatal network in an attempt to come to a consensus regarding future actions* [INQ0107653 §699] and as late as May 2017, notwithstanding the apparent centrality of this evidence, Mr Harvey does not appear to have been made aware of the disclosure about Child K [Harvey/week11/29Nov/132/2];

(c) despite the significance apparently attached to this disclosure, Ms Kelly did not follow up what had happened after Mr Chambers and Ms Hodkinson had met with Dr Jayaram;

(d) the planned *more substantive meeting* did not take place for another 11 days;

(e) Mr Chambers suggested that during the meeting on 27 March he *very deliberately* asked a *very open question for him to provide an update to what he had seen and heard in what was a safe environment* [Chambers/week11/27Nov/127/10]. It is unclear why Mr Chambers felt unable to ask a direct question. Moreso, as part of the purpose of the meeting was to follow up the paediatricians' concerns and that it was attended by Dr Subhedar and Julie Maddocks;

(f) the note of the meeting makes no reference to Dr Jayaram's conversation with Sue Hodkinson at all. This would be consistent with Mr Chambers' witness statement [INQ0107708 §557], which identifies the purpose of the meeting as being *to discuss the review work undertaken and the Consultants' remaining concerns*;

(g) thereafter, Dr Jayaram's disclosure appears not to have been mentioned again by the Executive Team:

(h) it did not form part of either Mr Cross or Mr Harvey's briefing papers for Mr Medland QC. Mr Harvey's omission to address it may be because it had not been brought to his attention (see (b) above);

(i) it was not mentioned to the Police despite Mr Chambers understanding that he needed to present his best or strongest case to them and despite the comment during the meeting with the Police on 12 May 2017 attended by both Mr Harvey and Mr Chambers that *[Mr Harvey] has repeatedly challenged the clinicians asking if there has been any act(s) which CoCH need to be aware of which would effectively give a case but repeatedly they have said no* [INQ0003076_0005]. If Mr Harvey was unaware of Dr Jayaram's disclosure, this was a clear opportunity for Mr Chambers to bring it to the attention of the Police; and,

(j) Ms Kelly did not mention it in her discussions with the NMC.

(6) Failure of the paediatricians to recognise Letby's actions earlier

241 Whilst CoCH accepts there were serious failings in the Trust's response as set out at Section C of these submissions, the criticism made by some that the deaths and collapses in 2015 and 2016 ought to have been recognised as suspicious simply by virtue of their number must be reviewed in light of the evidence of Professor Sir David Spiegelhalter. His evidence was that whilst the number of deaths at CoCH in 2015 was high, it would not have been considered an outlier [Spiegelhalter/week15/15Jan/38/13]. He went on to observe that the increase in deaths at CoCH would be expected in one NNU each year just by chance alone, absent any underlying cause [Spiegelhalter/week15/15Jan/43/23]. The evidence is that clusters of deaths do happen [Brearey/week11/19Nov/51/19], and indeed that humans may pay too much attention to runs of bad outcomes [Spiegelhalter/week15/15Jan/3/18].

242 We address below the criticism that the nature of the deaths should have been immediately suspicious.

243 First, it is easy with the benefit of hindsight to identify features of each child's collapse which, knowing what is known now, carry particular significance. That analysis overlooks the practical reality of working in an environment in which babies are hospitalised by reason of their ill health. The vast majority of practitioners over the entirety of their careers are unlikely to encounter an unnatural death. By way of example, Dr Gibbs' evidence was that he felt the collapses of Child H, Child J and Child N could be explained by their medical problems, notwithstanding that the latter two cases were *unusual* [INQ0102740 §§79 and 89]. The statements of the paediatricians explain their understanding as to the causes of the deaths and collapses in the children whose care they were involved in. The Inquiry should be slow to conclude that an alternative body of paediatricians would have developed suspicions as to Letby's involvement sooner on the basis of the children's clinical presentations.

244 Second, CoCH submits that it will be the natural tendency of doctors schooled in the recognition of ill health to try and accommodate clinical presentations within acknowledged patterns of disease [INQ0107962 §914]. Ultimately, that is what they are trained to do. The same phenomenon can be seen in the interpretation of several children's postmortem results. It was only when suspicions of Letby's involvement grew that the unsatisfactory explanations in those reports were recognised [INQ0102740 §71]. It is for this reason that the central recommendation of the Clothier report is so important. There is no evidence that the paediatricians at CoCH were an outlier in their approach.

245 Third, in some instances Letby's attacks gave the impression of a fragile or precarious patient when the true cause for the child's deterioration was her actions. Dr Gibbs addresses this in his witness statement when considering Child G: *Child G was a vulnerable baby who suffered a number of medical problems following her extremely premature birth in view of which I did not feel*

there was anything too unusual about the episodes that I dealt with in her. With hindsight, the previous collapses in Child G, that gave me the impression she was a vulnerable baby prone to intermittent episodes of deterioration, may have been partly due to Letby's attempts to harm her [INQ0102740 §76]. He gave similar evidence in respect of Child I [INQ0102740 §78].

246 Fourth, Dr Brearey observed that Letby's actions *may have resulted in a gradual shift in what staff perceived to be "normal" workload for the NNU* [INQ0103104 §80]. Professor Spiegelhalter noted the difficulties that exist in identifying slowly accumulating changes and long term trends [Spiegelhalter/week15/15Jan/3/15].

247 Fifth, Letby was protected by factors which distracted from her association with the deaths. The view held by many (articulated by Dr Gibbs [INQ0102740 §72]) that the unit was small, with low numbers of staff, and that she could be expected to be present for many of the events due to her qualification in specialty and her choice to work overtime, was not itself unreasonable. However, over time it was given too much weight.

248 Finally, COCH submits that it is telling that upon review of the medical records, neither Dr Subhedar nor Dr Hawdon concluded that the deaths were unnatural. Nor did the RCPCH reviewers, notwithstanding that they had been explicitly told of such concerns by Drs Brearey and Jayaram. No reviewer presented with the same information identified the events as criminal. Ultimately, that was something which required the powers of the criminal justice system.

249 The Trust accepts that there were omissions in the care provided and errors of judgment on behalf of the doctors who provided that care. It is worth observing however that those practising at COCH have had their practice exposed to the greatest scrutiny by virtue of the criminal justice process.

(7) Incident reporting and risk management

250 Some witnesses have sought to criticise the incident reporting culture on the NNU. This is unjustified because:

(a) insofar as concerns were raised in the summer of 2016 following the deaths of Child O and Child P, they can only have been in respect of a failure to report collapses, as all the deaths were reported;

(b) the Trust's incident reporting policy [INQ0006466_0003] only required that *an event or circumstance which could have resulted, or did result, in unnecessary damage, loss or harm to patients*… be reported. The important point is that it required the reporting of incidents which were recognised as either having caused, or having the potential to cause, unnecessary damage to patients. It did not impose an obligation to report all collapses *per se.* That position is sensible. The purpose of the incident reporting system is to identify and

respond to incidents which either caused harm or had the potential to do so, not to catalogue each deterioration of a patient in hospital regardless of whether this is natural; and,

(c) there are as Dr Gibbs explains difficulties in defining and identifying collapses [INQ0102740 §68].

251 Those features likely account for the evidence that the Inquiry has received that ordinary practice in other units at the time would not have been to report episodes of collapse unless they were felt to be due to deficiencies in care [McGuigan/week5/8Oct/81/5 – 81/17].

252 The Trust however accepts that the incident reporting process did not escalate the deaths effectively through the Trust's risk management processes. This is likely because:

(a) as Debbie Peacock explained [Peacock/week7/22Oct/14/9], risk management relied upon the interpretation of Datix forms by the paediatricians in order to establish whether a reported incident had occurred and whether it had caused harm; and,

(b) based upon the paediatricians' assessment of harm the incident may therefore be categorised as no or low harm. Child A, Child C, Child D, Child E and Child I were all recorded as 'no harm caused'. It was only with the deaths of Child P and Child O that the level of harm caused was reported to be 'death'. By that time, there was little question in the minds of the consultants the deaths were unnatural.

253 It follows that in practice the risk management process may not have added any significant additional safeguard beyond the paediatrician's own assessment of the incident. We submit that until such time as the paediatricians themselves developed concerns that the deaths were unnatural, the incident reporting system was poorly equipped to pre-empt those concerns and to raise an alarm.

254 Notwithstanding those limitations, the purpose of incident reporting is to draw to the attention of those in senior positions matters of importance in a timely manner. Insofar as the Inquiry finds failures in the reporting process, the issue of neonatal deaths was nevertheless escalated to QSPEC following the death of Child I. As we identified above that committee failed to take adequate steps in response.

(8) The route by which the paediatricians raised their concerns

255 CoCH submits that in the extraordinary circumstances of 2015/16, it was appropriate for the paediatricians to escalate their concerns direct to those at the highest levels of the Trust outside of the established governance systems.

256 The concerns they were raising from February 2016 onwards were of the upmost seriousness. Far from being *inappropriate*, it was if anything entirely *appropriate* that they were escalated

directly to those at the top of the organisation. Doing so was the clearest and quickest way to highlight the concern.

257 Several witnesses expressed discomfort at raising concerns of the nature voiced in February 2016 in public fora or in documents intended for wider dissemination (such as the thematic review) [INQ0103104 §§140 and 206, Subhedar/week10/20Nov/15/6]. The concerns held were at the time unproven and had the potential to severely damage a named individual's standing and career. It was entirely reasonable for those voicing them to do so in a confidential manner. The desire to maintain some confidentiality was thus at the very least understandable and the sensitivity of the information being conveyed should have been recognised by the executives as such.

(9) Difficulties in reporting concerns

258 We do not intend to address all the copious evidence on this topic, which includes the detailed and insightful report of Professor Dixon-Woods [INQ0102624]. We do however submit that the evidence before the Inquiry has identified three principal factors which may serve to prevent or inhibit the raising of concerns in circumstances where a member of healthcare staff is suspected of causing deliberate harm to patients:

(a) the difficulty in identifying the concern at all and that it is a concern which needs to be voiced;
(b) having done so, difficulties in voicing the concern and fears of being disbelieved; and
(c) the response from the receiver of that information and the impact on the person raising concerns if they are not seen to be taken seriously.

259 The first of those factors was observed by Professor Dixon-Woods at page 9 of her report:

Possible opportunities to speak are more complicated when they relate to an emerging or established pattern rather than to a specific, easily defined incident. Such patterns may lead to a generalised sense that things are 'not right', even though each individual signal or incident may be minor.
Identifying something as a voiceable concern is intimately linked to the quality of the evidence underlying the concern, and to whether people who notice it feel qualified to make a well informed judgement and feel they can justify the reasons for their concern. People can feel discomfort about a situation but insufficient certainty to determine whether the concern was legitimately a matter of concern requiring voice.

260 That accords entirely with the evidence given by several of CoCH's paediatric witnesses of a gradual recognition from the autumn of 2015 to the time of the thematic review in February 2016 that events on the NNU were a cause for concern [INQ0102740 §§74 and 81, Brearey/week10/19Nov/71/15 and 108/13, Jayaram/week9/13Nov/34/22 and 41/10].

261 Whilst the second of the features we identify will, in part, be related to the strength of the evidence which gives rise to concerns, Professor Dixon-Woods identifies various other features which can present serious barriers to an individual speaking out at all [INQ0102624_0020, Dixon-Woods/week3/26Sept/9/5]:

> *People may be especially prone to consider voice "out of place" when the issue involved is discomforting, when it involves potential blaming or criticism of others, when it involves challenge to the authority or competence of others, when it threatens relationships and harmony, when it lacks inherent plausibility or is based on uncertain, imperfect information, when it disturbs professional or peer loyalty or identity, or when it risks the person raising the concern looking ignorant, incompetent, negative or critical.*

262 We observe that several of those factors feature in the circumstances which faced CoCH's staff in 2015/16. Dr Jayaram told the Inquiry [Jayaram/week9/13Nov/39/1]:

> *There is a fear because it's such a seemingly outlandish and unlikely thing that someone is causing deliberate harm, it's the fear of not being believed, it's, you know, said to me: why didn't you just stand up and tell everyone what you thought had happened? It is the fear of not being believed, it is the fear of ridicule, it is the fear of accusations of bullying…*

Dr Jayaram's concerns would be entirely borne out by later events.

263 Lastly, the Inquiry heard evidence of the 'credibility gap' facing those who raise concerns which may cause them to encounter scepticism or even active resistance [INQ0102624_0037]. We consider that a prominent feature of the response to concerns about Letby. Further, the evidence of the paediatricians was that the scepticism and lack of similar concern shown by others influenced their own confidence in their concerns and their response [Gibbs/week4/1Oct/92/13 and 123/8, INQ0103104 §§173 and 233, Brearey/week10/19Nov/250/20].

(10) Executives' intention to refer doctors to the GMC

264 As set out above, at the meeting with the Police on 12 May 2017 Tony Chambers explained his view that the conduct of certain paediatricians was likely to give rise to the need to refer those individuals to the GMC. That he was actively contemplating action against Drs Brearey and Jayaram is demonstrated by Sue Hodkinson's handwritten note that same day setting out the measures being considered [INQ0015642_0048]: *RJ/SB plan re: management 1) GMC 2) actions from grievance 3) mitigation from SOS/whistleblowing 4) action plan to manage out.*

265 The natural reading of that note is that as of 12 May 2017: (i) Tony Chambers and Sue Hodkinson were giving consideration to options for removing Drs Brearey and Jayaram from their positions;

(ii) those options included *managing out* or GMC referral; and (iii) Mr Chambers and Ms Hodkinson were alert to the need to navigate the protections which might be afforded those doctors by the speak out safely policy and whistleblowing legislation. That analysis was accepted by Sue Hodkinson in her oral evidence [Hodkinson/week11/26Nov/171/8], who described Tony Chambers' approach as *disappointing* [Hodkinson/week11/26Nov/172/10]. Referral to the GMC was an option which, in Tony Chambers mind, had been a valid course of action since 16 March [INQ0003344_0003]. In his oral evidence, Mr Chambers was unable to explain Ms Hodkinson's note [Chambers/week11/27Nov/181/8].

266 If Dr Gilby's recollection of her conversation with Ian Harvey is correct, it is both striking and an insight into how rigid the thinking of the Executive Team had become that this course of action was still considered appropriate even *after Letby's arrest* [INQ0101076 §145].

(11) Impact on the paediatricians

267 It is important to acknowledge the significant impact the actions of the Executive Team had on the paediatric consultants involved. CoCH submits that is important context when considering their freedom to act and their ability to communicate concerns from July 2016 onwards. By way of illustration:

(a) by 27 March 2017, Dr Brearey describes having been shortlisted for roles outside the Trust so that he could take further steps to raise concerns whilst protected from disciplinary action [INQ0103104 §§417 and 435. Leaving to seek employment elsewhere was also considered by Dr Jayaram [INQ0107962 §931]. Dr ZA gave evidence that after the meeting of 26 January, she went home to discuss with her husband how long they could pay their mortgage were she to lose her job [DrZA/week5/7Oct/62/2];

(b) Dr Jayaram describes that the psychological impact of *continuing to press for what [he] believed was the right thing for patient safety was causing more harm and risk to [him] than just following the plan of the Board* [INQ0107962 §933]. Dr Gilby would observe that the impact on the paediatricians was so great she felt it necessary to arrange psychological assessments for them [INQ0101076 §193].

268 Against that backdrop, claims by some witnesses that they cannot understand why the paediatricians did not phone the Police themselves, or appear more open in their engagement with the Executive Team, display a telling lack of insight.

(12) CoCH's engagement and transparency with the CQC

269 CoCH accepts that there was a failure to be fully open and transparent with the Care Quality Commission (CQC) prior to and after the inspection undertaken in February 2016.

270 First, it is clear that by the time of the inspection in February 2016 and their meetings with the CQC as part of it, both Alison Kelly and Ian Harvey were aware of the increase in mortality on the NNU since the previous June. Whilst Mr Harvey appears to accept this [INQ0107653 §121], Ms Kelly's evidence to the contrary simply cannot stand [Kelly/week11/25Nov/74/4]. That remains the case regardless of whether Ms Kelly had actually read the thematic review when it was forwarded to her by Mr Harvey in the context of the CQC's visit [Kelly/week11/25Nov/72/19 and 75/6].

271 Second, the Trust accepts that it should have provided the thematic review to the CQC prior to the commencement of the inspection. That proposition appears to have been tacitly accepted by Ian Harvey in his oral evidence [Harvey/week11/28Nov/105/8, 29Nov/221/1]. Whilst Dr Brigham's review may have been provided to the CQC, there is no evidence before the Inquiry that the thematic review was indeed disclosed at this time. Given the limited inspection records available, CoCH does not comment on what information may have been forthcoming during interviews between its staff and the CQC inspection team nor whether the questions asked in those interviews should have resulted in the issue of increased neonatal mortality being discussed.

272 Third, there were further failures to update the CQC as to concerns in the spring of 2016. Obvious opportunities to do so include: (i) the dissemination of the final version of the thematic review on 2 March 2016; and (ii) following the meeting between Ian Harvey, Alison Kelly, Dr Brearey, Eirian Powell and Anne Murphy on 11 May 2016 at which concerns about Letby were raised.

273 Fourth, when the CQC was ultimately informed of the increase in neonatal mortality in June 2016, key information was still omitted. Ann Ford does not appear to have been given any details of the nature of the paediatrician's concerns or that it was those concerns which had precipitated the Trust's extensive actions in June/July 2016. Alison Kelly's otherwise detailed email to Ms Ford dated 30 June 2016 is remarkably silent on that point [INQ0017411]. Further, insofar as her email implied that the thematic review had been shared with the CQC as part of the inspection data pack when it had not, that email was misleading [Kelly/week11/25Nov/89/8]. Ms Kelly's duty was to keep the CQC, one of the Trust's principal regulators, properly informed.

274 Fifth, there was then an ongoing failure to update the CQC as to concerns about Letby, and the need for both Dr Hawdon and Dr McPartland's investigations in light of the findings of the RCPCH review. The update provided by executives during the CQC engagement meeting of 17 February 2017 was, if the note of the meeting is accurate, woefully deficient INQ0014405_0001].

275 A separate issue arises as to the engagement between CoCH's paediatric and nursing staff and the CQC's inspection team. CoCH makes the following submissions in that regard:

(a) CoCH accepts it is likely that Dr ZA did not, in 2016, raise concerns with the CQC about patient safety issues given she was away from work at the time of the inspection [ZA/week5/7Oct/47/15];

(b) the evidence suggests that the issue of neonatal mortality did not arise in the course of interviews held with paediatricians and nurses by the CQC's inspectors during the February 2016 inspection. On any analysis, the evidence is inconsistent as to whether questions which would have elicited their concerns would have been asked by the CQC's inspection team [Cain/week9/14Nov/62/4-65/3, Odeka/week9/14Nov/101/4, Potter/week9/14Nov/130/13-130/24]. That position is perhaps unsurprising given that the purpose of the inspection appears to have been to assess the Trust's *processes* for monitoring and investigating incidents, rather than to interrogate the details of those incidents [Cain/week9/14Nov/61/21, Odeka/week9/14Nov/100/20, 101/4, 103/16, 106/25]. Whether that approach is correct is something other Core Participants are better placed to comment on than CoCH;

(c) Dr Brearey explained in evidence that he was conflicted at the time of the meeting with the CQC, having only recently escalated his concerns to the Executive Team [Brearey/week10/19Nov/104/14]. That hesitancy is, in CoCH's submission, understandable, and should be seen in the context of his understanding that a meeting to discuss how to proceed in light of the thematic review was soon to be arranged with Ian Harvey;

(d) further, CoCH submits that bearing in mind Mr Harvey's request for a copy of the thematic review, Dr Brearey was entitled to rely on the Trust to share it (and any other relevant data or documents) with the CQC inspection team. Put simply, if CQC inspections are to be conducted in a practical and efficient manner, it cannot be that every individual doctor or nurse is required to separately satisfy themselves that their Trust has fulfilled its obligations to the CQC as part of the inspection. In CoCH's view, staff are entitled to expect that their Trust will have provided the inspection team with all necessary documentation.

(13) The use of WhatsApp messaging

276 The Inquiry has considered a large number of text or other messages shared using a variety of instant messaging platforms. We offer the Trust's brief observations:

(a) an instant messaging service such as WhatsApp that allows groups to communicate can be an enormously powerful tool if used appropriately. An example was the use of groups relating to work rotas; [Dr U/week5/7Oct/238/10];

(b) where employees are not provided with work mobile phones, there is much greater scope for misuse or the blurring of boundaries between personal and professional messaging. The Inquiry has seen a number of examples of this. It may be appropriate to restrict the use of mobile phones in some clinical areas as Ms Powell seems to have done with nurses on the NNU;

(c) ultimately responsibility must lie with the individual, who must continue to act professionally and ensure that patient confidentiality is maintained at all times even if messages are shared on a closed group with other healthcare professionals.

277 The Inquiry will be aware that the healthcare regulators provide guidance to their members as to what represents acceptable and unacceptable communication using social media. It may feel that local guidance to staff members is a sufficient adjunct to this.

E SUBMISSIONS IN RELATION TO INDIVIDUAL WITNESSES

278 We do not propose to make specific submissions on the large majority of the Trust's witnesses. We confine our comments below to those witnesses who were, we believe, subject to unjustified criticisms. We also make some brief introductory comments on some of the Former Executives. We have addressed some of the evidence given by the paediatricians in the text above and at this point would simply suggest that the Inquiry may find the evidence of Dr McGuigan of particular assistance as he was an impartial observer uninfluenced by the events of 2015 and 2016.

(1) Kathryn de Berger

279 Ms de Berger was the Trust's Occupational Health Manager for the period 2015 to 2017. She exchanged a significant number of messages with Letby by text and with Letby and others in a WhatsApp group. She acknowledged that the volume of messages was unusual, and she had not previously used WhatsApp for contact with a member of staff. Insofar as she was the subject of express or implied criticism for her contact or the nature of her contact with Letby, we make the following observations:

(a) Ms de Berger's role was different and discrete to others who have given evidence to the Inquiry. It was to support Letby as an employee in a neutral and non-judgmental manner. How an occupational health practitioner discharges her duties cannot and should not be influenced by the nature of the complaint or concern that has resulted in the occupational health referral. She explained her role in this way:

> *but I've not been supporting staff in this situation ever before and I felt at the time that I was the only support that Lucy Letby had.*
>
> *I was given that role by the Trust to support her, to support her mental health, to support her well-being going through what I thought at the time was a very distressing situation, and it was given to me to support her the best that I could and keep her in work, to maintain her mental health during that period, and I felt that fell just on me.*
>
> *So in order to do that, I did that to the best of my ability, and that was why there were so many messages to try and make sure that she was okay. And all the messages can't be about mindfulness and coping strategies to keep her grounded and to keep her in moment, it was about normally events as well.* [de Berger/week5/9Oct/51/19]

(b) although the nature and extent of Ms de Berger's contact with Letby was unusual it did not trespass outside the reasonable limits of her role. Irrespective of the nature and gravity of the allegations being made against Letby the Trust would be expected to continue to support her through the occupational health service so long as she remained an employee;

(c) it was understandable and reasonable for Ms de Berger to be part of a WhatsApp group with Letby given her occupational health role. Likewise, it is understandable that Hayley Cooper, as Letby's RCN representative should be part of the group. It appears that the group included Karen Rees because she had been asked by Alison Kelly and Sue Hodkinson to meet with Letby on a regular basis.

(2) Shirley Bowles

280 Dr Bowles was the consultant clinical pathologist at CoCH who received a call at 09.38 on 14 April 2016 from the laboratory in Liverpool apparently to query the glucose result for Child L. The insulin/C Peptide results were recorded in Child L's notes at 09.30 on 15 April 2016. She was the subject of some express and implied criticism which CoCH believes was either unwarranted or unfair. For the avoidance of doubt we do not in any way seek to undermine or dilute the acceptance on the part of the paediatricians of their collective (and individual) failures correctly to respond to the insulin/C Peptide results in either the case of Child L or Child F. We raise the following points specifically in relation to Dr Bowles:

(a) there was an implied criticism of a failure to analyse the possible explanations for exogenous insulin administration [Bowles/week5/9Oct/95/4-96/25]. The level of detailed forensic analysis that it was suggested that Dr Bowles should have undertaken may reasonably be expected with the benefit of knowledge of subsequent events, but it is unrealistic to expect such a structured thought process without knowledge of those events. It was reasonable for Dr Bowles to describe the results as *puzzling* and to *try and find out a bit more information about them* [Bowles/week5/9Oct/97/2]; if the results merited a Datix report, then this was for the treating clinician to complete as s/he would have the full clinical picture;

(b) Dr Bowles should not be criticised for the destruction of her diary (which may or may not have contained relevant information concerning her involvement in Child L's case). She recalled that she was first aware of an approach to the laboratory for insulin results in October 2018. She believes that by that stage her diary had not been destroyed, but, as she put it, it would not have occurred to her at that stage that she should keep her diary. CoCH suggests that this was a reasonable position for her to take.

(3) Alison Kelly

281 A recurring theme of Ms Kelly's evidence was a tendency to blame others. We identify the following examples:

(a) although Ms Kelly was the Trust's Safeguarding Lead, when challenged about her failure to make a safeguarding referral her immediate response was to point out that others had not made a safeguarding referral either;

(b) others (specifically Ms Powell) failed to indicate the urgency of emails or accurately state their concerns [Kelly/week11/25Nov/109/2];

(c) when challenged about her response to the thematic review and email requests for meetings her response was to blame others for failing to approach her or Ian Harvey directly to request a meeting; [Kelly/week11/25Nov/107/24 & 113/19];

(d) Dr Brearey's failure to disclose his "drawer of doom" when as an Executive Director she had the authority whether with or without the Medical Director's support to require its disclosure [Kelly/week11/25Nov/116/15].[12]

(4) Tony Chambers

282 Mr Chambers was a poor witness who struggled meaningfully to reflect on his actions and identify where he could and should have acted differently [Chambers/week11/27Nov/5/2-8/7]. The Inquiry should approach his evidence with real caution because of a tendency to ignore the question and deliver or repeat what appeared to be pre-prepared responses. When challenged that his evidence was contradicted by contemporaneous documents his answers were often unsatisfactory; an illustration of this was his evidence about his conversation with Ms Hodkinson on 12 May 2017 and the conflicting note that she made of that conversation.

283 Ms Hodkinson described a style that could be interpreted as intimidating and aggressive [Hodkinson/week11/26Nov/79/6]. We do not say that this was his invariable style. However, the Inquiry may wish to bear Mrs Hodkinson's evidence in mind when it considers how, for instance, Mr Chambers conducted himself in the meeting of 26 January 2017 and his communications with paediatricians that followed. We observe also a tendency to hear what he wanted to hear or to avoid hearing things which did not fit his preferred narrative; at times, a reluctance to understand the perspectives of others and appreciate the impact of his actions. The Inquiry may want to consider whether Mr Chambers demonstrated the management skills expected of a Chief Executive.

284 He did not appear to value the contribution and expertise of his medical staff. This was a failing that was both specific and general. Specific because of the omission to ensure that the paediatricians were included in the investigation of the increased mortality and general given his decision to exclude the Chair of the MSC from the Corporate Directors Group meetings. The Inquiry may conclude that the ultimate consequence of this attitude was the threatened vote of no confidence before the MSC.

(5) Ian Harvey

285 Whilst Mr Harvey expressed regret for not calling the Police earlier and for the deterioration in the relationship between the Executive Team and the paediatricians, it was unclear from his evidence whether he took any personal responsibility for either. That he bears some of the responsibility for the failure to engage with the paediatricians and for the deterioration in the relationship is, we submit, unarguable.

[12] Dr Brearey described the contents of the drawer as *important files, medico-legal files, files from Inquests… I had a drawer in which I would keep my reports of the babies who had died and those important sort of documents…* [Brearey/week10/19Nov/91/17].

286 A significant criticism of Mr Harvey is his willingness to take on the role of investigator despite having no relevant experience. This demonstrated a misplaced confidence in his ability to interpret matters which fell outside his skill set which was compounded by a reluctance to seek advice or adhere to it when it was provided. Insofar as the issue was a difficulty interpreting advice given by either the RCPCH or Dr Hawdon, he could and should have sought assistance from those with the experience and expertise to assist him. Moreover, when advice was offered, he appeared actively to reject it.

287 His interpretation of the RCPCH and Hawdon reports was coloured by his personal conclusions from the Silver Command exercise as presented to the Board on 14 July. He became wedded to this interpretation despite what was known to him or should have been obvious to him, namely that neither report (i) had actively addressed allegations of Letby's involvement or (ii) attributed all of the deaths to deficient care or systemic factors. Given that he took on the role of investigator and that he was the Trust's senior clinician, this rigidity of approach which meant that the Board on 10 January 2017 did not hear opposing views was a significant failing.

F RESPONSE TO STANCE OF THE FORMER EXECUTIVES

288 We here seek to address themes that arise from the Opening Statement of the Former Executives and from their evidence to the Inquiry. This will build upon some of the comments that we have made in section C of our submissions.

(1) Misinterpretation of RCPCH and Hawdon reports

289 The reports were wrongly characterised at the time as exculpatory of Letby and incriminating of the wider standard of care on the NNU. It is a matter of concern that at times some of the Former Executives continued to characterise the reports in this way in their oral evidence. That this interpretation was unsustainable is apparent from (i) the demonstrable inability to identify passages in the reports that supported it (ii) that this was ultimately accepted by Mr Harvey and (iii) that the limitations of in particular the RCPCH report were immediately apparent to Dr Gilby.

290 The impact of this misinterpretation was (i) the Board of Directors was misled on 10 January 2017 (ii) to discourage the Executive Team from contacting the Police, the coroner or any other investigating authority (iii) insofar as contact was made with those other bodies, they were provided with misleading or incomplete information.

(2) Calling the Police

291 We note the evolving views of the Former Executives to calling the Police. Early in the week commencing 27 June 2016 Mr Harvey, Mr Cross and Ms Kelly appear separately or collectively to have come to the conclusion that the Police should be called. That resolve appears to have been waning by 29 June and by 14 July was deferred as further investigations were deemed necessary. Thereafter there was little if any consideration by executives of the need to call the Police. Indeed, consideration of a need to call the Police would be inconsistent with the apparent wish to get Letby back on the unit. By the time of the Board of Directors meeting on 10 January there was only passing reference to calling the Police and no discussion of this outcome at the meeting with the paediatricians on 26 January. The issue does not appear to have arisen for consideration again until 27 March. Whether at that meeting it was the settled intention of the executives to call the Police and how consistent that is with their actions thereafter is addressed at [above.

292 It is likely that the initial plan to call the Police was changed because of a belief that the Trust itself could and should investigate the increased mortality and its cause. There was a failure to appreciate that the paediatricians' concerns were so serious that the only body with the appropriate powers and skills to investigate was the Police and that the Silver Command exercise was essentially a repetition of the investigations conducted by Dr Brearey, Eirian Powell and others between October 2015 and March 2016. The plan agreed on 14 July 2016 to defer calling the Police pending the outcome of the RCPCH review foundered on the executives'

misinterpretation of the report and their failure to appreciate that the report as commissioned did not and could not resolve the issue.

(3) Was there an intention to return Letby to the NNU?

293 The totality of the evidence tends to point to a desire to return Letby to the NNU. We note the assurances of a return given to Letby herself, Mr Chambers' letter to the paediatricians of 16 February, and the insistence on completing the mediation exercise recommended by the grievance process (which would have been unnecessary if she was not to return). In the terms of the evidence given by the Former Executives we note the following:

(a) The inference that can reasonably be drawn from Mr Hodkinson's evidence that there was never a genuine intention to return Letby to the NNU [Hodkinson/week11/26Nov/81/5];
(b) Ms Kelly's analysis of her comment she should go back on 16 March 2017 [INQ0003344_0003, Kelly/week11/25Nov/207/5 to 207/20];
(c) In a lengthy passage of his evidence [Chambers/week11/27Nov/103/8 - 109/25 and 132/5 – 133/17] Mr Chambers was unable to explain satisfactorily why he had given assurances to Letby about her return to the NNU if this had never been his intention – we note particularly the passage in his evidence at [Chambers/week11/27Nov/133/14] that he was *absolutely clear in my mind way back in June 2016, adamant that she had to be removed from the unit*.

294 The analysis that there was an intention to return Letby to the NNU is consistent with the evidence that they considered the reports commissioned to be exculpatory of Letby and to have identified systemic or clinical causes for the deaths.

295 From September 2016 the intention to call the Police was waning at the same time as the pressure to return Letby to the NNU was increasing.

(4) Paediatricians' concerns

296 The paediatricians' concerns were mischaracterised as being due to a "gut feeling" or as being concerns for which there was no evidence. That analysis was both incorrect and demeaning. It was incorrect because the evidence was the higher mortality rate, the unexpected and unexplained nature of the deaths, and the failure to respond to resuscitation. It was demeaning as it ignored the fact that the concerns were those of subject matter experts. All the more so, given the views of the subject matter experts were dismissed in favour of those of a non-expert in Mr Harvey.

(5) Attitude towards the paediatricians

297 The attitude of the Former Executives to the paediatricians evolved from one of dismissiveness to one of hostility. This is illustrated by the following: (i) the failure to attend the meeting at midday on 27 June 2016; (ii) holding a separate meeting that day with nursing staff to which they did not invite the paediatricians; (iii) confining the involvement of the paediatricians in the Silver Command exercise to a peripheral detail; (iv) excluding them from discussions about the terms of reference of a review by their own Royal College; (v) ignoring Dr Brearey's offer of help to prepare the notes for Dr Hawdon's review [INQ0103171]; (vi) permitting the grievance to become sidetracked into consideration of their behaviours; (vii) issuing Dr Brearey with a *direct management instruction*; (viii) only sharing the reports months later; (ix) the conduct of the meeting of 26 January 2017; (x) the requirement to apologise to Letby; (xi) the suggestions that the paediatricians inhabited their *own world*; and, (xii) an action plan to manage out Drs Brearey and Jayaram.

(6) Child K

298 Dr Jayaram's disclosure concerning Child K was described in the Former Executives' Opening Statement as "crucial information and direct evidence of wrongdoing by Letby" [§51b]. It may be convenient for the Former Executives to characterise this matter in this way and to say that their response would have been different had they been alerted to Dr Jayaram's concerns sooner. But that stance does not withstand analysis when viewed against their actions when they were told of the concerns on 15 March 2017. The Inquiry may regard the Former Executives' stance as opportunistic.[13] We have addressed this in detail above.

(7) "Behaviours"

299 The suggestion of inappropriate behaviour on behalf of the paediatricians was based almost entirely on multiple hearsay. This included the evidence given to Dr Green by Alison Kelly and Ian Harvey [INQ0003162_0003, INQ0003156_0002].

300 CoCH accepts that the grievance process which identified that purported behaviour was seriously deficient. It was a remarkable feature of its conclusions that Ms Weatherley identified the need for Dr McCormack to apologise for remarks supposedly made despite [INQ0001939_0191]: (i) that he was not interviewed as part of the grievance; and (ii) that there was evidence readily available from Dr Semple which would have dispelled any concerns about his behaviour [INQ0101326 §29].

301 It is concerning that in his evidence to the Inquiry, Ian Harvey continued to try to portray that there had been inappropriate comments made by the paediatric consultants. He appeared to attribute

[13] The same point can be made in relation to their stance concerning Child F and the "near miss incidents".

the comment *killing babies* to Dr Jayaram [Harvey/week11/29Nov/58/6 to 59/23][14] notwithstanding that Nurse T denied ever hearing those words [Nurse T/week6/14Oct/64/11] and that the contemporaneous record of his interview with Dr Green stated only *There was behaviour in clinic it being heard, talking about killing babies on the unit. I had to speak to Ravi about comments about killing babies. This was not denied and RJ did accept that it was inappropriate*.

302 As to the comment about the angel of death, Mr Harvey accepted, and the contemporaneous record confirms, that insofar as Dr Jayaram apologised for those words he did so on behalf of his trainee [INQ0003156_0002, Harvey/week11/28Nov/57/11].

303 COCH submits that there is no proper evidence to establish that there were inappropriate comments or behaviours made by the paediatric consultants towards Letby. It invites the Inquiry to find the same.

(8) Datix

304 It is opportunistic for the Former Executives now to criticise the failure to report collapses and to characterise collapses as 'near misses'. We address this in greater detail at paragraphs 207 to 218 above. Insofar as criticism of the incident reporting system is made, the criticism should not be of the processes by which concerns were escalated, but of the processes for responding to those concerns once escalated. By way of illustration, Alison Kelly's intention was for the deaths of Child A, Child C and Child D to be discussed in the September QSPEC meeting. Notwithstanding any failings in the incident reporting system, the increase in mortality was brought before QSPEC in December 2015. However, it was then inappropriately remitted back to the WCCGB.

[14] We suggest that the reference to *someone* in Dr Harvey's answer to the question *You say that Dr Jayaram said he had said "She's killing babies"* was a reference to the person about who the comment was made (i.e. Letby) rather than the person making the comment.

G CHANGES

(1) Bereavement

305 The bereavement midwife service now provided by the Trust, known as “Lavender Midwives”, comprises a bereavement midwife and miscarriage support midwife.

306 There is no standard or maximum number of appointments offered to affected families. The service is not time limited and can be accessed at any point following the death of a baby and the frequency of visits is subject to the needs of the grieving family.

307 Where the mental health of either parent poses an immediate risk or is assessed to be severely affected, the midwife can arrange an urgent GP appointment or refer straight to the Hospital Emergency Department. The midwife can also contact the Trust’s crisis line for access to the Mental Health Team. If at home with the parent, the midwife could contact the police or ambulance services if necessary. In non-emergency situations, referrals into mental health services can be made. There are also support services such as Elsie’s Moon and Alder Centre which the bereavement midwife can make referrals to or signpost parents to. Talking Therapies is also an available option and referrals from the bereavement midwife team can be made to this service.

(2) Child Death Review Lead

308 Dr Katherine Davis has been appointed as the Trust’s Child Death Review Lead. This role did not exist in 2015/16. Dr Davis has produced an updated Child Death Guideline dated January 2025 which sets out the processes, including SUDIC, to be followed after a baby death. The draft version of the updated Guideline was disclosed to the Inquiry by Dr Brearey [INQ0108408_0034].[15]All sudden and unexpected baby deaths at the Trust must now be managed in accordance with this and the pan-Cheshire SUDIC guidelines (April 2024). Dr Davis is available for colleagues to ask her if they need any information or help with the processes to be followed after a baby death.

(3) Child Death Overview Panel and reporting

309 In January 2025, a new system called ‘Cascade’ was introduced nationally for deaths of babies reportable to MBRRACE (all neonatal babies born alive at 20 weeks’ gestation or greater who die up to 28 days after birth). A separate notification of death to CDOP is no longer required because the notification of death to MBRRACE triggers a notification to the appropriate CDOP and to the National Child Mortality Database (NCMD). The Trust would provide any additional information that the CDOP requires.

[15] The first version of this Guideline was approved in October 2023.

310 In circumstances in which a death is not reportable to MBRRACE, the paediatrician will still be required to complete the CDOP forms. The Trust is in the process of incorporating the changes consequent upon the introduction of Cascade into its Child Death Guideline.

311 As the Trust treats babies from both England and Wales, it has been agreed with NHS Wales that where a PRUDiC referral is necessary the Trust will submit SUDIC paperwork as it captures the same information and ensures consistency for staff completing the documents. CDOP does not exist in Wales, but the Cheshire CDOP has oversight of all baby deaths in its area so any baby death at the Countess of Chester Hospital would be notified to the Cheshire CDOP. The Cheshire coroner would also be informed of the death of a baby from Wales.

(4) Governance, leadership and culture

312 As we set out in the Trust's Opening Note, as part of the exercise of reflecting on and learning from the events of 2015/16, the Trust in 2019 commissioned a review of its corporate governance arrangements. That review was undertaken by Facere Melius. The Trust has continued to strengthen its governance arrangements in recent years to address the findings of the 2022 CQC inspection.

313 The changes made by the Trust to its governance structures and processes since 2016 were set out in the Trust's Opening Note to the Inquiry and in the witness statement of Susan Pemberton [INQ0107960]. It is not the intention to repeat all of what was said again here. In brief, changes include:

(a) the Trust divisional structure – in September 2022 the Trust Board approved a new divisional structure that brought paediatric and neonatal services and maternity services into one division ("Women and Children's Division") with a single leadership team;
(b) establishment of the Operational Management Board (OMB) in January 2023. The OMB oversees implementation of the Trust's operational strategies and objectives. It provides assurance to the Board of Directors around the delivery of these strategies and objectives;
(c) reporting –
    (i) in contrast to the previous position where the Women & Children's Care Governance Board (now the Women and Children's Division Governance Committee) reported to QSPEC (and not direct to the Trust Board), the Women and Children's Division Governance Committee now reports directly to the Trust Board on perinatal quality, performance and safety metrics, with the Director of Midwifery regularly attending the Trust Board to provide updates directly. This provides for more direct oversight of paediatrics and obstetrics by the Trust Board;
    (ii) QSPEC has been replaced by the Quality and Safety Committee with a streamlined membership. It reports to the Trust Board;

(d) facilities - a new neonatal unit was opened in 2021. As a larger and modern space, it is possible to facilitate family integrated care - a framework for practice that is promoted by the British Association of Perinatal Medicine (BAPM). In addition, a new Women & Children's Unit is under construction. This is expected to open in summer 2025 and will bring all women and children's services under one roof;

(e) service oversight - creation of the post of Clinical Lead for Neonatal Risk who now has dedicated time within the role to oversee risk management. The post is held by a consultant neonatologist who leads the Neonatal Incident Review Group (NIRG). The NIRG meets monthly to review all Datix reports, themes and learning. Following the change in the divisional structure, all Women and Children's divisional Datix reports are also reviewed daily by the divisional leadership. A Women and Children's division incident report is received and reviewed at the monthly Women and Children's Division Governance Committee;

(f) Maternity Safety Support Program - in June 2022, the Trust joined the Maternity Safety Support Program (MSSP). In July 2024 the Trust, along with the Maternity Improvement Advisor and Regional Chief Midwife, agreed that the criteria for leaving the MSSP had been successfully met;[16]

(g) Perinatal Assurance and Improvement Board - from March 2023 perinatal services are reviewed on a monthly basis by the Perinatal Assurance and Improvement Board (PAIB) which reports to the Women and Children's Division Governance Committee;

(h) safety champion - the Trust has introduced an executive and non-executive safety champion for the neonatal unit and maternity services. The former is Susan Pemberton, the Deputy Chief Executive and Director of Nursing, Quality and Safety and the latter is a non-executive director. This is intended to provide an alternative route by which any concerns can be raised or escalated;

(i) freedom to speak up - speak out safely has been replaced by freedom to speak up. Although there were speak out safely initiatives and whistleblowing policies in 2015-16, there was no speak out safely champion. The Trust now has a freedom to speak up guardian and 72 freedom to speak up champions. At Board level there is an executive and non-executive lead for freedom to speak up. The effectiveness of freedom to speak up is monitored through a quarterly update to the Executive Directors Group on issues and trends and a twice yearly update to the People and Organisational Development Committee and the Board of Directors. The update to the Board of Directors is delivered by the freedom to speak up guardian;

(j) management of incidents – the Trust now manages incidents in accordance with the national Patient Safety and Incident Reporting Framework (PSIRF). Incidents are reported through Datix. The Deputy Director of Nursing and Quality Governance provides executive oversight of incidents (including checking that they have been recorded on Datix) at the 8am daily Senior Site Meeting. This meeting is attended by executives, clinicians, nurses, and

[16] https://www.england.nhs.uk/mat-transformation/maternity-safety-support-programme/

other staff each morning and acts as a forum through which any concerns can be immediately escalated to senior management. A daily review of incidents in the previous 24 hours is also undertaken by the divisional risk teams and senior managers. They ensure incidents are allocated to appropriate leads, nominate investigators, and allocate duty of candour responsibilities. Datix now has a clear Duty of Candour section in which to record matters associated with this duty. All Duty of Candour letters are attached to Datix for storage and easy access;

(k) Patient Safety Learning Meetings – these meetings take place weekly. The meeting undertakes a review of the previous week's incidents, focusing on the themes of all incidents, concerns, complaints, organisational learning, and subsequent actions. This meeting is led by the Deputy Director of Nursing and Quality Governance and attended by senior health care professionals across the divisions;

(l) weekly learning bulletin – this is shared with all doctors, nurses and trainees across the Trust each week;

(m) Patient Incident Oversight Meeting – this meeting also takes place weekly, led by the Deputy Director of Nursing and Quality Governance and the Deputy Medical Director and attended by the Director of Nursing, Medical Director, divisional risk and governance leads and divisional representatives. The meeting undertakes a review of all moderate and above incidents on a rolling weekly basis and includes any urgent matters. Agreement is reached regarding the level of investigation required, timeframes for completion and oversight of action plans;

(n) incident monitoring – in addition to the above, incidents are monitored through the provision of a monthly Patient Safety Incident Report and a quarterly Integrated Incidents, Complaints and Inquests Report, which are received at the Quality Governance Group, and are then sent to the Quality and Safety Committee and the Board.

314 In making changes to its internal governance structures, reporting lines, incident and risk management and assurance processes, the Trust has sought to learn from the events of 2015/16. Its intention has been to put in place structures and processes to support the raising of concerns about patient safety and safeguarding, the actions of members of staff which may impact on patient safety, and to support the appropriate investigation and escalation of such concerns.

315 We have made a number of observations about the leadership and culture of the Trust in 2015/16 throughout these submissions. We referred to the current Trust culture and leadership in the Trust's Opening Note to the Inquiry (specifically at paragraphs 69-72). What was said in the Opening Note was reinforced by the Trust's current Chief Executive, Jane Tomkinson, in her oral evidence to the Inquiry. The Trust's current Board and leadership seeks to embed an open culture and to improve listening and communication across the organisation. Ms Tomkinson noted that *I feel it's really important that we set the culture and tone to speak up from the absolute top of the shop* [Tomkinson/week15/13Jan/79/4-6]. She also noted*:*

So you can have all the policies and processes in the world but unless people feel accountable for following them, then they will never be effective and the accountability piece comes from a number of areas. One is around the expectations of the senior leadership in implementation but also audit and embedding. But also with my lens, the culture is very much influenced by not just the words but the style and the action of the leaders...[Tomkinson/week15/13Jan/117/7-15].

316 It is recognised that there is more that can be done in addition to the changes set out above. The Trust welcomes further learning from the Inquiry process and any recommendations that the Chair feels it appropriate to provide. Whilst the implementation of some learning will be outside the Trust's control, CoCH is committed to continuing to learn lessons from the events of 2015/16 and to improve its own practices, processes and service provision to ensure the delivery of high quality and safe care to all its patients and a safety and learning culture that encourages and supports staff to raise concerns and seek appropriate resolution.

(5) Protocols for when to refer to the Police

317 It was outlined in the Trust's Opening Note that CoCH supported Professor Bowers' proposal for a protocol for determining when employers should refer matters to the Police [INQ0106946_0015 §11A]. The Trust is currently working on a Police referral process to aid and support referrals to the Police by the Trust and its staff. This will link with the new guidance "Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm" published by the Department of Health and Social Care on 17th December 2024.[17]

[17] https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version

H RECOMMENDATIONS

318 We make brief observations on the potential recommendations the Inquiry has explored over the course of the evidence hearings. The Trust listened carefully to the evidence given to the Inquiry by Sir Gordon Messenger and others about multiplicity of guidance and targets and what Professor Dixon-Woods referred to as "priority thickets". It acknowledges that this may be a topic for recommendations. The Trust does not offer any observations on this issue as it is likely that others, specifically DHSC and NHS England, are better placed to comment.

(1) CCTV

319 Whilst the use of CCTV in NNUs was supported by many, a prevailing concern was for the privacy and dignity of parents and their babies. Doctors and nurses at CoCH explained that intimate moments such as skin-to-skin contact and breast feeding, which are significant for babies' health and development, could be disrupted by the intrusive presence of CCTV. Accordingly, some advocated for the limited use of CCTV, for example having cameras only in non-clinical or resuscitation areas.

320 Another concern was that CCTV might fail to prevent deliberate criminal behaviour. Several witnesses considered that Letby's methods of attack, for example injecting air, would have been too discreet for cameras to detect. More generally, some felt that an individual intent on causing harm would inevitably avoid the systems designed to identify them.

321 That is not to say CCTV is without benefit. Witnesses frequently emphasised the importance of parents feeling reassured about the safety of their baby. This is particularly so where parents may live some distance from the NNU. Whilst CoCH now has 24/7 cot access for parents, it was posited that live video links to cots or incubators from which parents could watch their baby might advance that aim further.[18] CoCH would support any recommendations intended to provide for better contact and engagement between parents and their child whilst they are on the NNU.

(2) Insulin

322 It is now known that Letby attacked Child F and Child L with insulin. Beverley Allitt used the same method of attack against children in 1991 and it was used Stepping Hill Hospital closer to the events at CoCH. Suggestions from Trust's witnesses for controlling access to insulin included the categorisation of insulin as a controlled drug on the NNU and investing in intelligent drug dispensing systems.

[18] The new neonatal unit has been built with the possibility of CCTV being installed in mind. Hence, the infrastructure necessary is part of the build process.

323 Other Core Participants may be better placed to weigh the competing advantages and disadvantages as to the categorisation of insulin as a controlled drug than CoCH. The Trust notes Professor Powis' evidence in that regard [Powis/week15/17Jan/48/19]. CoCH would however support the expansion of systems designed to encourage best practice in the administration of medications and the storage of drugs on NNUs.

324 The Trust also endorses the evidence of Dr Brearey, who suggested that a nationally agreed process for the testing and reporting of insulin and C-peptide results be developed. The simple act of asking whether a patient had received insulin at the time the request for insulin/c-peptide testing is made would be enough to establish the significance of any result. Once identified, this would allow for automatic notification of senior clinicians by the laboratory and a serious incident investigation[19] to be commenced into a result that suggested that raised insulin and low c-peptide results had been returned in a patient who was not prescribed insulin. This would significantly reduce the scope for such results to be missed.

(3) Data monitoring and reporting

325 The collection and monitoring of data on NNUs was of interest to the Inquiry and the evidence of Professor Marian Knight and Professor Sir David Spiegelhalter highlighted the importance of investing in real-time data systems and analysis. Both witnesses also placed importance on oversight of data collection to ensure robust monitoring and identification of trends.

326 Professor Spiegelhalter stressed the importance of systems of data collection not imposing an undue burden on those tasked with its collection. That is likely to rely upon systems of single data entry. There was also support for regular reviews of historical data and improved sharing of data across Trusts. CoCH would welcome recommendations to that effect.

(4) SUDIC and Safeguarding

327 The Trust would support recommendations addressing both consistency of practice and the adequacy of existing guidance. Others will be better qualified to express a view as to the detail of the guidance. We would simply observe that a fundamental must be guidance that promotes a uniformity of approach. The existence of guidance promulgated by a variety of bodies with subtly different emphasis is unhelpful to both the organisation and the practitioner. Sir Robert Francis KC addressed the undesirability of and dangers associated with the multiplicity of guidance [Francis/week4/30Sep/143/20 and 145/19].

[19] Dr Brearey's evidence was that the NHS should consider making this a 'never event' [INQ0103104 §150c]. Whilst this may be appropriate, the Trust recognises that other factors beyond its knowledge may influence NHSE's decision as to which incidents it wishes to be 'never events'.

(5) Freedom to Speak Up and Whistleblowing

328 CoCH supports any recommendations intended to strengthen the whistleblowing and freedom to speak up (FTSU) systems. The Inquiry heard evidence as to the benefits of: (i) increasing the awareness of how NHS employees can utilise FTSU; (ii) the need to publish data around FTSU so that it can be observed and scrutinised; and (iii) more robust protection for whistleblowers.

329 The evidence of Sybille Raphael, Professor John Bowers KC and Stuart Lythgoe offered practical proposals to put into effect the kind of strengthening that witnesses have called for. A commonality in their recommendations was for England to create a body similar to the Scottish Independent Whistleblowing Officer (INWO).

(6) Regulation and scrutiny of NHS managers

330 As we set out in our Opening Note, CoCH supports proposals for the regulation of healthcare managers. Whilst others will be better placed to comment on the exact structure and form of such regulation, the Trust maintains its position that an independent regulator with the power of disqualification as proposed by Tom Kark KC would be appropriate. Suggestions were made for an external regulatory body independent from NHSE.

331 CoCH would support recommendations aimed at preventing poorly performing managers from taking roles in other Trusts. Measures to address this problem may include an open and transparent referencing system with a record of complaints and disciplinaries, a change to directors' employment contracts to prevent "golden goodbye packages" when the director has been dismissed, and more robust and uniform disciplinary processes for managers.

I REPSONSE TO CHAIR'S NOTE 4 FEBRUARY 2025

332 CoCH has been invited to make specific submissions in response to questions posed by the Chair as part of her consideration of what recommendations she should make.

333 We set out below those questions relevant to the Trust along with its response. It is understood that the questions arise from differences of understanding expressed by witnesses regarding the applicability to babies in hospital of child safeguarding procedures and/or duties; and the correct process following a sudden and unexpected baby death.

(1) Please set out clearly how safeguarding duties and obligations operate in respect of the Core Participant you represent.

334 The Trust has a Safeguarding and Promoting the Welfare of Children Policy, with the most recent policy dated 1 September 2022 [INQ0014166]. The policy sets out the Trust's statutory duty to safeguard and promote the welfare of children and young people, set out in the Children Act 2004, and reflects national guidance on safeguarding (Working Together to Safeguard Children). Within the policy, the Trust commits to ensuring that all staff have access to expert advice, support, and safeguarding supervision and training in relation to safeguarding children.

335 The safeguarding lead at the Trust is currently Dr Bowling. The safeguarding and complex care organisational chart is set out at Appendix 1 [INQ0104166_0037] of the Policy. There has been an amendment to one job title in the chart, with the job title now reading Associate Director of Nursing (Safeguarding and Complex Care).

(2) Is it accepted that child safeguarding duties and/or procedures in respect of babies apply to all of the Core Participants listed above.

336 The Trust's position is that child safeguarding duties and/or procedures apply to all of the Core Participants listed. However, each Core Participant is best placed to advise on the child safeguarding duties and procedures applicable to them.

(3) What safeguarding duties and procedures apply where a member of staff has a suspicion or concern that another member of staff may be harming a baby who is in the hospital?

337 The Trust's Safeguarding and Promoting the Welfare of Children Policy recognises that staff may have concerns about care or treatment given to any patient. By reference to the Trust's Freedom to Speak Up Policy and Whistle Blowing Policy, staff are advised to raise concerns with managers and are informed that such concerns will be dealt with seriously, promptly, thoroughly and impartially. The safeguarding policy also makes it clear that *No recriminations will follow reports which are made in good faith about low standards of care or possible abuses* [INQ0104166_0031]

338 The Trust's safeguarding policy specifically addresses the possibility that a member of staff may have harmed a child, committed a criminal offence or displayed behaviours which may indicate

that they are not suited to work with children. This is expressed to apply *whether [the allegations] are made in connection to duties within CoCH or if they fall outside of this such as in their private life* [INQ0101466_0033]. In such circumstances, so far as is relevant, the Associate Director of Safeguarding is directed to (i) ensure that a referral is made to the LADO, (ii) cooperate with a disciplinary investigation and/or disciplinary action, (iii) to attend strategy meeting where required and (iv) consider whether there are any lessons to be learned for the safeguarding procedures of those agencies involved.

339 The Trust's Freedom to Speak Up Policy (revised July 2023) [INQ0014172] addresses the opportunity to speak up within the Trust but also explains that there may be occasions when it will be appropriate to speak to someone outside the Trust. It provides links to appropriate organisations and to the independent advice and support available through the National Health & Social Care Whistleblowing helpline. The policy emphasises that an individual should not wait for proof and should raise the matter whilst it is still a concern and that it does not matter if you turn out to be mistaken. The policy also signposts to health and wellbeing support through NHS England and other organisations that can be contacted.

(4) What safeguarding duties and procedures should HR professionals apply when they learn that a member of staff at the hospital is suspected of harming babies in the hospital? Why and to what effect?

340 The safeguarding duties and procedures applied by HR professionals working in the NHS should be the same duties/procedures applicable to NHS staff. HR professionals should have a reasonable working knowledge of the applicable duties and procedures and ensure that they report any issues of concern to the Trust's safeguarding lead(s).

341 Appendix 6 of the Trust's Disciplinary Policy (2024) [INQ0099084] requires consideration of three possible actions: involvement of children's or adult social services; a Police investigation; disciplinary action. If the allegation is made about an individual who works with the children, the Policy directs that the LADO process should be followed. There is equivalent advice for young people and adults. The types of concern considered are a member of staff may have harmed a child, committed a criminal offence may have been committed or whose behaviours may indicate that they are not suited to work with children. In the event that a disciplinary process is followed which results in dismissal or resignation the Police advises consideration of a DBS referral.

342 In addition to involving the Trust's safeguarding lead(s), HR professionals should also follow applicable HR procedures. Where there is a suggestion of a member of staff harming babies, the actions required should include the following:

(a) liaison with the Trust's safeguarding lead(s) will ensure that actions taken by the Trust as an organisation in this scenario are joined up;

(b) informing the police as a matter of urgency, to ensure that critical evidence can be preserved;

(c) subject to appropriate direction from the police, commencing an internal investigation;

(d) taking appropriate and immediate action to ensure that no further harm can be caused whilst the issue of concern is investigated (whether the investigation is being conducted by police and/or the Trust). In a case of this nature, this would almost always involve the immediate suspension of the employee concerned whilst the issue is investigated;

(e) ensuring that the employee cannot work as a health professional in any other establishment whilst the issue is investigated and making an urgent referral to the relevant regulatory body; and,

(f) once appropriate having regard to any criminal investigation, following through the disciplinary process.

343 The HR professional should keep in mind the possibility of allegations that lack credibility or are malicious and ensure that implementation of the Dido Harding guidance to NHS Trusts and a "Just Culture" approach to managing disciplinary issues

(5) How should an HR professional reconcile any employment process with child protection procedures. If they cannot be reconciled, which takes precedence? Why and to what effect?

344 It should be possible to reconcile employment processes with child protection procedures. As stated above, if a credible allegation of deliberate harm arises, an employee can be suspended from duty and the issue reported to the Police, professional regulator or investigated internally.

345 It is difficult to envisage circumstances when differences between employment and child protection processes cannot be resolved but were that the case the Trust would accept that child protection must be the paramount consideration.

(6) Where a union representative is providing support and/or representation to a person about whom the representative knows there are suspicions of causing harm to a baby or babies what, in law, is the union representative's duty to take steps to safeguard the baby or other babies?

346 We can only answer this question from the perspective of CoCH. All employees of the Trust will undergo safeguarding training and will be required to comply with safeguarding processes and policy. We understand that in their role as a trade union representative, training would be provided by the trade union on how to deal with issues, including safeguarding matters, that they become aware of while undertaking the trade union representative role. Trade unions such as the British Medical Association or the Royal College of Nursing may be better placed to respond to this question.

(7) What duty, if any, is owed by a lawyer advising a hospital, or other institution, on the safeguarding steps it should take where suspicions have been raised that a member of staff may be harming a baby or babies? Is there a duty on the lawyer to take any steps in the absence of action from the hospital or other institution? If so, what?

347 A lawyer advising a hospital is clearly bound first and foremost by a duty of confidentiality to the client. That duty means that any information shared by a hospital while obtaining legal advice must be kept confidential and not disclosed to third parties without the hospital's informed consent.

348 However, when confronted with suspicions about a member of staff, there is a duty to advise appropriately on the client's legal obligations. The extent of advice given may be restricted by the client's instructions and requirements. However, ideally the lawyer would be given the opportunity by the client to provide advice on both the hospital's legal and regulatory obligations regarding the safeguarding of children and the management of the member of staff. This may include outlining:

(a) ensuring that the hospital understands its duties under the Children Act 2004 and statutory guidance and professional/regulatory standards (e.g. "Working Together to Safeguard Children 2023") and may include advising on immediate actions such as conducting investigations and/or reporting to local authorities or the police;
(b) the consequences of inaction, so that the hospital understands the potential legal, criminal and reputational risks that may arise if the institution fails to act on suspicions about a member of staff; and,
(c) identifying safeguarding measures that the hospital has in place that should be followed to ensure that safeguarding concerns are identified, escalated and reported appropriately.

349 A lawyer's duty to preserve confidentiality is unqualified; it is a duty to keep the information confidential, not merely to take all reasonable steps to do so.

350 The Solicitors Regulation Authority ("SRA") confidentiality guidance gives examples of circumstances where a breach of the duty of confidentiality may be justified. The examples are not exceptions to the duty, but the SRA's view is that it would not want concerns about possible regulatory action to prevent solicitors raising issues when it is necessary to prevent an event which could lead to harm to the client or a third party. The SRA would take the justification into account, and it would be likely to mitigate against regulatory action. One example given is "disclosure of client information may be justified where there are safeguarding concerns in order to prevent harm to children or vulnerable adults."

351 The SRA's confidentiality guidance further advises a solicitor to consider a disclosure assessment plan to identify the extent and nature of any safeguarding concerns and the seriousness of the risk of harm if no action is taken. A solicitor would need to be prepared to show powerful

justification (including documentation) for breaching client confidentiality and must always consider:

(a) whether it is more appropriate to discuss concerns with the client and get their agreement to take steps to prevent the harm;
(b) the most appropriate person to disclose concerns to, e.g. a family member, doctor, social worker, police or other public authority; and,
(c) the amount of information being disclosed, i.e. only what is strictly necessary.

352 The SRA recognises that in practice these judgments can be difficult, particularly where the facts or risks are not clear cut. However, the SRA supports solicitors erring on the side of disclosure when faced with genuine safeguarding concerns.

353 The Bar Standards Board "BSB" takes a similar approach. BSB rule C15.5 allows a barrister to breach a duty of confidentiality 'as permitted by law'. Broadly, the BSB considers that the law permits a barrister to do so where s/he has "reasonable grounds for believing that there is a significant risk of death or serious injury to an identifiable person or persons, at least (or particularly) if the risk is imminent".

354 The Bar Council considers that barristers may, given the seriousness (and potential imminence) required to meet the threshold for disclosure, report the threat to the police or other appropriate agency to take appropriate protective measures. Any disclosure should be no wider than is reasonably necessary in the circumstances in order for threatened victim(s) to be protected.

355 Therefore:

(a) a lawyer does not have an independent duty to report concerns externally without the hospital's consent, nor do they have a fixed legal duty to take any safeguarding steps of their own if the hospital does not take any action; but,
(b) there may be a justification to do so, therefore breaching the duty of confidentiality, if the disclosure is necessary to prevent imminent and/or serious future harm. The appropriate course of action will be highly fact-sensitive and will depend on the specific circumstances, including the severity and immediacy of the risk.

(8) What is the process that must be followed and by whom on the occasion of a sudden and unexpected baby death?

356 All sudden and unexpected baby deaths at the Trust are now managed in accordance with the Trust's Child Death Guideline (2025) and the Sudden Unexpected Death in Infancy & Childhood ("SUDIC") pan-Cheshire guidelines (April 2024). For babies from Wales, their death will be managed in accordance with the Procedural Response to Unexpected Deaths in Childhood

("PRUDiC") 2023 guidance. The Trust's Child Death Guideline contains checklists to ensure the necessary actions are taken.

357 Appendix 1a of the SUDIC pan-Cheshire guidelines includes a form containing actions that must be completed within 1-2 hours of death being declared. Appendix 1b includes the relevant contacts who should be contacted following a sudden and unexpected baby death. This includes a child death notification to be sent to the Child Death Overview Panel via the e-CDOP link, reporting a death and/or seeking advice from the coroner's office, and contacting the local Designated Doctor for Child Deaths. The Trust's Child Death Guideline summarises this guidance.

(9) The Inquiry heard evidence that it took an experienced paediatrician six hours to complete the form required as part of reporting a baby death. What, if any, work is being done, to shorten this time, by (for example) reducing the number of questions to be answered and providing administrative support to the doctor who is completing the form?

358 In addition to documenting all care given during the resuscitation, examination and findings and discussions with parents in the medical notes, the forms/notifications required to be completed on the death of a baby include:

(a) a form on the Trust's IT system, Cerner, to verify the death;
(b) an immediate decisions proforma in Cerner to consider any immediate service delivery problems or whether a joint agency response is needed;
(c) informing CHIS (Child Health Information Services) of the death which triggers all urgent notifications. Due to the importance of ensuring appropriate notification, this task is now on the consultant's checklist of notifications to be made (this was previously part of the nursing checklist but was moved to the consultant's checklist to ensure notification to all relevant parties);
(d) referral to the Coroner / initiation of a joint agency response with the Police and social care (as appropriate);
(e) dictation of a summary letter explaining the circumstances of the death to be sent to the GP and to be sent to the coroner to inform the post mortem;
(f) completion of CDOP referral/documentation (via online form); and,
(g) where appropriate, completion of SUDIC documentation (which can be submitted to the PRUDiC process for babies from Wales).

359 The forms on Cerner are tick box forms and usually do not take long to complete. They did not exist in 2015/16.

360 The CDOP and SUDIC forms are not produced by the Trust and therefore the length of the forms, the number of questions to complete and the time it takes to complete the forms is not within the control of the Trust. As the forms require clinical information, it can be difficult for others (including administration staff) to complete the forms. The documentation is lengthy and often requires

information to be entered numerous times. The CDOP form is completed online. SUDIC documentation is provided to the Trust in PDF format so needs to be printed out and completed by hand.

361 The forms for reporting deaths to various bodies and agencies are long and inefficient. Paper forms are still required for the SUDIC process. However, as set out in paragraphs 309 and 311 above, changes to processes have been made which will help simplify reporting.

(10) What administrative support is given to doctors to support them i) in their clinical role and ii) in their leadership role? Where, for example, a doctor is allocated 25% of his or her time to a leadership or other administrative role, how many hours of administrative support are available to the doctor. What efforts if any, are made to ensure that the support is available when needed?

362 A doctor is given administrative support as part of their clinical role, including secretarial support to help with patient queries, the scheduling of patient appointments and answering the telephones. A Consultant will have a named secretary who will be shared with other Consultants. There will usually be a personal assistant (PA) for the division who provides dedicated support to the Divisional Director. It is for the doctor to write their own notes, fill in forms, order tests, chase results and dictate letters which will then be typed by the secretarial team. It is understood that this is normal practice across NHS Trusts.

363 Doctors in a leadership role, such as a Clinical Director, will have one day a week dedicated to the leadership role. There is no additional administrative time for the doctor associated with the leadership role. It may be that if the doctor is chairing a meeting for example, another individual such as the service manager or a secretary may take the minutes of the meeting and send follow up emails after the meeting.

364 There may be particular roles which require the individual to attend frequent meetings. This may involve the individual being provided with dedicated administrative support. For example, the named doctor for safeguarding in paediatrics has a dedicated individual in an administrative role who has responsibility for organising and minuting meetings.

(11) What administrative support is given respectively to a Chief Executive, Medical Director, Nursing Director? Is that available at the time the manager requires it?

365 The Executive Directors are supported by an executive office team led by a Head of Corporate Governance with five executive assistants (the Trust currently holds one vacancy). Each executive assistant is assigned two executives and provides administrative support to those executives. The executive assistants have direct access to their respective executives' emails and diaries as required. The Chief Executive, Director of Nursing and Medical Director each have an assigned executive assistant from the group of five executive assistants and can access the executive office team as required.

366 The executive assistants support the Executive Directors with a wide range of administrative duties. The executive assistant will have regular 1-1s with their executive to update on actions/tasks, agree the priorities for the week, discuss upcoming meetings, for diary management and to directly report matters that need to be brought to their attention.

367 This administrative support is available Monday to Friday 8am – 5pm. During annual leave of the executive's assigned executive assistant, another executive assistant is assigned to support the executive. The executive directors also have access to the wider corporate teams who are specialised in areas including governance, legal, information governance and risk and patient safety and can utilise their support as needed.

J APPLICATION TO POSTPONE

368 The Trust has considered the request received by the Inquiry from the legal team for the Former Executives (dated 21 February 2025) and from Sir David Davis (dated 28 February 2025) to pause the Inquiry's proceedings. It is noted that the request is based on *recent developments which directly relate to matters at the heart of this Inquiry* and made *pending the outcome of Letby's application in respect of her criminal convictions to the Criminal Cases Review Commission* (CCRC). The Inquiry has invited all Core Participants to comment on the request to pause the Inquiry within written closing submissions should they wish to do so.

369 Section 17(1) of the Inquiries Act 2005 provides that the procedure and conduct of the Inquiry is a matter for the Chair. The request refers to the Chair's duty under section 17(3) that, in taking such decisions, she act fairly and have regard to the need to avoid unnecessary cost. It is the Trust's position that the Chair may proceed to consider the evidence received and conclude the Inquiry in line with the section 17(3) duty.

370 CoCH makes two preliminary observations:

(a) To pause the Inquiry pending the outcome of the CCRC application process and any further process that may subsequently be initiated would be to effectively suspend it for an indeterminate period. That period could be lengthy. Any pause therefore risks preventing the Inquiry from fulfilling its Terms of Reference in a timely manner. Those Terms of Reference were decided by the Secretary of State, and it can be in neither the public interest nor the interests of those involved in the Inquiry process for the fulfilment of those Terms to be frustrated for a long period.

(b) Letby's convictions result from a full and lengthy judicial process. Those convictions stand. Leave to appeal on the basis of new medical evidence has already been considered and refused. Whilst the Trust does not comment on the strength of the application made by Letby's legal team to the CCRC, it observes that it cannot be fair, reasonable or proportionate to postpone the Inquiry based on the mere possibility that her case will be referred to the Court of Appeal. That possibility will always exist. Were her case in fact to be referred to the Court of Appeal by the CCRC on its merits, the Trust may wish to revisit its stance.

371 Turning first to the question of unnecessary cost, any postponement and later resumption of the Inquiry will inevitably increase costs compared to continuing the Inquiry at this stage.

372 As to the issue of fairness:

(a) to postpone at this stage will result in the Trust's witnesses and wider staff being subjected to ongoing uncertainty which is likely to have a significant personal, physical and psychological impact.

(b) any delay prevents Core Participants from implementing the recommendations of the Inquiry process in a timely manner. Many of those recommendations will not be dependent on any finding of guilt. A pause in proceedings only postpones the learning of lessons.

(c) the suggestion of an unfairness to the Former Executives is misplaced. Contrary to the assertion in the request for a pause, witnesses were asked questions about their response to concerns about Letby and not whether they accepted the reality of Letby's criminality. That was the case for all witnesses. The Inquiry can therefore proceed regardless of the status of Letby's convictions and without any unfairness.

(d) it would be open to the Chair to frame her conclusions in such a way so as to recognise the steps being taken by Letby's legal team in respect of her criminal convictions and to overcome any perceived unfairness.

1 Crown Office Row,
Temple,
EC4Y 7HH

ANDREW KENNEDY KC
THOMAS HAYES

Hill Dickinson,
Liverpool,
L3 9SJ

EMMA STOCKWELL

4 March 2025