THE THIRLWALL INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF FAMILY GROUPS TWO AND THREE

Introduction

1. These submissions are made on behalf of the families of: Child C, Child D, Child E, Child F, Child G, Child H, Child J, Child K, Child O, Child P, Child R and Child Q. They will be collectively referred to as "the Families".

2. Between June 2015 and June 2016, Lucy Letby committed multiple attacks on babies in her care. On 21st August 2023, following a long trial at Manchester Crown Court, she was sentenced to life imprisonment with a whole life order on each of seven counts of murder and seven counts of attempted murder. In 2024 she was convicted, following trial, of a further count of attempted murder and sentenced to a further term of life imprisonment and at the time of writing she remains Britain's most prolific child killer. Her case has been the subject of two unsuccessful appeals to the Court of Appeal but continues to be the subject of controversy. Letby's supporters contend that she is innocent and, throughout the course of the Inquiry, Letby's supporters, latterly assisted by expert witnesses and a PR agency, have operated a slick media campaign promoting that view. The Families have no doubts about Letby's guilt. They sat with dignified silence through both trials, both appeals and through this Inquiry. They did so because they wanted to find the truth and see justice for their babies. They asked for privacy because their lives have already been damaged enough. They do not want that harm to multiply and continue.

3. The Families' voices are heard through the words they spoke in those proceedings and through these submissions. They will not hold press conferences, they will not mount publicity stunts, they will not appear on television to push their narrative. Their narrative is the truth as found by two juries following proper and fair legal process. As we said on their behalf at the start of this Inquiry, they do not want their lives to become a sideshow within a ghoulish media circus. Many of them have told us that they cannot watch or read the news because of the fear that they will see their own babies metaphorically dissected in front of them. As the anonymity of victims can sometimes dehumanise them in the eyes of those who read about their experiences, it is important to remember that all of the victims named on the indictment are or were real people, with families who love them, and who often struggled to bring them into the world. Eight families have struggled with the grief of losing their babies before their lives had begun; and for others, they have continued to care for children with severe disabilities with the knowledge that those disabilities were the consequence of deliberate harm. All of the Families have been severely affected by these events.

None of them should have to ask the press or the public to remember them when writing about the details of this case.

4. The Families throughout this Inquiry avoided commenting directly upon the arguments advanced in support of Letby. In the closing days of the Inquiry an application was made by the Former Executives of the Trust to halt the Inquiry whilst an application is made to the Criminal Cases Review Commission (CCRC), which the other Core Participants have been asked to comment upon. The Families submissions with regard to that application are set out towards the end of this document and will provide some analysis of the fundamental issues that are obvious both with regard to the application for a further appeal to the Court of Appeal and with the application to adjourn the Inquiry. The Families will leave discussion of that application to the end of this submission. We say that it is made in a naked attempt by the Executives to avoid criticism and is entirely without merit.

5. This Inquiry, by its terms of reference and in the way in which it has been conducted has never involved an analysis of Letby's convictions. Instead, the Inquiry has looked at how an NHS Trust investigates suspicions of deliberate harm and, then, how it reacts when allegations of deliberate harm are made. The Families would hope that one thing that should unite everyone who reads the evidence given before this Inquiry is a sense that the NHS should do better when faced with these issues. The evidence given before the Inquiry demonstrates poor systems for investigating unusual deaths, the failure to react to unusual blood tests, a failure of safeguarding structures, a failure to listen to concerns when raised, a deliberate cover-up, the suppression of evidence, a lack of candour with families and the suppression and persecution of whistleblowers. The message that comes through the evidence is that there was a total and absolute failure of culture at the Countess of Chester Hospital and, on the part of individuals, a total failure to meet the basic standards to be expected of senior, powerful and well-paid NHS executives. The noise surrounding this Inquiry should not be allowed to distract from the message at its heart. The failure of basic patient safety mechanisms within NHS Trusts cannot be allowed to continue in this way. Many features of this case are common and have been repeated through multiple Inquiries and investigations into healthcare disasters. If they are not addressed, they will continue to cause harm to patients and their families by many different routes.

Referencing

6. Where these submissions refer to documents from the Relativity database, we will provide their INQ number followed by the relevant page (/) or paragraph (§) number. Where the submissions

refer to oral evidence given before the Inquiry the transcripts will be referred to as (T) followed by the date and page number.

Summary

7. The submissions will be structured around the facts of what happened, seeking to identify themes from the evidence heard before the Inquiry before drawing out some major themes in conclusion. The themes that will be identified by the Families are the same themes that were highlighted within the written opening provided to the Inquiry in preparation for the opening of the hearing in September. Those themes can be summarised in outline as follows:

7.1. The opportunity to identify the crimes sooner and prevent further murders and further acts of attempted murder. There appears to be little doubt that Letby's attempt to poison Child F with insulin provided a clear opportunity to detect her actions and prevent further crimes. The Families are concerned that the deaths of Children A, C, D and E were not adequately investigated and that a lack of professional curiosity on the part of the individuals who treated them and/or inadequate systemic structures for the investigation of sudden death prevented crimes from being identified sooner and provided an environment within which Letby felt unhindered.

7.2. The results of Child F's insulin tests in August 2015 were noted but disregarded. These represented clear evidence of a malevolent force at work within the unit and provided the clearest opportunity to detect and stop Letby. The Families will say that this represents a bright line within the chronology after which no babies should have been harmed. The failure to detect and act upon these findings represents a clear missed opportunity to stop further harm. It is disturbing that the receipt of the same results in the Grantham and Kesteven Hospital in 1991 halted the crimes of Beverley Allitt but failed to achieve the same result at the Countess of Chester Hospital (CoCH) 26 years later. c

7.3. During the latter part of 2015 a number of clinicians working within the Neonatal Unit began to suspect the possibility that someone might be causing deliberate harm to babies. This should have led to effective safeguarding action but did not.

7.4. During 2016 the concerns of the paediatricians were communicated to senior executives but did not lead to safeguarding action as they should have done. It is a matter for evidence when those concerns were first communicated, how they were communicated and whether those communications were effective.

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

7.6. Following the death of Child P the behaviour of the senior executives demonstrated a total failure in the culture of the CoCH. The suspicions regarding the crimes of Letby were covered-up and hidden from families, from external bodies, from the Coroner and from the public at large. This was done to preserve the reputation of the trust and of the executives. In prioritising those factors over patient safety there was an absolute failure of candour, honesty, openness and transparency, all key components of an effective patient safety driven culture. Senior executives deliberately deceived family members and allowed important information to be withheld from external bodies and from the Coroner. It is likely that staff giving evidence at an Inquest into the death of Child A were told to withhold important information from the Coroner.

7.7. The failure in culture was contributed to by a profound tribalism between doctors and nurses on the NNU. The doctors' legitimate concerns were opposed by groups within the nursing body whose priority was to protect a fellow nurse, driven by innate bias towards the nursing profession and against doctors. This tribalism permeated to the top of the executive board.

7.8. The individuals who raised the concerns were persecuted by the nurses and senior executives. They were subject to a badly managed and biased grievance procedure; they were bullied by the Chief Executive and other senior executives and ultimately threatened with reporting to their professional bodies. In the final act before the police investigation began the Chief Executive determined that he would bypass "Speak out Safely" protocols to have the consultants managed out of the Trust. This represented a gross derivation from his duties and responsibilities as a Chief Executive of an NHS Trust. It was reprehensible, however, given a lack of professional regulation for hospital managers it would not only go unpunished but would result in attempts by the NHS to move him to a different role in a different NHS Trust.

7.9. The cultural failings in the Trust following the death of Child P are sadly common and resonate with findings made in previous Public Inquiries and Investigations. The fact that these issues continue to arise demonstrates that the NHS has been slow to learn lessons from previous healthcare disasters. The only real option is to enforce and embed the duty to afford primacy to patient safety through the effective and robust regulation of hospital managers.

7.10. A poor patient safety culture likely contributed to the failures to detect Letby's crimes sooner. There was also a lack of robust patient safety safeguarding systems or systems to ensure the effective investigation of sudden death in children in hospital. It is surprising that doctors and nurses treating children in hospitals would recognise the need for safeguarding procedures in the face of suspicions that harm was being caused by parents or carers but wouldn't recognise the need for the same procedures to be followed in cases where the source of suspected harm is a colleague. Better clarity is required with regard to safeguarding procedures. It is no longer enough to say, as Cecil Clothier said in 1994, that those working in a healthcare setting should be aware of the possibility that harm is being caused malevolently. Better systems and triggers for safeguarding are required.

The Neonatal Unit and the Countess of Chester Hospital (CoCH)

8. Between June 2015 and June 2016, the Neonatal Unit (NNU) at the CoCH was a designated level 2 unit, which provided care to babies delivered at greater than 27 weeks' gestation and those who required short-term ventilator support. Following June 2016, the unit was voluntarily downgraded to a level 1 unit. The NNU contained sixteen cots across three sub-units, referred to as nurseries. The nurseries were numbered according to the intensity of support being provided to the patients within them, with nursery one caring for babies requiring intensive support, and nursery three caring for babies who required less intensive support. The NNU had three intensive care costs, three high dependency cots and ten special care cots. The unit additionally provided four transitional cots within the maternity ward.

9. Although the NNU provided care to vulnerable babies, death was uncommon. Between 2010 and 2014, mortality rates on the NNU were stable with three or fewer deaths per annum. The mortality rate rose dramatically within the period between June 2015 and July 2016, with three deaths occurring in June and July 2015 alone. The Inquiry heard evidence from Professor Speigelhalter (an eminent statistician) that, from a purely statistical perspective, a substantial rise in mortality would require investigation in order that it could be properly contextualised but may not be remarkable in and of itself **[T/15.01.25/51 & 57]**. The Inquiry may infer, however, that prior to June 2015, the NNU appeared to be functioning well, without evidence of an unusually poor mortality outcome in respect of its patients.

10. The babies on the NNU were cared for by specialist paediatric nurses and by paediatricians, many of whom had a specialist interest in caring for neonates. The doctors working on the ward had various levels of seniority, being either junior doctors or consultants. The consultants were relatively autonomous but were represented in management meetings by a lead clinician, at that time Dr Jayaram. Another consultant, Dr Brearey, was designated as the consultant neonatal lead. This provided him with responsibility for interacting with the wider regional neonatal network and also for organising risk management/clinical incident meetings. The doctors within the NNU were ultimately managed by Ian Harvey (Medical Director and Deputy Chief Executive). Mr Harvey was an orthopaedic surgeon by training and had little if any experience of paediatrics or neonatology. As medical director, he was responsible for managing all of the physicians or surgeons working at the hospital.

11. The nursing staff worked within a more obviously hierarchical structure, with specialist nurses ranked between bands 5 and 7 providing care to babies on the unit. A band 7 Nurse, Eirian Powell, was the NNU ward manager, responsible for the day to day running of the unit with responsibility for staff rotas, liaison with more senior managers, staff welfare, target setting and equipment. She reported to Karen Rees (Head of Nursing in Medicine and Urgent Care). They all worked under Alison Kelly (Director of Nursing and Quality).

12. Both groups: nursing and medical, operated under the umbrella of the executive board and under the oversight of the Chief Executive, Tony Chambers. Ian Harvey and Alison Kelly were members of the executive board.

13. The Families would observe at the outset that the structure that existed within the CoCH at the time, although perhaps not remarkable within an NHS hospital, created two separate groups: one effectively managing doctors and/or representing their interests to the executive board; and another managing nurses and representing their interests to the executive board. This created the potential for both groups to operate autonomously and to come into conflict. It relied heavily upon the personalities of the individuals who held positions of responsibility and their ability to manage the potential for tribalism as between the respective groups. It had the potential to remove the autonomy of those who were lower down in the structure in the face of resistance from those above them.

The local systems for investigating death

14. It was the practice of the NNU to treat all deaths as clinical incidents requiring investigation. Non-fatal collapses were not automatically treated as clinical incidents unless their individual circumstances led to them being reported as such **[INQ0102740§11]**. As neonatal lead, Dr Brearey had responsibility for organising and chairing clinical incident/risk management meetings.

15. The CoCH worked within a broader framework for reporting and investigating child death.

16. All deaths were reportable to the local Coroner, who had a statutory duty to investigate unnatural or unexplained deaths. Unnatural deaths, in this context, included those where death by natural causes were determined to be unnatural deaths by virtue of the fact that they involved failures in medical care. **[T/06.12.24/25-26]**.

17. The "Pan-Cheshire Guidelines for The Management of Sudden Unexpected Death in Infants and Children (SUDIC)" issued on 1st July 2015 provides that the SUDIC procedure should be followed in cases of "unexpected and unexplained death of a child within a hospital setting" **[INQ0014582/27]**. Even where the death of the child is "explained" but occurred "unexpectedly", there is still a duty on the Duty Consultant Paediatrician to "*discuss with parents and the Coroner to decide if there is an explanation for the child's unexpected death for issue of the death certificate*" (emphasis added). Such discussion allows the parents or staff involved in the child's care an opportunity to raise any concerns about the child's management.

18. The concept of "unexpected child death" was not new at the time events began to unfold at the COCH in 2015. In the Department of Education publication titled "Working Together to safeguard

children: A Guide to inter-agency working to safeguard and promote the welfare of children", unexpected child death is defined as follows **[INQ0013235/85]**:

"In this guidance an unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; ***or*** *where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.*

The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the procedure for unexpected child deaths should be followed until the available evidence enables a different decision to be made." (emphasis added)

19. Section 11(2) of the Children Act 2004 provides that an NHS Trust:

"…must make arrangements for ensuring that –

(a) Their functions are discharged having regard to the need to safeguard and promote the welfare of children and
(b) Any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need."

20. Guidance about the need for raising safety concerns was similarly embedded in the rules of professional conduct for doctors by the time of the index events.

21. In 2012, the General Medical Council (GMC) issued a guidance titled "Raising and acting on concerns about patient safety" **[INQ0103201/9].** It provides that:

"All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work. They must also encourage and support a culture in which staff can raise concerns openly and safely."

22. Later in the same year, the GMC issued a guidance titled "Protecting children and young people – The responsibility of all doctors" **[INQ0007318/14]**, which provides that:

"…you should have a working knowledge of local procedures for protecting children and young people in your area. You should know who your named or designated professional or lead clinician is, or you should have identified an experienced colleague to go to for advice, and know how to contact them."

23. The Families note that whilst safeguarding procedures were commonly understood when it came to suspicions regarding parents or other care givers causing harm to children, they were little understood when it came to the suspicion that harm might be caused by a staff member or clinical professional. That position was indefensible in light of the findings of the Clothier Inquiry into the crimes of Beverley Allitt and its recommendation that her actions should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events (recommendation 13). That this recommendation was lost from the NHS's collective memory within a little over 20 years after it was made and did not feature in any organised way within the systems operating at the CoCH, or within the minds of those who worked there, is a significant contributing factor to the failure to stop Lucy Letby sooner. Although probably multifactorial, this likely permitted her to kill and harm babies in two ways: by creating an environment in which she could operate without detection and by affording her the confidence that she was able to commit crimes without detection. Had robust systems been in place for the investigation of death, with proper emphasis on the possibility that unexpected and/or unexplained death may be a hallmark of malevolent intervention, then Letby's crimes would either have been detected sooner, or else the risk of detection would have been greater, thus affecting her sense that she could prey on vulnerable babies with impunity.

Events at the Countess of Chester Hospital

Phase One: June 2015 to November 2015

24. The events at the CoCH can be subdivided into various phases. The first phase covers the period from June 2015 to October 2015. This marks the period from the first crime listed indictment, the murder of Child A, to the collapse of Child I. The Families draw a line of demarcation at the end of this period based upon a body of evidence given before the Inquiry that suggests that it was around this point in time that staff at the CoCH began to suspect the possibility that Letby may be causing harm to babies on the NNU. What they actually suspected, and when those suspicions first began to evolve will be discussed below. and it should not be assumed that the use of this demarcation represents the actual point when concern regarding a rise in neonatal mortality transformed into suspicion. The end of the period does however involve a transition into more organised investigations into the rise in neonatal mortality.

25. Child A died on 8th June 2015. His death is the first listed on the indictment and whilst his family are represented by Family Group One, his case, and Child B's, are referred to in order to provide context to the events that followed.

26. Dr Harkness reviewed Child A just before 20:26 on the day of his death and recalled seeing *"unusual blotchy pattern of well-perfused pink skin over the whole of Child A's body coupled with patches of white and blue skin*". Dr Harkness had never seen that pattern of discolouration prior to

the collapse of Child A. Dr Harkness recalls that this observation was discussed in multiple conversations following Child A's death **[INQ0102350§13-14]**.

27. Dr Jayaram was also involved in Child A's resuscitation and reflected on his observations in his statement to the police. He recalled an unusual discoloration on Child A's body that was an *"odd sort of discolouration where there were flitting patches of pink areas on the background of bluey grey skin [that] seemed to appear and disappear. It wasn't like the rash seen with a meningococcal sepsis …It didn't fit with anything I'd ever seen before*" **[INQ0001982/11]**.

28. Child A's death was reported to the Coroner by Dr Saladi with no recorded cause of death. A Datix report was made regarding Child A's "sudden and unexpected deterioration and death …after full resuscitation".

29. Child A's death highlights unusual features that were present in subsequent collapses and deaths: Child A was apparently well and his collapse was sudden and unexpected. The doctors who treated him noted unusual discolouration on his skin. These observations are important, coming from doctors who would have previously witnessed skin changes caused by infection or ischaemia. Having collapsed seemingly out of the blue, Child A could not be resuscitated. The evidence of witnesses before the Inquiry suggested that, whilst collapses and deteriorations were not uncommon, they would ordinarily be reversible with resuscitation **[T/01.10.24/42-43]** Similarly, Dr Hawdon gave evidence that an unexpected collapse in an otherwise stable baby is rare **[T/12.11.24/37]**. As with subsequent children, Child A could not be resuscitated. This was perceived as unusual **[T/13.11.24/242]** and **[T/12.11.24/61]**.

30. Child B required some resuscitation at birth but recovered quickly and stabilised. She recorded a high Apgar score at 10 minutes. She was admitted to Nursery 1 at the NNU at 30 minutes of age. She was initially provided with respiratory support via a ventilator. However, Child B's respiratory support was incrementally reduced and by day two of life she managed periods of independent breathing. All observations were normal and she remained stable.

31. Child B collapsed on 10th June 2015, two days after her brother's death. Dr Lambie, who attended the crash call, recalls seeing Child B being "profoundly grey with a blotchy purple/red rash that slowly appeared and disappeared, appearing to 'move' across her body" **[INQ0102683§14].** This was something that Dr Lambie had never seen before and has not seen since. As with the collapse of Child A, this observation should not be readily ignored, nor should it have been allowed to pass without further investigation at the time. Those treating Child A and Child B were experienced doctors, familiar with the common and uncommon causes of collapse on the NNU. As with Child A, Child B was not expected to collapse. She appeared to be doing well and appeared to be stable **[INQ0000688/2]**.

32. Dr Lambie recalled discussions among the junior medical staff and nurses following the death of Child A and collapse of Child B. The unusual rash observed on both children was discussed in particular and was felt to link both cases **[INQ0102683§20]**.

33. Child C was born in June 2015 at 30 weeks gestation in good condition. He was his parents' first child.

34. Child C weighed 800g at birth and required no resuscitation. He was small in size for his gestation, on the 2nd centile, which was roughly half the expected size for a child of that gestation. Dr Gibbs, his treating doctor noted the risks arising from size and prematurity but did not expect that he would not survive. He explained that the risks associated with prematurity were specific and well understood. These were the risk of respiratory distress syndrome, necrotising enterocolitis, intracranial haemorrhage and sepsis. He considered that these conditions or diseases would give rise to signs and symptoms that would be observable or treatable **[T/1.10.24/199-204]**.

35. Child C required mechanical ventilation and oxygen during the first two hours of life. He then managed with CPAP and Optiflow on the fourth day of life. His breathing and need for support improved over the first days of his life. Biochemical markers such as his lactate levels also improved to the extent that they had normalised by the time of his collapse **[T/1.10.24/199-204]**.

36. Dr Gibbs, who reviewed Child C on 13th June 2015, observed that he was "progressing well and … I was not worried about him when I saw him twice during the day on his [last] day of life." **[INQ0102740§106]**.

37. Mother C, who was still an inpatient on the postnatal ward, said goodnight to Child C at around 22:00 on 13th June 2015. She believed, with good cause, that Child C was stable and improving. She had been able to begin skin to skin contact with him during the previous day and the family had had a good day with him and his maternal grandparents were able to visit for the first time. Although this was her first child, Mother C was well placed to be able to judge Child C's progress and condition. She saw Dr Gibbs on the 13th June and they discussed giving Child C his first milk feed if things continued 'to go well'. They did and Child C was given milk on 13th June **[T/16.09.24/62]**. As far as Mother and Father C, and the doctors who were treating him, were concerned, Child C was doing well and improving.

38. Child C collapsed at around 23.25 on 13th June 2015. His collapse was sudden and unexpected and was not preceded by any of the signs or symptoms that would be expected in the case of any of the risk factors that would be anticipated to apply to a baby of his size and gestation **[T/1.10.24/199-205]**.

39. Sophie Ellis, who was Child C's designated nurse was outside of Nursery 1 at the time of his collapse. She returned to the room when she heard his monitors begin to alarm and found Letby in the room. Child C was the only baby being cared for in Nursery 1. Letby was at the time allocated to care for a baby in Nursery 3 **[INQ0000135/5-6]**.

40. Mother C recalled being woken shortly after 23:00: "…the door to my room was flung open by a midwife on the postnatal ward who was really panicked and was telling me that I needed to come immediately because my son had become unwell really quickly." **[T/16.09.24/63]**.

41. Dr Gibbs arrived at the NNU at 23:35 after receiving an urgent call at home at 23:28. Full resuscitation had been commenced prior to his arrival. Dr Gibbs recalls that Child C was "pale and mottled" on his arrival **[INQ0102740§112]**. In total, Child C was given 7 doses of intravenous adrenaline, two doses of bicarbonate, dextrose, and one dose of calcium gluconate. Letby inserted herself into the resuscitation, despite being allocated to care for another baby in Nursery 3. Although perhaps not unusual in isolation, it formed part of a pattern of behaviour whereby Letby, having caused a collapse, would try to take the nursing lead in resuscitations and then spend time observing grieving parents or deliberately inserting herself into the rituals that followed a death, such as washing or dressing the baby. Subsequently Families would discover that she had taken pages from their children's medical records home with her, and had searched for them on Facebook and social media.

42. Full resuscitation was stopped at 23:55 on 13th June 2015. Dr Gibbs could not understand the cause of Child C's collapse and checked for a pneumothorax and a cerebral bleed. Both were excluded. Although the results were not reported immediately, Child C's blood, taken before and after his collapse, was sent for culture. None of the samples grew bacteria as would be expected were he suffering from sepsis **[T/1.10.24/201-202]**.

43. Dr Gibbs considered that the absence of any response to resuscitation, combined with Child C's sudden collapse was unusual. He didn't understand why Child C had collapsed and then did not respond to resuscitation **[T/1.10.24/42-44]**.

44. Child C's parents wished for him to be baptised, so chest compressions and ventilation were continued after cessation of full resuscitation. During the period between the withdrawal of full resuscitation and Child C's baptism (around 50 minutes), Child C began to show some gasping breaths/gasping respiratory movements. Heart sounds were detectable after his baptism had been completed. As it was obvious that he would not survive Child C was moved to be with his parents in a side room, so that they could hold him and be with him. He lived until sometime before 06.00 hours on 14th June 2015, when his death was confirmed. His death occurred only 6 days after Child A's death and only 4 days after Child B's collapse. Lucy Letby repeatedly inserted herself

into the family room whilst Child C was dying, despite having no reason to be there being the designated nurse for a baby in Nursery 3.

45. After Child C had been moved to the Family Room, Nurse Melanie Taylor (Band 6 nurse) was assigned to support his family. Letby deliberately and repeatedly ignored Nurse W's instruction that she should return to Nursery 3 and look after her allocated baby. Instead, she repeatedly inserted herself into Family C's grief when they were saying a private goodbye to their child. Nurse W was so concerned about Letby's behaviour in this regard that she raised the issue formally, complaining that the baby who Letby had been allocated to care for deteriorated in her absence. Despite Nurse W reporting this concerning event, which likely resulted in patient harm, Eirian Powell failed to take any action to investigate Letby's serious breach of NNU protocol. When giving evidence, Nurse W regarded Letby's behaviour as "very selfish…she seemed to be working for herself". When Nurse W gave her instructions to return caring for the baby allocated to her, Letby ignored her **[T/14.10.24/143]**. In giving evidence before the Inquiry, Eirian Powell accepted that Nurse W had been angry at Letby's actions and had complained to her about them, that the nature of Nurse W's complaint was that she had put the life of another baby at risk by disobeying a direct instruction from a senior nurse, and that this was a serious complaint. Eirian Powell could not explain why this incident had not been recorded by her and had not been recorded in Letby's personnel file **[T/17.10.24.187-198]**. When questioned by Counsel to the Inquiry, Eirian Powell accepted that this amounted to a 'serious breach of protocol' which had worried Nurse W and which was not adequately recorded in the form of a Datix report **[T/17.10.24/78-79]**. The Families suggest that this incident was ignored by Eirian Powell and not appropriately escalated because of special treatment afforded to Letby by Eirian Powell. It was allowed to pass because Letby was a favourite of hers.

46. Nurse Taylor and Letby put together a memory box for Family C which contained hand and footprints of Child C and a cutting of his hair. Letby's involvement in the process contaminated the only precious token of memory that Family C has of their child.

47. Before Child C died and while his parents were saying their private goodbyes, Letby went into the Family Room, plugged in a cold cot and said to his parents: "You've said your goodbyes now. Do you want to put him in here?". A cold cot is a device to preserve the body of a baby after they have died, it is not something that a live baby would be put into. The parents of Child C recalled being horrified by this and responding with words to the effect 'but he's not dead yet'.

48. Dr Gibbs could not explain Child C's death, so reported the death to the Coroner on 14th June 2015. A post-mortem was subsequently performed by Dr Kokai, a paediatric pathologist working at Alder Hey Hospital. Dr Kokai suggested that Child C's death occurred due to ischaemia of the myocardium. Mother C recalled that she discussed this finding with Dr Gibbs and that, as she understood things, Dr Gibbs disagreed with that finding – believing that the damage to Child C's

heart had occurred due to his resuscitation and the prolonged time that it took him to die once care was withdrawn. She understood him to be saying that the damage to Child C's heart found at post-mortem was a consequence of his collapse rather than the cause of it, and that the cause of the collapse remained unknown. Insofar as Dr Gibb's evidence before the Inquiry might be said to depart from that account, the Families would ask the Inquiry to prefer Mother C's account (see further analysis below). The Families note that Mother C's evidence is entirely in line with the comments within the letter written by Dr Gibbs to her after Child C's death **[INQ0008978/3].**

49. A Datix was created on 14th June 2015 in relation to Child C's "sudden deterioration …following full resuscitation" **[INQ0000111/1]** under the sub-category "Expected and unexpected death".

50. Dr Katherine Davis recalled in her statement to the police that "At the time, some of us began to question why this was happening…I was aware of other babies who had suddenly arrested in the same manner, which was odd." **[INQ0000138/10]**

51. Child D was born by Caesarean section in June 2015 at 37 weeks and one day gestation. She weighed just over 3kg (90th centile). She was born in a good condition, with a good Apgar score and having normal respiration within 3 minutes of birth. She was the first child of her parents. In giving evidence before the Inquiry, Mother D recalled that her pregnancy had been a smooth one and she was not concerned when she began her labour a little earlier than expected. She felt that she was almost at full term and they had already decided what they would call their baby. Mother D had crafted everything that was in her baby's nursery, which was already painted and decorated ready to bring her daughter home **[T/17.09.24/9]**.

52. Mother D's labour was not without incident, and she recalled in evidence that she contacted the hospital a number of times before being advised that she would be admitted for an induction. She was concerned about the amount of time that had passed since her waters had broken and whether this might cause harm to her baby **[T/17.09.24/12]**.

53. When Child D was born her mother was concerned about her condition and felt that she was not as lively as she should be and that she was not interested in feeding **[T/17.09.24/17]**. She was transferred to the NNU at 18.40 on the day of her birth and intubated at 22.30.

54. Child D's oxygen saturation improved quickly after commencement of assisted ventilation. Her blood gases had normalised by 23:25 and her parents were told that she was clinically stable. Her observations remained stable overnight and her ventilatory requirements were reduced. By 08:15 on 21st June 2015, Child D was breathing air. She was extubated at 09:00. Repeat tests at 13:00 showed stable condition and observations were within normal limits. When Child D was reviewed by Dr Rylance at 19:00, she had a CRP of 1, she had been in air all day, was saturating well and her blood gases were good. On examination, she was responsive, her chest was clear and she

was stable. Child D was reviewed by Dr Brunton at 21:00 and was noted to be in a good condition. A decision was made to commence Child D on a small amount of gastric feeds **[INQ0002045/212-214]**

55. When Mother D was able to visit her on the NNU she looked better, her colour had improved, and she seemed active and responsive. Mother D spoke with Dr Brunton who told her that everything was fine and Child D seemed much better and was 'picking up'. Mother D was told that Child D was on her way to a full recovery. As concerned as she had been when Child D was born, Mother D never thought that Child D would die. She thought that she had experienced a shaky start to her life but with support and medical treatment she would be fine **[T/17.09.24/18-19]**.

56. Mother D recalled in a statement made to the Cheshire Police in September 2018 that she visited Child D between 19.00 and 19.20 hours on 21st June 2015 and saw bubbles around Child D's mouth. Letby was standing nearby and when Mother D asked her if her baby was ok. Letby responded 'Yeah, she's ok'. Mother D felt that Letby seemed 'detached'. At the same time the monitors that Child D was attached to were sounding alarms. This unnerved Mother D. **[INQ0000792/1-2]**

57. Child D collapsed for the first time at 01:30 on 22nd June 2015. Dr Brunton examined her at 01:40 and noted that she had become "mottled" **[INQ0002045/214].** The clinical notes recorded that Child D required 60% oxygen to maintain her oxygen saturations despite having been in air earlier. Nursing staff had noted Child D looking "mottled with tracking purpuric looking lesions across her trunk" **[INQ0000800/5].** Dr Newby was called to assist at 02:00. Child D's oxygen saturation improved on CPAP. Repeat abdominal x-rays were normal. Child D's antibiotic cover was increased based on a suspected diagnosis of sepsis. Dr Newby recorded two "bruised" areas on Child D's abdomen, which she thought were likely evolving purpura. In her report to the Coroner, Dr Newby noted that **[INQ0000762/116]**: "The lesions were resolving and they were just two bruised-looking areas on the abdomen around 2cm across which looked like they could be evolving purpura, however over the next 30 minutes they also resolved."

58. In her evidence before the Inquiry, Dr Newby explained that the colour change that she saw on Child D was unusual, unlike anything that she had seen before or since. It became a topic of conversation between her and Dr Brunton **[T/3.10.24/21]**.

59. Dr Brearey remarked upon Child D's discolouration in his statement to the police **[INQ0001390/8]:** "This is unusual. I am used to seeing rashes in very sick, septic babies and this rash is called purpura. This does not come and go and will stay for a longer time, well after the baby has got better. I think in this circumstance at the time, the rash was interpreted as purpura of sepsis but the fact it disappeared relatively quickly is perplexing and very unusual. I do not think the hospital paediatricians or neonatologists who reviewed this case could explain a cause for these rashes…"

60. This transient or flitting discolouration had been seen on Child A and Child B. However, the significance of this clinical feature and/or the association of the cluster of cases of unexpected collapses and deaths were not (sufficiently) appreciated at the time. Subsequently they became a topic of conversation amongst the doctors on the NNU, who discussed Child A, B, C and D and their unexpected and unexplained collapses and deaths **[T/3.10.24/22]**.

61. Child D's [first] collapse was unexpected. In her statement to the Inquiry **[INQ0101317§47]**, Dr Newby observed that: "Child D's collapse was unexpected. She had been unwell, requiring a short period of ventilation but had successfully been extubated and was on CPAP in air. She had not required significant cardiovascular support during her course, only 3 boluses of additional fluid support. Blood gases were reassuring around the time of her collapse with no evidence of a significant respiratory or metabolic acidosis with a lactate of 2.75 at the most, indicating reasonable tissue perfusion."

62. Blood gases at 02:22 showed that Child D's condition had improved significantly, so much so that the clinicians involved in her care felt that it was not necessary to update her parents about her condition.

63. Child D suffered a second collapse at 03:15 on 22nd June 2015, with further desaturation (requiring 100% oxygen) and skin discoloration. She had improved by the time of Dr Brunton's review, who noted "skin discoloration again became more pronounced but not as obvious as previously" **[INQ0002045/215]**. Dr Bruton prescribed a further bolus of fluid and stopping CPAP.

64. Child D suffered a third and final collapse at 03:35 on 22nd June 2015. Child D had again suffered a "profound colour change" and had become apnoeic and then asystolic **[INQ0000762/116]**. Full resuscitation was commenced within 2 minutes of the third collapse. Dr Newby was called in to assist. Child D was given external cardiac massage, was immediately reintubated and offered assisted ventilation. She was given 6 doses of adrenaline in total, with no effect. Resuscitation was stopped after 25 minutes. CPR was stopped at 04:21 on 22nd June 2015.

65. Child D's parents were woken in the early hours on 22nd June 2015 and taken to the NNU. They arrived during the final attempt to resuscitate Child D. Shortly thereafter, Dr Newby informed them that their child had died **[INQ0000793/9]**.

66. Mother D saw Letby in the nursery after Child D's death. She felt that Letby was 'observing' them. She felt out of place and 'cold'. Her presence made Mother D feel uncomfortable. **[INQ0000792/2]**

67. Child D's CRP taken on the morning of 22nd June 2015 was subsequently reported as 6 **[INQ0002045/217]** which is normal.

68. Dr Newby felt at the time that Child D's death was likely caused by sepsis, but it was nonetheless unexpected, and so she reported it to the Coroner **[INQ0000762/114]**. The Families would observe that it was not normal practice to refer cases of natural death to the Coroner for further investigation. Whilst Dr Newby thought that the death was probably due to sepsis, there were obviously features that caused her to question that diagnosis, not least Child D's sudden collapse and the unusual skin discolouration that she had observed.

69. It is quite clear that Dr Newby was puzzled and concerned by the discolouration that was seen on Child D during each of her collapses. She discussed this with Dr Brearey in the morning on 22nd June 2015 **[T/3.10.24/18]**. She recalls spending a lot of time discussing the possible aetiology that could have caused the rash with her junior colleagues **[T/3.10.24/21]**. This accords with Dr Lambie's recollection of being approached by Dr Newby a few days after Child B's collapse **[INQ0102683§20]** to discuss the rash that she had seen on Child B.

70. On 23rd June 2015, Dr Lambie went to see Dr Gibbs and raised the Registrars' concerns "about the recent neonatal deaths and collapses … where all the infants showed a strange purpuric looking rash (that probably wasn't true purpura)". Dr Gibbs communicated this to his fellow consultants by an email at 10:04 on 23rd June 2015 **[INQ0025743/2]** and went on to say that "I pointed out that Child C who also died did not have this rash, but it's true that Child A and Child B and the recent death Child D did show a similar strange colour change on "collapsing". [Dr Lambie] also said that "all" the neonatal nurses are very worried. They felt we "ought to be doing something" and also asked what else different the Registrars can do."

71. Dr Newby responded by email at 10:46 on 23rd June 2015 **[INQ0025743/1]**: "I agree, I have just been grilled by Dave Harkness. This is causing a lot of concern/upset." In her oral evidence to the Inquiry, Dr Newby explained by reference to her email that "[Dr Harkness] was also …very concerned about the three deaths and he also mentioned the link between the rashes that were seen on each baby." **[T/3.10.24/23]**

72. Dr Brearey's response by email at 10:55 on 23rd June 2015 recorded that he had reviewed Child D's case with Eirian Powell the previous day "to see if there are any common threads in the deaths" **[INQ0025743/1]**. Dr Brearey's "review" was referred to in his email to Dr Jayaram at 19:41 on 22nd June 2015. Of the three recent deaths on the NNU, the following points were noted:

"In regard to the 3 deaths:

- All deaths occurred in room 1, our intensive care room, but in different cot spaces.
- All microbiology results have been negative to date.
- Initial post mortem result for Child A did not identify any definite cause of death…The other two PMs are in process.

- Child D was not on TPN and died less than [2 days] of age, so nosocomial infection is very unlikely.
- There does not seem to be any staff (medical or nursing) members present at all three episodes other than one nurse, who was not the nurse responsible for Child D on that shift."
  The nurse referred to was Letby.

73. The Families say that this is, at best, the product of a superficial review of the cases. The sudden, unexpected and unexplained nature of Child A, Child C and Child D's collapses and subsequent deaths were not emphasized. Child B's collapse was not considered. The link between the unusual rashes on Child A, B and D was not mentioned. Other unusual features, such as the good progress made by the children prior to their sudden collapses, and the fact that the collapses did not correlate with the usual sequence of events expected to precede a collapse in the NNU, were not expressly recognised. Despite the gaps in this initial review, it ought to have been clear to Dr Brearey and other senior clinicians on the NNU that this was a concerning and fast-developing situation which required urgent attention and thorough review. Against this background and the subsequent email exchange between the NNU consultants on 23rd June 2015 which highlighted the junior doctors' shared concerns about the unexpected nature of the recent deaths and the similarities of colour changes on Child A, Child B and Child D, it is difficult to understand why Dr Brearey decided to "dismiss" Dr Newby's suggestion to discuss all three cases together **[INQ0025743/1]**.

74. In his statement to the Inquiry, Dr Brearey expressed his regret in not paying more attention to the skin discolouration, that were not typical of a septic rash **[INQ0103104§108]**. The Families would echo that regret. It is clear from the contemporaneous documents that this is something that was regarded as unusual at the time, amongst a collection of other unusual or unexpected events. Greater focus on this issue would have provided an opportunity to consider the possibility of malign intervention as a cause of the collapses and deaths. It is notable that when this issue was explored subsequently by the consultant group and, following the deaths of Child O and Child P, it led to the question of air embolism being raised by Dr Jayaram.

75. The Families will say that the unusual and unexpected nature of the collapses and deaths warranted further investigation in and of itself. It is unclear why none of the consultants on the NNU appeared to have considered their obligation to report the deaths as serious incidents and/or follow the SUDIC protocol.

76. Had the recommendations made within the Clothier Report been adequately embedded within the culture of the NHS, the possibility of a malevolent cause for unexpected deaths or collapses would or should have been considered. Although documents indicate that the presence of Letby at all of the collapses and deaths had been observed and recorded, the possibility that she might have been the cause of those collapses was not explicitly documented or seemingly explored. Adopting

a Clothier approach to the issue would have provided an opportunity to bring further focus not only on the causes of the collapses and deaths, but also on Letby's behaviour in the aftermath of events. Given Nurse W's explicit concerns regarding Letby's behaviour following the collapse of Child C, the Families will say that there was an opportunity to bring greater focus on Letby's actions and the possibility that she had caused deliberate harm to the children. Even if this had not led to her crimes being detected, it provided the opportunity to influence her behaviour.

77. The clinicians' concerns were not shared or discussed with the parents. Had the parents' views been sought, as they ought to have been, the consultants would have been provided with further accounts of Letby's behaviour in the period following Child C's collapse. They would likely have been told of Mother D's recollection of seeing Letby with Child D at around 19:00 on 21st June 2015 with bubbles around her mouth, and her intrusive behaviour after Child D's death **[INQ0000792/1-2]**. The parents' concerns and observations would have provided further focus or attention on the potential involvement of Letby.

78. A Datix was created in relation to Child D's death on 23rd June 2015 **[INQ0000766]** under the sub-category "Expected and unexpected death" the risk grading was "No Harm". In the section titled "Action taken", it was recorded that "…A review was completed by the Neonatal Lead Consultant and the Manager to ascertain if there were any commonalities or poor standards of care. There was none found." This statement is inaccurate as various observations had been made with regard to the failure to provide Mother D or Child D with antibiotics and of a delay in transferring her to the NNU. The same message was recorded in the COCH NNIRG on 24th June 2015 **[INQ0025769/16]**.

79. Child A's death was discussed at the Perinatal Morbidity and Mortality meeting on 24th June 2015 **[INQ0007132]**. The unexpected nature of Child A's death and his skin discolouration were not reflected in the meeting record.

80. Dr Newby met with Child D's parents on 24th June 2015. Dr Newby made no notes of the meeting. She could not recall, at the time of giving evidence to the Inquiry, what was discussed. A Coroner's investigation into the death of Child D commenced on 25th June 2015.

81. Ruth Millward (Head of Risk & Patient Safety) emailed Alison Kelly, Ian Harvey and others on 26th June 2015 ahead of the Situation, Background, Assessment and Recommendation (SBAR) meeting on 29th June 2015. She noted: "We have 3 neonatal deaths under review via specialty M&M. The plan is to arrange a specialty specific SI Panel for next Friday 3rd July to go through all 3 cases. *child death is no longer included as Serious Incident by definition [in the SI Framework or on STEIS]. However, it may be reported as a serious incident under another category, e.g. medication error." **[INQ0003144/5]**

82. The cases of Child B, Child C and Child D were never considered by SBAR. Considering the cases together would have afforded a further opportunity for review of the unusual features that surrounded the collapses and deaths and for common themes to be highlighted, in particular the fact that the collapses were sudden, unexpected and unexplained, that in the case of Child A, C and D the usual methods of effective resuscitation had proven ineffective, and that in the case of Child A, B and D unusual skin discolouration had been observed.

83. A senior clinicians meeting took place on 29th June 2015. The junior doctors' concerns about the three recent neonatal deaths were discussed, as was the feeling that "nothing is being done". It was felt that "formal debriefs should probably take place, rather than any specific meeting to discuss all three". This once again failed to recognise the importance of considering the commonalities between the recent cases of Child A, Child B, Child C and Child D, including clinical features that clearly puzzled and worried both junior and senior doctors on the NNU. **[INQ0036166]**

84. An Executive Team meeting took place on the same day. The meeting notes refer to "existing baby death, LWH providing external investigation" **[INQ0003203/2]**. The witnesses who gave evidence to the Inquiry, including Alison Kelly who was present at the meeting, were unable to clarify the reference to an external investigation by LWH. The Inquiry has not seen any evidence of a LWH investigation around June 2015. The Families note that at paragraph 147 of her witness statement, Alison Kelly refers to a 'level 2 tabletop' – a type of case review into clinical care and learning points **[INQ0107704§147]**. The handwritten notes of a meeting on 2 July 2015 **[INQ0003530]** refer to Claire Fitzpatrick, described by Ms Kelly as the Head of Midwifery at Liverpool Women's Hospital. There is no evidence, insofar as the Families know, of an external review by Ms Fitzpatrick.

85. Dr Joanne Davies (Clinical Lead Obstetrics) carried out an obstetrics secondary review of the care given to Mother C and Child C on 30th June 2015. It did not consider or explore the events in the NNU leading up to Child C's death.

86. Dr Gibb's evidence before the Inquiry was that "People were talking about strange events [that had happened from June 2015]. The rashes in Baby A&B were very strange and worried my colleagues and some of the Registrars…", albeit to his recollection no one had mentioned to him any suggestion that the events might be caused by deliberate harm **[T/1.10.24/126-127]**. He recalled first hearing concerns about 'harm' in late 2015 or early 2016, although he accepted that his colleagues may have discussed this sooner **[T/1.10.24/125-128]**. In his Inquiry witness statement he commented that any suggestion that the increased death rate in the NNU might be part of a natural fluctuation became less tenable as the death rate increased through 2015 and 2016 **[INQ0102740§74]**.

87. On 1st July 2015, Dr Brearey prepared a document titled "Summary of cases", which referred to Child A, Child C, and Child D. This was again a desktop/case note review which was prepared

without contribution from the other consultants and junior doctors who were involved in the children's care and/or from their parents. The deficiencies in the earlier review (see above) were repeated. There was a failure to recognise the unexpected and unexplained nature of the deaths and the collapses leading up to them. The junior clinicians' concern shared by their senior colleagues (e.g. Dr Newby) and described by Dr Gibbs above of the skin discolouration, which also applied to Child B's case, does not appear to have been considered. The review was ultimately superficial and failed to engage with the concerns that undoubtedly were being expressed at the time. It failed to identify that the collapses and deaths were sudden, unexpected and unexplained. It failed to consider the possibility of malevolent intervention. In addition to achieving little if any progress towards answering the questions raised by the recent events on the NNU, the review also had the potential to provide false reassurance at the Serious Incident Review meeting, which took place the following day.

88. A number of meetings took place on 2nd July 2015:

89. At 09:10, a debrief of Child C's case took place and was attended by Eirian Powell, Nurse Taylor, Dr Davis, Nurse Ellis, Letby, and Dr Gibbs **[INQ0000108/27]**. It was noted that Child C did not seem unwell before his "arrest"; he was active; whilst earlier CRP (C-reactive protein) and WCC (White Cell Count) results could provide evidence of infection, he had been treated with broad spectrum antibiotics for a number of days preceding his collapse. His "arrest" was not related to the 0.5ml feed that he had been given shortly before. It was further recorded that by the end of the baptism, Child C had a pulse and made gasping respirations.

90. Dr Gibbs produced a separate summary of Child C's case for the meeting on 2nd July 2015 [**INQ0000108/184; INQ0102740§120**]. Dr Gibbs' conclusion was that "The cause of Child C's sudden cardio-respiratory collapse is not known at present."

91. Dr Brearey commented in his witness statement to the Inquiry that two issues struck him from Dr Gibbs' presentation regarding the case of Child C: (i) Child C's completely normal and stable observation chart in the 12 hours before his sudden collapse; and (ii) Child C continuing to make some respiratory effort after resuscitation had been stopped **[INQ0103104§92]**. These features of Child C's case do not appear to have been raised by Dr Brearey in his meeting with Alison Kelly later on the same day.

92. A Serious Incident Review meeting took place on 2nd July 2015 and was attended by, amongst others, Dr Brearey, Alison Kelly and Ruth Millward **[INQ0003530]**. None of the doctors involved in the care of Child A, Child C or Child D attended the meeting.

93. There is a factual dispute as to whether Eirian Powell attended this meeting. Dr Brearey recalled that she was present but his recollection differs from that of Alison Kelly. Eirian Powell accepted

that she was on duty that day, but could not recall if she attended the meeting **[INQ0108000§104]**. In his written evidence, Dr Brearey explained **[INQ0103104§144]** that the reason for the SIR meeting was to "meet with Alison Kelly and describe the events [relating to Child A, Child C and Child D] and what had been done since". As a matter of fact, this meeting did not result in any progression or focus of direction in relation to the investigation of the care and deaths of Child A, Child C and Child D.

94. Dr Brearey's recollection is Letby's presence on the NNU at the time of the babies' deaths was discussed at this meeting and Alison Kelly instructed the team to "keep an eye on it", by which he understood her to be referring to the increase in mortality. Dr Brearey further recalled that Alison Kelly decided that a StEIS (NHS England's Strategic Executive Information System) report should be submitted in relation to Child D's case. A StEIS report was filed on 3rd July 2015 in relation to the delay in recognising the signs of sepsis in Child D **[INQ0107009]**. In his oral evidence before the Inquiry, Dr Brearey recalled that Letby's presence at the time of the incidents was discussed, having been raised by Eirian Powell, causing him to remark "not Lucy, not nice Lucy". He conceded that to make this comment some part of his mind must have been thinking the worst. He would not set this as high as a suspicion, but he was concerned, concerned that there might be somebody harming babies **[T/19.11.24/60-61]**. That these conversations took place in these terms at this meeting was disputed by Julie Fogarty and by Alison Kelly. Eirian Powell had no memory of the meeting so couldn't say whether she was there or whether she made those comments. It was suggested to Dr Brearey that Eirian Powell was not at the meeting so could not have made the remarks attributed to her at that time. It is notable that Ms Blackwell KC in examining Dr Brearey did not suggest that a same or similar conversation did not happen but rather it did not take place at this specific meeting. Dr Brearey strongly disputed this **[T/19.11.24/199-201]**. The Families neither support nor dispute Dr Brearey's evidence on this issue having no direct knowledge of the meeting or the conversations that took place. It is inevitable that recollections about the events at this time will differ and it is plausible that all of the witnesses are giving honest accounts of what they recall. It is plausible that Eirian Powell's name was left of the minutes because she arrived late to the meeting, or that her name is absent because she was not there. The Families will say that whether the discussion took place at this specific meeting or not, it is likely that an association was being made at this time between Letby and the events, whether that led to a suspicion about deliberate harm or not. It is likely that Dr Brearey is correct in saying that the association was first raised with him by Eirian Powell, given his clear recollection of a conversation with her and his response to that suggestion. Given his recollection that he had subsequent conversations with Dr ZA following the death of Child E, which raised the issue of Letby being present and that he did not experience a similar sense of surprise or use the words described above, it is likely that the issue was first raised with him between Child D's death at the end of June 2015 and Child E's death in August 2015.

95. In his oral evidence before the Inquiry, Dr Brearey conceded that a Serious Incident Review of Child A, Child C and Child D as a cluster "would have led to greater scrutiny, family involvement, external reporting, and increased objectivity" **[T/19.11.24/54-55]**. In response to questions put to him by Kate Blackwell KC, Dr Brearey explained that whilst the words "unexpected" and "unexplained" were not used, "it was very clear that the babies collapsed suddenly as described in the narrative of all three cases", and the deaths of Child A and Child C were unexplained at that stage **[T/19.11.24/197]**.

96. In her witness statement to the Inquiry, Ruth Millward acknowledged that "it would have been appropriate for the hospital to have reported the overall increase in neonatal deaths that occurred in June 2015 as a serious incident. This would have then triggered a comprehensive investigation into the increased mortality rate at a much earlier stage…" **[INQ0101332§260]**.

97. Dr Gibbs presented Child C's case at the Sudden Unexpected Death in Infancy/Childhood Initial Strategy Meeting on 2nd July 2015 **[INQ0000108/178]**. The decision reached was that "the case does not meet the threshold for a consideration for a Serious Case Review" **[INQ0002047/22]**. It is unclear to the Families why this was the case, or why that issue was not considered alongside the other cases.

98. The Families will say that the events on 2nd July 2015 were a missed opportunity to investigate and detect Letby's crimes, or at the very least, to increase the level of scrutiny of her actions and the chances of detection following subsequent events.

99. The death of Child A was reported to the NHS England's National Reporting and Learning System on 9th July 2015 **[INQ0107009]**.

100. Child D's death was reviewed on 16th July 2015 by the Death Review Panel in Wales, where CDOP did not formally exist **[INQ0012220]**. It gave Child D's cause of death as "complications of delivery" without any explanation or apparent justification. It is difficult to reconcile how on any analysis Child D's death could be attributed to a complication of her birth. The fact that Child D's death had been reported to StEIS was not recognised, nor were the deaths of Child A and Child C.

101. A Quality, Safety & Patient Experience Committee (QSPEC) meeting took place on 20th July 2015 and was attended, unusually, by Dr Brearey **[INQ0003211]**. Dr Brearey's attendance appeared to relate solely to the discussion of the Kirkup Report. Dr Brearey considered it surprising that the cluster of neonatal deaths were not discussed under Item 11 of the agenda, namely, "SUI update and other incidents". He also considered it surprising that he was not invited back to a future QSPEC meeting to discuss the continuing neonatal mortality in 2015 and 2016 **[INQ0103104§132]**. There is no contemporaneous evidence to suggest that Dr Brearey raised

such concerns, communicated with Ruth Millward (a member of QSPEC) or requested an invitation to attend future QSPEC meetings.

102. Representatives of the CQC attended a meeting with Ian Harvey, Tony Chambers, Alison Kelly and Ruth Millward on 21st July 2015 **[INQ0017285]**. Whilst various patient safety incidents were discussed, none of the deaths that had occurred recently on the NNU was discussed.

103. A Quarterly Neonatal Mortality Meeting took place on 29th July 2015. This was held outside the normal schedule for the 1-2 monthly Perinatal and Neonatal Mortality and Morbidity Meetings because "the number of NNU deaths in 2015 – 2016 meant that not all of them could be discussed in the [normal meetings]" **[INQ0102740§134]**.

104. Only Child C and Child D's deaths were discussed at the meeting. Their deaths were not viewed in the context of the earlier death and collapse of Child A and Child B. There is no reference in the meeting notes to the unexpected and unexplained nature of Child C and Child D's deaths. The return of Child C's cardiac output and respiratory efforts after cessation of full resuscitation was not mentioned. Whilst Dr Newby recalls a discussion about Child D's "episode of ?pupura …that resolved" **[INQ0000762/119]**, discussion of Child D's case in isolation meant that another important opportunity to recognise this highly unusual feature by the doctors treating Child D and that a similar feature had been observed in other cases recently and similarly regarded as highly unusual was again missed. There was a missed opportunity to explore the unusual and suspicious features surrounding these cases in more detail and consider whether they might be explained by a common cause.

105. A WCGB (Women and Children's Care Governance Board) meeting took place on 30th July 2015 **[INQ0004240]**. Dr Jayaram told the Inquiry that in hindsight, the detailed reports by Dr Brearey and the outcome of the review(s) on 2nd July 2015 should have been brought to this meeting **[INQ0107962§264]**.

106. Child E and Child F were twins, delivered towards the end of July 2015 by Caesarean section at 29 weeks and five days gestation. They were of a good size, weighing 1.327 kg and 1.430 kg respectively. They required additional support due to their prematurity but there appears to have been no concern regarding their condition. Mother EF recalled that all of the professionals that she came into contact with remarked about how well the twins were doing: Child E was breathing for himself and Child F needed very little support **[T/18.09.24/8]**. Mother and Father EF spent time with the twins on 3rd August 2015, Mother EF spending all day with them. She recalled that Child E appeared to be 'thriving' and had skin to skin contact with Father EF **[T/18.09.24/9]**. She recalled that on 30th or 31st July she had been informed of a plan to transfer the twins to a hospital closer to Mother and Father EF's home. Everybody she spoke to said that the boys were doing 'really well' and that a transfer would not have been possible had either of them been unwell, or unstable.

She understood that the only factor delaying the transfer by the 3rd August 2015 was the availability of a specialised ambulance to transfer them **[T/18.09.24/59]**.

107. Dr ZA received a handover at 16:00 on 3rd August 2015. No concern was raised in relation to Child E or Child F at this time. Letby was Child E's designated nurse for the night shift on 3rd/4th August 2015. Child E was in Nursery 1.

108. Both twins were receiving expressed breast milk from their mother, so it was necessary for Mother EF to make her way from the maternity ward to the NNU on a regular basis with their milk. During the evening of 3rd August 2015, she made her usual journey to the NNU, arriving there at about 21.00 hours. She was confident in her recollection about the time because she was working to a feeding schedule **[T/18.09.24/60]**. In her evidence before the Inquiry, she recalled that as she came onto the corridor in the unit, she heard screaming and crying. She had been visiting the NNU for almost a week by this time and: "I'd never heard a baby cry like that…" **[T/18.09.24/10]**. In her evidence before the criminal trial she described the sound as "more of a scream than a cry". As she walked into the room she realised that the cry was coming from Child E. Child E had blood around his mouth and was screaming. Letby was standing close by, between the incubator and the workstation but not providing support to Child E **[T/18.09.24/61]**. Mother EF recalled that Letby was 'dismissive' of Mother EF's concerns. She told Mother EF that she had contacted the Registrar, who was on his way. She said: "Go back… you go back to the ward and if there's any problems I'll ring for you." **[T/18.09.24/10]**. Mother EF had encountered Letby before and had previously felt that she was kind, but on this occasion perceived a distinct change in her attitude. To her Letby appeared abrasive and would not look her in the eye **[T/18.09.24/61]**. When asked to reflect on what she had witnessed when she walked into Nursery 1 on 3rd August she said:

"An attack on my son. An interrupted attack. I think I caught her off guard. Something had happened to him for him to be bleeding. Stable babies don't bleed" **[T/18.09.24/63]**.

109. Mother EF went back to the maternity ward, from where she called her husband. She wanted to speak with him because she "knew there was something not right…" He reassured her that Child E was in hospital and would be safe **[T/18.09.24/11]**. During the criminal investigation it was confirmed using Mother EF's mobile phone records that the call to Father EF was made at 21.11 hours, consistent with her account that she went to the NNU at about 21.00 hours and saw Letby then **[T/18.09.24/11]**.

110. Letby's clinical notes record that Child E suffered a gastric bleed at 21.40 hours and that the Registrar was called at 22.10 hours, an hour after Mother EF's visit. The timing in the notes is confirmed by Dr Harkness, the Registrar who attended. Dr Harkness recalled that he was called by Letby to attend at around 22.00 – 22.30 on 3rd August 2015. Mother EF gave evidence before the Inquiry that:

"I found out that the notes had been changed to suit a different narrative of when Child E's bleed started and that's why the registrar hadn't been contacted, because he didn't know I'd been there and he didn't know that Child E was bleeding at just before 9 o'clock" **[T/18.09.24/62]**

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

112. Dr Harkness recalled that he was called because Child E had experienced a bloody vomit. He thought Child E appeared fine and his observations had all been okay. He prescribed medication (Ranitidine) to settle Child E's stomach lining, but no further intervention was felt necessary at that time **[INQ0000222/3]**. Dr Harkness did not expect Child E's condition to change.

113. Child E deteriorated suddenly around 30 minutes after Dr Harkness had assessed him, bringing up large amounts of fresh blood. In his statement to the police, he commented that he had never before or since seen a case of bleeding that occurred so suddenly and out of nowhere **[INQ0000222/3]**.

114. Child E then suffered a sudden collapse. Dr Harkness observed that Child E had developed "quite a strange colouration over his body. This appeared as purple and pale patches and was quite unusual. His breathing had deteriorated and all of Child E's observations had suddenly deteriorated which [was] when he required ventilating. The colour was not solid purple, it was patchy and I would expect his entire body to go purple or pale if due to poor perfusion. If the blood supply is really poor they go white, initially it is arms and legs and then it affects the rest of the body. But it does not appear as a patch on the chest and then a [patch] somewhere else. Child E's colouration appeared so quickly and was not reflected by the monitor, potentially it would disappear to the touch but with perfusion problem if you touch it would tend to go pale. There was no bruising or any sign of blood under the skin, it was just patchy." **[INQ0000222/4]**

115. This unusual presentation rang alarm bells for Dr Harkness. He went on to observe in his statement to the police: "If I thought this was straightforward perfusion that is what I would have written on the medical notes, but I'd seen it before in another patient. A couple of months prior I had seen the same skin discolouration patches in a baby named Child A…". **[INQ0000222/4]**

116. Dr Harkness called Dr ZA (consultant on call) for assistance. By the time Dr ZA arrived, Child E's skin discolouration had disappeared. Child E's cardiac output ceased when Dr ZA was on the Unit. Despite successive attempts to resuscitate him, Child E's condition deteriorated very rapidly. Dr ZA recalled Dr Harkness describing Child E having discolouration of his abdomen but didn't see it

herself. When questioned by Counsel to the Inquiry she explained that his reference to discolouration of the abdomen made her think of Necrotising Enterocolitis (NEC) **[T/7.10.24/21-22]**. When questioned on behalf of the Families she confirmed that discolouration of the abdomen associated with NEC is caused by an internal septic process and would be permanent rather than transient. On reflection she agreed that the transient discolouration reported by Dr Harkness could not be consistent with NEC **[T/7.10.24/67-68]**. Whilst accepting that her diagnosis of NEC was wrong, Dr ZA also explained that something struck her at the time as unusual about Child E's collapse and death. She could not understand why he deteriorated so quickly. This surprised her but she assumed that there must be a medical explanation for it, albeit one that she couldn't explain **[T/7.10.24/22-23]**.

117. Child E's parents were contacted, and he died in his mother's arms at 01:40 on 4th August 2015. Mother EF recalled that Dr ZA spoke to them after Child E's death and said that she was confident that Child E's death was caused by NEC but that a post-mortem could be arranged if they wanted it. Mother EF asked Dr ZA 'what will this tell us?" to which Dr ZA said that she was confident that the cause of death was NEC and it would not tell them anything more. Dr ZA accepted this account in evidence and agreed that had she expressed any significant doubt about that conclusion she would have been obliged to report the death to the Coroner for further investigation by way of a post-mortem **[T/7.10.24/66-67]**.

118. Dr ZA notified the coroner that Child E had died due to natural causes, namely prematurity and necrotising enterocolitis. A natural cause of death having been offered by the treating doctor, the Coroner determined that he had no jurisdiction to investigate further. Had the Coroner been advised that Dr ZA was unsure of the cause of death the Coroner would inevitably have ordered a post-mortem examination to be carried out. . This would have revealed that, as a matter of fact, Child E did not have NEC. It would have prompted further investigations into Child E's death and afforded further opportunities for Mother EF's account to become known. As things stood, Dr ZA's conclusion that Child E died from natural causes subsequently influenced the interpretation of his case by the CoCH and others.

119. Mother E describes being in a state of shock after Child E's death. She watched as Letby bathed Child E, dressed him in a woollen gown and placed him back in his incubator. She feels that her final memories of her child have been forever tainted by Letby's act of malice. She is haunted by the knowledge that Child E was buried in the clothes that Letby dressed him with **[T/18.09.2024/2-3]**.

120. A Datix was created in relation to Child E's death on 4th August 2015 **[INQ0000194]** under the sub-category "Expected and unexpected death". The risk grading was "No Harm".

121. Child E's death did not lead to a review of the earlier decision made on 2nd July 2015. Dr Gibbs recalled in his statement to the Inquiry that "There was concern that Child E was the fourth death since June 2015 and it was noted that Letby was again involved. This was discussed between us consultant paediatricians informally…" **[INQ0102740§144]**. Ruth Millward acknowledged in her statement to the Inquiry that "the death of Child E …was a further missed opportunity to report the overall increase in neonatal deaths that had occurred since June 2015 as a serious incident, [which] would have triggered a comprehensive investigation into the increased mortality rate at a much earlier stage." **[INQ0101332§265]**. The Families would concur with this but repeat that opportunities to engage in a comprehensive investigation had arisen before Child E's death.

122. Dr ZA's confidence in her diagnosis influenced Dr Brearey's analysis of the situation. He recalled a conversation with Dr ZA in August or September 2015 when Dr ZA mentioned the death of Child E and the fact that Letby had been present. She reassured him that Child E died from natural causes. He commented in his evidence before the Inquiry that: "So I was reassured by her somewhat and by the review that I did as well" **[T/19.11.24/60]**. He did not question Dr ZA's decision to categorise the death as natural because: "I trusted her clinical opinion and the joint decision she had made with the Coroner " **[INQ0103104§143]**. Given the form of this discussion and his need to feel reassured by Dr ZA's words, if Dr Brearey's memory is to any extent reliable, it is likely that he had already been made aware of the connection and felt some need for reassurance.

123. On 5th August 2015, Dr ZA referred Child E's death to the Child Death Overview Panel recording it as "unexpected but meets exclusion criteria" **[INQ0012016]**. During her evidence to the Inquiry, Dr ZA could not recall what the "exclusion criteria" were, she suspected that she felt that Child E's death was excluded because she had discussed it with the Coroner and offered a natural cause of death **[T/7.10.24/27]**.

124. Like his brother, Child F was born in a good condition. He cried immediately after birth. To maintain his oxygen saturations, Child F was intubated, after which blood gases showed satisfactory oxygen saturation and normal blood pH **[INQ0000887/2]**.

125. On 30th July 2015, Child F was stable, on minimal ventilation settings and had acceptable blood gas values. His CRP taken 18-24 hours after birth was 14 mg/l so he was commenced on intravenous antibiotics. Child F was extubated at 23:00 and replaced by BiPAP. He continued to do well off the ventilator. Parenteral nutrition (PN) was commenced at 16:00 via an intravenous peripheral long line.

126. On 31st July 2015, Child F had consecutive blood glucose measurements above 10 mmol/l. Dr Davis prescribed intravenous insulin, which was given at a rate of 0.05 units/kg/hour between 03:40 and 06:20. Insulin was stopped when Child F's blood glucose measurements rapidly

normalised while he was receiving the Actrapid infusion. It is important to note that exogenous insulin was last given to him legitimately several days prior to his collapse, the prescribed doses of insulin had no impact on events that followed.

127. Child F's condition remained stable over the next few days. His ventilation requirement and blood glucose levels were stable on 1st August 2015. He was reviewed by Dr Gibbs on 2nd August 2015, Dr Ventress on 3rd August 2015, and Dr Beech on 4th August 2015. His ventilatory support was reducing and he was stepped down to Optiflow on 3rd August 2015. His blood glucose measurements were in the normal range. He was tolerating increasing amount of milk given via a nasogastric tube. He had almost completed 7 days of intravenous antibiotics.

128. Lucy Letby was responsible for caring for Child F during the night shift on 4th to 5th August 2015.

129. Child F received nutrition (food) primarily through his venous system (total parental nutrition – TPN). A new TPN bag was started by Letby at 00:25 on 5th August 2015.

130. Child F was reviewed by Dr Harkness at 01:30 on 5th August 2015 as he had had multiple small milky aspirates from his NG tube and had become tachycardic. Child F was otherwise settled and the examination by Dr Harkness was noted to be unremarkable. Blood gas samples taken at the time showed a blood glucose level of 0.8 mmol/l which is well below the normal range. There was no evidence of infection. Dr Harkness prescribed dextrose and sodium chloride. Enteral feeds were stopped overnight and the rate of TPN was increased so that Child F continued to receive 150 ml/kg/day.

131. Child F was still tachycardic and hypoglycaemic when reviewed at 02:30 on 5th August 2015. Further boluses were given at 04:20 and 08:30. At 03:06 an additional 10% dextrose infusion was started.

132. Dr Gibbs reviewed Child F at 08:30 on 5th August 2015 and considered infection as a possible diagnosis, as this was the most common reason why neonates would experience episodes of hypoglycaemia **[T/1.10.24/60]**. A further 10% dextrose bolus was given at 10:15.

133. Dr Ogden reviewed Child F at 10:00 on 5th August 2015 and exchanged his intravenous longline. A new prescription for TPN was written by Dr Ventress and PN was started using the new longline at 12:00 (unclear whether the new PN was used at this time, but that is considered likely). A second CRP test taken at 07:22 on 6th August 2015 was 40 mg/l.

134. Dr Beech reviewed Child F at 17:40 on 5th August 2015. TPN was stopped. Blood samples were taken at between 17:40 – 17:56.

135. Child F's blood glucose levels rapidly improved after 17:40. His tachycardia also settled to normal range. Enteral feeds were restarted and intravenous dextrose was reduced further to 10% on 6th August 2015. By 8th August 2015 Child F was tolerating full enteral feeds and his blood glucose levels remained stable.

136. The blood sample that had been collected at around 17:56 on 5th August 2015 was analysed on 12th August 2015 at a laboratory in Liverpool **[INQ0098712§8]**. It showed: "C-Peptide: < 169; Insulin: 671.0; Insulin (SI): 4657" **[INQ0000861]**.

137. Anna Milan, a Clinical Scientist working at the Liverpool Clinical Laboratories confirmed that the c-peptide result recorded on the sample result were recorded as <169 as 169 units of c-peptide represents the lower end of their measuring range. In actual fact, c-peptide was undetectable on the sample that they recorded **[T/9.10.24/8]**. She confirmed that when an insulin molecule is formed naturally in the pancreas it is cleaved equally into one unit of insulin and one unit of c-peptide (equimolar production). As insulin has a short half-life and c-peptide a longer half-life the two appear to have different ratios when tested, with the ratio between c-peptide and insulin usually being 10 to 1 but sometimes 5 to 1. If produced naturally, the ratio between c-peptide and insulin will always be such that the levels of c-peptide exceed the levels of insulin **[T/9.10.24/10-12]**. If insulin is given to the patient exogenously, i.e. via an injection of manufactured insulin, the level of insulin within the body will rise without a corresponding rise in c-peptide. This is because c-peptide is a byproduct when the body produces insulin naturally, it is not present in manufactured insulin and is not created by the body in response to exogenous insulin **[T/9.10.24/10-13]**. Exogenous insulin is given to treat hyperglycaemia and is given in a dose intended to normalise blood glucose without causing hypoglycaemia. These results (very high insulin, undetectable c-peptide), in the presence of hypoglycaemia, suggested to Ms Milan that either too much insulin had been given to a patient who was hyperglycaemic, or that insulin had been given to a patient who did not need insulin **[T/9.10.24/13-16]**.

138. Ms Milan considered that these laboratory results were serious and required investigation by the treating team. She telephoned the CoCH at 16.40 on 12th August 2015 to confirm that the patient from whom the samples had been taken had been hypoglycaemic and to report her findings. In doing so, she would have advised that the results demonstrated exogenous insulin and that it was for the clinical team to investigate how the patient had come to receive the drug **[T/9.10.24/15-18]**.

139. It is notable that amongst the various clinicians and scientists who gave evidence before the Inquiry regarding Child F's blood test results, not one suggested that the test might be unreliable, or that it demonstrated anything other than the fact that exogenous insulin had been administered to Child F. They were unanimous in confirming that this provided proof of deliberate harm. Although he did not give evidence before the Inquiry, a Professor Peter Hindmarsh, Professor of Paediatric Endocrinology and Diabetes at University College Hospital and then a consultant at University

College Hospitals London and Great Ormond Street Hospital, gave evidence at Letby's criminal trial that these results confirmed, beyond reasonable doubt, that Child F was given exogenous insulin.

140. The records confirm that the result was telephoned through to the duty biochemist at CoCH laboratory at 16:40 on 12th August 2015 **[INQ0000862]**: "Low C-Peptide to insulin. ?Exogenous – suggest send sample to Guildford for exogenous insulin". This result was then conveyed to the ward at CoCH by the duty biochemist and was recorded **[INQ0000859/39]**.

141. The Inquiry has been told that Child F's insulin results were received by Dr Kate Lyddon who discussed it with Dr ZA on 13th August 2015 **[INQ0099097§46]**.

142. Dr ZA's statement to the Inquiry explains her thoughts and actions at that time **[INQ0099097§47 - 48]**:

"As the results showed high insulin and low peptide, the results suggest that Child F was given exogenous insulin (i.e. insulin injected externally). This result was very confusing as Child F had not been given prescribed insulin and I checked no other baby on NNU had been prescribed insulin that day, making accidental administration unlikely…I felt that the most likely explanation for the results were some sort of inaccuracy with the test and I would have liked to repeat them, but Child F had no further periods of hypoglycaemia and was transferred back to his local unit…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."

143. In her oral evidence before the Inquiry, Dr ZA candidly accepted that she failed to act in a way that she should have done after being notified of the blood results. She explained this by saying that she could not recognise the possibility that someone might be deliberately harming babies with insulin **[T/7.10.24/36-37]**. When questioned further she accepted that she failed to take any steps to confirm whether there was a possibility that the test results might be an error and accepted that she should have appreciated that insofar as they demonstrated that Child F had suffered hypoglycaemia after receiving exogenous insulin which had not been prescribed to him the results should have caused her to be concerned about the possibility that a major safety incident had occurred, either deliberate or due to a serious failure in care. She confirmed that she was unaware that the results had prompted a senior scientist at the Liverpool laboratory to telephone the CoCH. She could not recall any other occasions when an insulin result had prompted a clinical scientist to telephone the hospital to notify them **[T/7.10.24/73-74]**. The Families will say that Dr ZA's failure to act in response to the abnormal insulin results cannot reasonably be explained by the improbability in her mind that this was a case of deliberate harm. More likely, she demonstrated a lack of interest or curiosity as to why those results were so abnormal, influenced by the fact that Child F had recovered and that the danger appeared to have passed. This was a basic failure in

care that would have profound consequences for the children who were cared for by Letby thereafter. It represents a bright line in the chronology when a clear opportunity to stop Letby was missed.

144. Dr Gibbs and Dr Brearey accept that the failure to recognise the significance of Child F's insulin result (which was noted by the junior doctor in his discharge document) was a collective failure of the paediatric team. **[T/1.10.24/61; T/19.11.24/64]**

145. Ian Harvey, in his evidence, observed that the failure to report or act upon these abnormal results was a substantial failing. He suggested that, had he been aware of this result, it would have entirely altered his approach to Letby subsequently **[INQ0107653§54]**.

146. At the time when Child F's insulin result was noted by Dr Lyddon and discussed with Dr ZA, both Child F and his parents were still on the NNU. He was subsequently transferred to a hospital close to his parent's home on 13th August 2015. There was a missed opportunity to discuss these results with Child F's parents and to reflect further on the causes of Child E's death.

147. The Inquiry has heard that Dr ZA discussed Child E's case with Dr Brearey on 17th August 2015. She told Dr Brearey that Letby had been present on the NNU when Child E died **[INQ0103104§142]**. Dr Brearey's oral evidence to the Inquiry suggests that by around "late August, maybe early September [2015]" when Dr ZA discussed the death of Child E there was growing concern regarding the association of recent neonatal deaths/collapses with Letby, the idea of which was first raised at the meeting on 2nd July 2015 **[T19.11.24/59–64]**. Dr ZA did not discuss the deterioration in Child F's condition with Dr Brearey at this time, nor reflect on the unusual blood test results, nor link the deterioration in Child F, the unusual blood results, the death of Child E (his twin) shortly before and the other unusual deaths and collapses that preceded it. The Families struggle to understand why, if suspicions were being voiced, a link was not made with Child F's collapse, he was after all the twin brother of Child E. It is troubling to think that had any curiosity been expressed by Dr ZA it might have prompted Child F's case to be considered alongside others, revealing what would remain hidden for years afterwards, the tell-tale blood test results.

148. The account that suspicions were being voiced on the NNU at this time is consistent with Dr Lambie's recollection of the NNU nursing staff "in a small huddle in the NNU ITU, going through their rota to see if they could identify a single member of staff who was present at all the unexpected collapses and deaths" with one member of staff saying "this is just a horrible thing to think, but we just want to make sure" **[INQ0102683§23]**. Dr Lambie recalls this conversation taking place at around the time she left the NNU, which was on 1st September 2015 **[INQ0102683§23]**.

149. Whilst Child F survived his attack by Letby, he is left with permanent learning disabilities as a result of the protracted period of hypoglycaemia on 5th August 2015.

150. Child E was discussed at the Serious Incident Panel meeting on 13th August 2015 **[INQ0002659/4]**. The likely cause of death was again recorded as NEC, based upon Dr ZA's erroneous diagnosis. No StEIS report was deemed necessary.

151. On 14th August 2015, Dr Gibbs discussed Child C's case with Dr George Kokai (Consultant Paediatric Pathologist). In particular, they discussed the finding of myocardial ischaemia that was found during the post mortem **[INQ0000108/184]**.

152. The Inquiry has heard detailed evidence about this discussion. The Families will submit that Dr Gibbs was clearly not convinced at that stage that the myocardial ischaemia (adequately or satisfactorily) explained Child C's collapse and death **[T/1.10.24/65]**. Mother C recalls him saying to her that he struggled to accept that myocardial ischaemia was the cause of Child C's collapse, preferring instead to see it as a product of the collapse, the prolonged resuscitation and the elongated period over which Child C died. Dr Gibbs accepted that he conveyed this to Parents C when they met them on 21st August 2015 **[T/1.10.24/212]** and again in his letter to them on 24th September 2015 **[INQ0008978/3]**.

153. Dr Kokai issued Child C's final post-mortem report on 19th November 2015 **[INQ0000108/152]**. Dr Kokai concluded that Child C died of 1a: widespread hypoxic/ischaemic damage to heart/myocardium due to; 1b: immaturity of lung (atelectasis, hyaline membrane and fresh bleeding) due to; 1c: severe maternal vascular underperfusion/MVUP.

154. The death of Child C was uploaded to the NHS England's National Reporting and Learning System on 14th August 2015 **[INQ0107009]** as "no harm".

155. The death of Child E was uploaded to the NHS England's National Reporting and Learning System on 24th August 2015 **[INQ0107009]** as "no harm".

156. Dr McPartland (Consultant Paediatric Histopathologist) produced Child D's post mortem report **[INQ0000762/139]** on 26th August 2015, over 2 months after the post mortem examination on 23rd June 2015. Her conclusion of cause of death was "IA: Pneumonia with acute lung injury".

157. Dr McPartland concluded that **[INQ0000762/149]** "I think it is likely that the pneumonia was already present at birth, and is the underlying cause of Child D's initial collapse and ultimate death". This conclusion is inconsistent with Child D's clinical presentation, some features of which were noted in the post-mortem report, including: Child D's normal CRP; negative microbiology tests; negative virology tests for viral infections.

158. As the Families had submitted at the start of this Inquiry, Dr McPartland's post-mortem conclusion differs from the cause of death recorded in CDOP on 16th July 2015 (i.e. complications of delivery) and does not adequately explain Child D's sudden and unexpected death or her unsuccessful resuscitation. The conclusion of overwhelming infection is not consistent with Child D's condition prior to death.

159. When Dr Mecrow (Consultant Paediatrician) was subsequently asked to review Child D's case by Mr Rheinberg (then Senior Coroner for Cheshire) in June 2016 **[INQ0002045/206]**, he highlighted some of the concerning features in Child D's case:

(i) "Child D's death is disturbing, not because I perceive there to be significant deficiencies in her care, but because her collapse was so sudden and unexpected" **[INQ0002045/218§43]**.

(ii) Child D's clinical and biomechanical features were at odds with a diagnosis of septicaemia as a result of pneumonia (a conclusion Dr Mecrow agrees with): (a) cultures failed at any point to identify the presence of bacterial infection; (b) CRP had been normal on two consecutive occasions, which is "very unusual in the face of bacterial infection"; (c) Child D's deterioration and collapse occurred at a time when she had been on antibiotic treatment for over 30 hours. The combination of Gentamicin and Benzylpenicillin are thought to be almost completely effective against neonatal sepsis at or shortly after birth.

(iii) "Quite why Child D should have collapsed and become unwell after a period of more than 24 hours when she seemed to be making good progress is wholly unexplained." **[INQ0002045/219§50]**.

(iv) In conclusion, "Child D's sudden deterioration and collapse were wholly unexpected and unpredictable" **[INQ0002045/222]**.

160. A Level 2 Root Cause Analysis Investigation Report was submitted in relation to Child D on 28th August 2015 **[INQ0014204]**. It comprised of the case review previously undertaken by Dr Brearey and Eirian Powell **[INQ0003299]** and the separate obstetric secondary review. Under the heading "Detection of Incident", it was recorded that:

"The incident [i.e. Child D's death] was escalated to the Medical Director and Director of Nursing and Quality and was subsequently discussed at an extraordinary Executive Serious Incident Panel on 2nd July 2015; there had been three neonatal deaths in a short period of time and the circumstances were discussed to <u>identify any commonality which linked the deaths</u>. Two of the babies had medical conditions which could be <u>clearly seen to have contributed to their deaths</u>. The third baby appeared to be an unexplained death and, at this time, this baby's cause of death was unknown. It was agreed that no further investigation was warranted at this stage as there were <u>no concerns highlighted</u> in the obstetric or neonatal reviews; however the SI Panel were of the opinion that the

Obstetric Secondary Review findings and the Neonatal Review findings should be consolidated into one report on a Level 2 template." (emphasis added)

161. It would appear that the Level 2 report was purely an administrative exercise that consolidated previous reports into one report. It served no real purpose.

162. Insofar as the meeting on 2nd July 2015 was intended to "identify any commonality which linked the deaths", it had clearly failed to achieve that aim. Dr Brearey thinks that instead of asserting that there were "no concern highlighted", it would have been more accurate to say there were "no significant concerns highlighted" since the association with Letby was noted. Dr Brearey described a sense of unease following the meeting on 2nd July 2015 **[INQ0103104§121]** but fails to explain why he failed to do more at the time given his unique position of being a conduit between the clinicians and the managers and having been informed of the concerns raised by his colleagues.

163. The Families will say that it is difficult to understand the comment that "two of the babies had medical conditions which could be clearly seen to have contributed to their deaths". At that time, the deaths of Child A, Child C and Child D were reported to the Coroner with no medical cause of death. At the time of the Level 2 report, only Child D's post-mortem report was available. Child C's post-mortem report was not available until 19th November 2015. Child A's post-mortem report was not available until 18th December 2015.

164. The Board of Directors met on 1st September 2015 **[INQ0014812]**. The recent sharp increase in neonatal mortality was not discussed at the meeting.

165. In September 2015, Child G was a patient on the NNU. She was born at Arrowe Park Hospital in May 2015 and was subsequently transferred to the NNU at CoCH on 13th August 2015. Although at the extremes of prematurity at the time of her birth, Child G had grown considerably over the months that followed. At the time of her collapses, she was approaching her due date and a normal size for a term baby.

At the time of her discharge from APH, Child G was "stable on CPAP pressure 7, in 30-35% oxygen and [was] having one hour BD off and tolerating this well. [Child G] was fully enterally fed 185 ml/kg/day 1 hourly feeds EBM + fortifier via OG tube"

166. Child G, who had been steadily improving and growing on the NNU, collapsed for the first time on 7th September 2015. This date represented an important milestone for Child G and her family, being the 100th day since her birth. Child G's father had fed her a small quantity of expressed breast milk at 22:00 on 6th September 2015, which she drank well. She seemed to be in a good condition, as she had been on previous occasions. Father G left Child G for the night after feeding her. Lucy Letby looked after her that night.

167. Child G suffered repeated collapses in the early hours on 7th September 2015 after a large projectile vomit at around 02:15. The vomit was substantial and said to have projected several feet across the room, away from her cot. During subsequent attempts to resuscitate Child G, 100ml of milk was aspirated from her stomach. The volume of milk taken from Child G's stomach combined with the volume that she had vomited far exceeded the small volume of expressed breast milk that she had been fed **[INQ0103104§158]**.

168. After initial resuscitation efforts, Child G was treated for presumed sepsis with antibiotics. The initial diagnosis (of sepsis) was recorded even though Child G's CRP was (at that point) normal and she had no other signs or symptoms of infection **[INQ0000272/2366; Core Bundle/A596]**.

169. A clinical note made by Dr Harkness at 09:00 on 7th September 2015 recorded the CRP as "< 1" **[INQ0000272/2366; Core Bundle/A596].** Blood samples taken at 14:18 on 7th September 2015 showed CRP at 28 and did not rise to 218 until 07:23 on 9th September 2015, several days following her collapse. Child G's contemporaneous medical records show that all other histology samples collected on or around the day of her collapse (i.e. 7th September 2015) were reported as negative for bacterial growth, including venous blood, CSF, respiratory and urine cultures.

170. Child G's parents were called in the early hours on 7th September 2015 and were told that their child had vomited and aspirated her vomit. They were not told that Child G had had a large projectile vomit. They were told that her blood tests confirmed neonatal sepsis. Father G recalls that his main concern at that time was that his daughter had been left unattended drowning in her own vomit. He was not informed of the important detail that 100 ml of gas or fluid were aspirated from Child G's stomach after she had suffered the substantial vomit. Dr Brearey later described this as "very unusual" but it does not appear to have been noticed at the time **[INQ0103104§158]** and **[T/19.11.24/66-67]**.

171. The Family of Child G would concur that it is highly unusual. The volume of milk aspirated from her stomach combined with the volume vomited across the nursery far exceeded the amount that she had been fed. There was, in short, no good reason why she should have such a volume of milk in her stomach. Letby would subsequently be convicted of causing Child G's collapse by overfeeding her with milk.

172. Had Father or Mother G been informed of the severity and amount of Child G's vomit and aspirate at the time, they would have asked further questions regarding the cause of this sudden and unexpected deterioration.

173. Dr Brearey also reflected in his evidence to the police that although Child G's blood tests showed a raised CRP, he was uncertain whether her sudden collapse could be completely attributed to infection **[INQ0001111/3]**.

174. Child G was transferred to Arrowe Park Hospital on 8th September 2015 where her condition improved quickly. She was transferred back to COCH on 16th September 2015. By the time Child G went back to COCH, she was self-ventilating in room air. She had no respiratory concerns.

175. Child G suffered two further collapses on the next "milestone" date, i.e. 21st September 2015, which was her "due date". At the time of those collapses she was being cared for in Nursery 4 with Letby as her designated nurse.

176. Mother G recalls visiting her daughter on the NNU on 21st September 2015. She was told by Letby to wait in the parents' room as she had to do some tests on Child G. After a while, Mother G heard Child G screaming, so she ran back into the room to make sure that her baby was okay. **[T/01.10.24/77]**

177. Child G suffered two large projectile vomits and period of desaturation at around 10:20 on 21st September 2015. She collapsed again at 15:30 **[INQ0000272/3149; Core Bundle/A619]**.

178. This episode was again put down to sepsis even though negative cultures were again reported and Child G's slightly raised CRP was not considered to support such a diagnosis and was likely a reflection of the reducing level from the very high value of 218 measured at APH two weeks earlier **[INQ0102740§169]**.

179. Child G's parents were not informed that their baby collapsed and stopped breathing on 21st September 2015 **[T/18.09.24/78 & 99]**. They did not learn the full details of the events on that day until the criminal trial.

180. Child G was discharged from COCH on 2nd November 2015. Whilst she survived the repeated attacks by Letby, she is left with permanent life-changing disabilities due to the hypoxic injury to her brain. She has been deprived of the life that she would have had with her loving and devoted parents.

181. On 9th September 2015, Child D's death was uploaded to the NHS England's National Reporting and Learning System as "moderate harm" **[INQ0107009]**. This differed from the categorisation of "severe severity level" recorded in the Obstetric Secondary Review on 28th August 2015.

182. A Perinatal Mortality and Morbidity Reviewing meeting took place on 10th September 2015 **[INQ0034745]**. The deaths of Child D and another baby were discussed at this meeting. The skin

rash seen on Child D and the sudden and unexpected nature of his collapse and death were not highlighted/discussed. Child D's case was not reviewed in the context of previous and subsequent deaths. Child E's case was not discussed at the meeting due to lack of time.

183. A Cheshire and Merseyside Neonatal Network Clinical Effectiveness Group meeting took place on 16th September 2015 **[INQ0005531/5]**. In respect of the CoCH, it was noted that "Mortality: 3 deaths under review will be discussed at subsequent CEGs". These are the three deaths referred to in Dr Brearey's Incident and Mortality report (dated 9th September 2015) **[INQ0103118]**. It is not clear which of the indictment babies were included in this statistic.

184. On the same day, Dr Brearey attended a Steering Group meeting **[INQ0005538]** where the increased mortality on the CoCH NNU was again not discussed, even though the role of the Steering Group was to monitor performance and identify variation in clinical outcomes, which would include neonatal mortality **[INQ0102685§13]**.

185. Dr Brearey recalls having an informal discussion with Dr Subhedar after the meetings about the five deaths that had occurred since June 2015 (a non-indictment baby had died on 4th September 2015) and recalls that Dr Subhedar was "supportive but did not suggest anything else I should be doing" **[INQ0103104§166]**.

186. A Local Safeguarding Children Board meeting took place on 18th September 2015 **[INQ0013193]**. Neonatal mortality on the NNU was not discussed.

187. Child H was born in September 2015 at 34 weeks and four days gestation, weighing 2.33 kg.

188. Child H was the first child of her parents. She was delivered by Caesarean section due to maternal diabetes. She had initial respiratory difficulties due to her stiff premature lungs during the first 2 days of life requiring CPAP and then BiPAP to reduce her work of breathing. She continued to improve and between 02:00 and 04:00 on 24th September 2015 she was changed back to CPAP (indicating that she was needing less support with breathing) and she no longer required supplemental oxygen **[INQ0102740§181]].**

189. Child H suffered a series of deteriorations/collapses between 24th and 27th September 2015.

190. Child H deteriorated on 24th September 2015 at 07:00 requiring ventilation, again at 09:00 requiring a chest drain for pneumothorax, then on 25th September 2015 at 01:14 requiring a second chest drain, at 16:45 requiring an endotracheal tube change and again due to recurrence of the pneumothorax requiring a third chest drain in the early hours of 26th September 2015.

191. When Child H was first taken to the NNU Mother H had been prevented from going with her. She was still on the labour ward and recovering from surgery and, once she refused to wait until the next morning, was told that she was required to be able to *"get up, get dressed and walk"* before she could go to the NNU **[T/19.11.24/28]**. It took several hours before she was fit enough to do so, and she was eventually assisted to attend in a wheelchair. Child H was receiving breathing support with CPAP but she was described as stable, and Mother H was able to hold her daughter for a short period before returning to the maternity ward

192. On the morning of 24th September 2015 Mother H was still confined to a wheelchair and obliged to wait until a family member attended the hospital before she was allowed to revisit the NNU. When she arrived at the NNU, she saw at once that she had deteriorated and been ventilated since her visit the previous evening. No one had informed her or anyone else in the family about those events. She reacted with entirely understandable bewilderment **[T/19.09.24/12-13]**

"I asked the doctor what was going on and I was told that she had been put on a ventilator. I really couldn't understand why I'd not been informed of this earlier because we were told that she was okay. You know, I'd always check and would always ask how she was, and we were told that she was okay, you know, that she was okay. I was only upstairs. I knew they were busy but if it was something that significant to me, a ventilator sounds like a really scary and a really big change and there was no indication that that was going to happen that we were told of. You know, they never said, "Oh she's going to need maybe, you know, more breathing support or to need extra care".

193. Mother H queried why there had been a failure to involve her in the important developments of Child H's treatments and – when no explanation was forthcoming – sought the assistance of PALS. PALS then facilitated a conversation between the family and Dr Gibbs later on the same day in which he offered an entirely appropriate apology and undertook that there would be more timely communication in the future.

194. Eirian Powell's reaction to that same complaint was, to the contrary, entirely inappropriate but revelatory of her managerial style and operating sympathies. In an email to Dr Gibbs and copied to the PALS representative **[INQ0030106]** she simultaneously both: blamed Mother H for the communication failure; whilst reserving all her empathy for a nurse involved in the events,

"My question as an addendum is why had it taken mum so long to come to the unit when she was aware how poorly her baby is. (just a thought) especially as she is an inpatient or even ask the midwife to ring/use her mobile for an update. I have spoken to Belinda and Nurse W as you can imagine Nurse W is upset that she has tried her best — only to receive this complaint."

195. As the days passed, Mother H was finding her prolonged separation from Child H distressing as they both continued to receive treatment, particularly whilst surrounded with other mothers who

had their children at their bedsides. She moved into a side-room to give her some privacy **[T/19.9.24/25].** Late on the 26th September she was hurriedly taken back down to the NNU after Child H collapsed again Mother H recalls a conversation with Dr Gibbs in the early hours of the next morning after Child H had been resuscitated. Dr Gibbs was unable to explain why Child H had (repeatedly) collapsed. **[T/19.9.24/28-29]**

196. She went on to suffer two more collapses, the first at 21:15 on 26th September 2015 associated with a blocked endotracheal tube and the second around 01:05 on 27th September 2015 for which the cause was uncertain. **[INQ0102740§191]**

197. At Mother H's request, Child H was transferred to Arrowe Park Hospital on 27th September 2015 after which she made good progress. No cause for Child H's collapses were found by the doctors caring for her at APH. Mother H recalls that Child H stabilised in the ambulance en route to Arrowe Park and that "she was a completely different baby". **[T/19.09.24/38]**

198. Mother H recalls that after Child H was taken in the ambulance for her transfer, Letby handed her a red box with a bear on top of it. Inside the box was Child H's CPAP hat, hospital band and cot card from COCH, and a note "for mummy and daddy" written by Letby. Mother H found this behaviour odd at the time since Child H had survived. **[T/19.09.24/35]**

199. Child H was transferred back to the COCH after two nights at APH. When she was put into her cot, Mother H recalls someone commenting "that's the cot of doom" and "let's not put her back in there". **[T.19.09.24/39]**

200. Child H's collapses were unexpected. The circumstances of her collapses were unusual.

201. Dr Gibbs observed in his statement to the police that "it was unusual for an infant to have experienced as many sudden deteriorations (collapses) as occurred in Child H over a relatively short period of time." **[INQ0102740§191]**

202. Dr Gibbs further commented in his statement to the Inquiry that "Although there were potential explanations for Child H's collapses, it was strange on reflection that no further collapses or any problems with her chest drains occurred after she was transferred to Arrowe Park Hospital on 27th September 2015" **[INQ0102740§192]**.

203. Dr Jayaram and Dr Gibbs both noticed that Letby had been the nurse caring for Child H when they were called in to resuscitate her on consecutive nights. They and other consultants on the NNU were aware of Letby's involvement in several of the deaths that had occurred on the NNU during the previous few months, and "over time this continued association caused increasing concern" **[INQ0102740§193]**.

204. The Families note that this observation within Dr Gibb's witness statement is only partially consistent with his oral evidence before the Inquiry that he became aware of suspicions regarding Letby's presence at the time of collapses or deaths in late 2015 or early 2016. It is consistent with Dr Lambie's evidence that discussions were taking place within the unit before 1 September 2015 about the possibility that one individual was present for all of the cases **[T/2.10.24/27]**. It is consistent with Dr Brearey's evidence that the association between Letby and the unusual events on the NNU had been raised with him prior to August 2015 and that Dr ZA referred to it when discussing the death of Child E.

205. This interpretation is also consistent with other evidence about the level of concern within the unit about the number of deaths and collapses on the NNU: Dr Newby observed in her statement to the Inquiry that "I was extremely concerned about the number of deaths and collapses on the neonatal unit as we were all as a group of consultants… Dr Gibbs, Dr Brearey and/or Dr Jayram expressed their suspicions regarding Lucy Letby to me around October 2015 and discussed their intent to raise this with the Hospital." **[INQ0101317§63]**.

206. On 1st October 2015, Dr Brearey produced an Incident Review on Child E even though he was not on duty at the time of Child E's death **[INQ0003296]**. Dr Brearey concluded that "[Child E] is likely to have died from a perforated bowel secondary to NEC. Neonatal care was appropriate and record keeping of a high standard…". Dr Brearey failed to note Child E's radiological and clinical presentations which contradicted a diagnosis of NEC and, on the face of things, appeared to accept Dr ZA's erroneous diagnosis without closer analysis. In this regard, the Incident Review was inadequate and served little purpose. Even though there was a clear concern regarding the incidents of deaths and collapses on the NNU at this time, Dr Brearey failed to consider the need to review all of the cases together. The Families would repeat that the persisting failure to analyse the cases in a consistent or holistic way was a missed opportunity to identify that they were the product of deliberate harm.

207. A tabletop meeting took place in relation to Child D's case on 12th October 2015 following receipt of her post mortem report **[INQ0003299/10]**. No further action was taken.

208. Child I, was born in August 2015, collapsed on 30th September 2015, 13th October 2015, and 23rd October 2015. She died following her final collapse on 23rd October 2015.

209. Child I's death prompted a series of actions on the NNU. Dr Gibbs reported her death to the Coroner because he could not understand why it had happened.

210. In his oral evidence to the Inquiry, Dr Jayaram recalled that "When I returned to work in early November 2015 and became aware of the death of Child I, and the repeated associated presence

of Letby, I became concerned for the first time that Letby could somehow be causing inadvertent or even deliberate harm." [T/13.11.24/34]

211. When asked about Dr Jayaram's view during the hearing, Dr Brearey confirmed that he too had serious concerns around the time of Child I's death, saying: "It was certainly a significant moment that raised my level of concern quite considerably. The -the nature of her care, having come from Liverpool Women's Hospital, being relatively mature when she arrived with us, then having abdominal problems and having to go back to Liverpool Women's Hospital with assumed necrotised enterocolitis where she stabilised for a week, then coming back to Chester and then deteriorating on a number of occasions, before going to Arrowe Park, recovering very quickly and coming back to Chester again, before having the same problems again, and collapsing and dying, to me set a few alarm bells going." [T/19.11.24/71]

212. There is evidence to confirm that Letby's association with the deaths and collapses that had been occurring over the preceding months was being discussed at a senior level in the NNU following Child I's death on 23rd October 2015. The Families would observe that given Dr Lambie's evidence (see above) it is likely that discussions were occurring substantially before this date. Dr Lambie worked at CoCH between 27 April 2015 and 1 September 2015, so would not have been present in the NNU to see discussions taking place beyond that date **[T/2.10.24/2]**.

213. Dr Brearey contacted Eirian Powell on 23rd October 2015 and discussed his concerns regarding Child I's case and the association with Letby **[INQ0103104§169]**.

214. Eirian Powell's actions from this point onwards are likely to have been motivated by her close relationship with Letby and her bias in her favour. It is suggested that Eirian Powell's management of the NNU was uneven, with divisions between those who were favoured by her and those who were not. Letby undoubtedly fell into the category of favourite. Eirian Powell's management of both the morphine overdose error that occurred in July 2013 and thereafter the complaint raised by Nurse W evidence how Letby was treated more leniently and favourably even when obvious and serious mistakes had been made. This is likely to have affected her independence of thought when it became apparent that Letby was the common denominator in the unusual pattern of deaths and collapses on the NNU.

215. Eirian Powell emailed Dr Brearey on the same day attaching a document titled "Neonatal Mortality 2015" **[INQ0003189]** with Letby's name highlighted in red in each of the considered cases. In her email, Eirian Powell confirmed that "it is unfortunate that she was on – however each cause of death was different, some were poorly prior to their arrival on the unit and other were ?NEC or gastric bleeding/congenital abnormalities."

216. Eirian Powell's assessment, which has been repeated in the media since she gave evidence, is superficial and provides little by way of helpful analysis. Closer analysis of the cases should have revealed to her that the causes of death were unascertained, that the affected babies were not suffering from 'congenital abnormalities', that whilst some of the babies were unwell at the time of their admission to the NNU, they were improving by the time of their collapses, that their collapses and deaths were sudden, unexpected and unexplained, that the diagnosis of NEC in the case of Child E was incorrect and that his gastric bleeding was inconsistent with his given cause of death and unexplained. Her assessment either ignored or failed to understand that the collapses and deaths involved features that were highly unusual and perceived to be by those involved in the care provided to the affected babies, including but not limited to unusual skin discolouration. In providing this document Eirian Powell either lacked the skills or information to properly understand the issues and concerns underpinning the recent collapses and deaths or her judgement was clouded by her bias towards Letby and an inability to acknowledge the direction that the investigation was taken. Possibly both factors were at play.

217. By 27th October 2015, Eirian Powell had spoken to Debbie Peacock. They decided that "it was necessary to create a table that includes all the doctors that was involved with the deceased patients on the unit…Debbie was of the same opinion that we did not think there was a connection…" **[INQ0003107]**. This process did not, as a matter of fact, reveal that any particular doctor had been present at all of the collapses or deaths. It is obvious that some doctors, Dr Gibbs and Dr Harkness for example, were present following a number of the collapses but this was of questionable relevance given that they attended to assess the patients following deteriorations in their condition, or to provide resuscitation after they had collapsed. The Families regard this observation by Eirian Powell and Ms Peacock as an attempt to divert attention away from the possibility that a member of nursing staff might be responsible for the collapses and instead seek to shift the focus onto the doctors on the NNU. This was likely motivated by conscious or subconscious bias towards Letby in particular and nurses in general and a sense of antipathy towards the doctors. It is not suggested that there was a deliberate attempt by either to cover up criminal behaviour.

218. The Families would observe that this period marked the beginning of clear tribal divisions between doctors and nurses, with doctors noticing that the nursing staff's attitude towards them changed. The nurses prioritised defending Letby, led in no small part by Eirian Powell. This would prove to be the enemy of patient safety in this context and hindered a balanced and objective assessment of the facts. These reactions were to some extent predictable given human factors and it is equally predictable that they will impair objective and even handed assessment of risk in other contexts. The Families will however say that the senior nursing staff within the hospital, from Eirian Powell upwards, owed a responsibility to rise above tribal loyalties and to maintain an open mind to the concerns being raised.

219. Dr Brearey performed a "Mortality Review" of Child I's death on 31st October 2015 **[INQ0003286]**.

220. In his statement to the Inquiry, Dr Jayaram explained that **[INQ0107962§347]** "From November 2015 onwards I had several informal "corridor conversations" with both Dr Brearey and other consultant colleagues about our concerns regarding the association with Letby and these events although not in any recorded meetings. The thematic review had not identified any themes in terms of <u>clinical practice</u> that could have explained the increased rate of deaths and as time went on without any clear explanation for these events, I felt that I had to escalate our concerns around the association with Letby even in the absence of direct evidence…" (emphasis added)

221. The Families will submit that the consultants were clearly aware of a "theme" of unexpected and unexplained deaths and collapses with an apparent association with Letby by this time. Regardless of whether they did or ought to have suspected deliberate harm, they should have realised that previous informal discussions and clinical/case note reviews of cases were insufficient and could not be relied upon to assure them that patients on the NNU were safe. The Families will say that the only appropriate action to be taken, once the suspicion that harm might be caused deliberately, was through a defined safeguarding route with a special emphasis on protecting the safety of children being treated within the NNU. The Families will say that this should have involved interactions with senior management within the CoCH and with the police leading to a robust safeguarding strategy. Inevitably this would have involved removing Letby from the NNU whilst investigations were undertaken, which would have prevented further crimes, as a matter of fact it did following her transfer from the NNU in 2016.

222. Child J was born at the CoCH in late October 2015 at 32 weeks + 2 days gestation. Mother J and Father J's journey to parenthood was long and difficult. A family history of a rare genetic disorder necessitated extensive testing before they could safely attempt to conceive. They felt 'truly blessed' when they discovered that, with the assistance of IVF, they had conceived twins. During the course of her pregnancy, Mother J discovered that her twins were affected by twin-to-twin transfusion syndrome, a condition that could potentially lead to the death of one or both twins. She underwent laser ablation surgery in July 2015 at King's College Hospital, London, in an attempt to prevent the loss of both twins. Sadly, this resulted in the death of one of the twins, leaving Mother and Father J grief stricken and filled with apprehension for their surviving twin. As Mother J recovered in the Labour Ward, she was visited by a neonatal nurse who asked what name should be recorded on the death certificate for Child J's twin sibling. Mother J was wholly unprepared for this untimely question and respectfully invites the Inquiry to include this event in any consideration of recommendations directed at improving the care of bereaved parents, in her words: *'We are sharing this information in case it helps the NHS to prepare parents going through a similar pregnancy to ours, so parents can make some decisions earlier in the pregnancy to remove making important decisions so soon after giving birth when they could be experiencing extremely stressful circumstances and uncertainty'* **[T/23.09.24/9-10]**.

223. Child J was initially stable. However, upon discovery of a necrotic and perforated bowel she was transferred to Alder Hey for surgical intervention on 1st November 2015. Mother J had to remain in Chester and described feeling '*incredibly upset and isolated and just removed from something that was so serious and our daughter is so precious that I felt pretty helpless.'* **[T/23.09.24/11]** Mother and Father J observe that whilst the separation of a mother from her new-born is sometimes unavoidable the consequent anguish could be easily mitigated by the use of audio visual technology to diminish the sense of isolation.

224. Child J underwent a bowel resection and ileostomy and was fitted with a bag and intravenous catheter (Broviac line) at AHCH. During their daughter's time at Alder Hey, Mother and Father J were impressed by the staff's attention to detail, meticulous record-keeping and willingness to involve the parents in clinical discussions about their daughter.

Phase Two: November 2015 – July 2016

225. On 1st November 2015, Dr Sara Brigham, a Consultant Obstetrician and Gynaecologist at CoCH produced her misleadingly entitled report "Review of neonatal deaths and still births at Countess of Chester Hospital – January 2015 to November 2015" **[INQ0003589]**. The document considered the rise in perinatal mortality in 2015 from a purely obstetric (rather than paediatric) perspective and, unsurprisingly, found no common cause. The Brigham report provided a missed opportunity to properly investigate the rise in neonatal mortality and morbidity at the NNU by reference to other potential causes. Given the interval of time between the births of most of the affected babies and their collapses and deaths it should have been plain that causes arising during their time on the NNU should be considered alongside potential factors with obstetric care. The title of the document had the potential to mislead in suggesting that all relevant factors had been looked at, including causes arising during the neonatal period.

226. Child J recovered well in Alder-Hey and was returned to the CoCH on the 10th November 2015. Child J's condition was stable thereafter and she made slow but steady progress. She had no respiratory problems or other complications and by the time that she was two and a half weeks old she was receiving her feeds by bottle. Although her care could at times be challenging, her condition did not cause concern to those who were treating her at the CoCH.

227. Child J's parents were not impressed by the standard of nursing care and attention their daughter received at Chester and felt excluded from important clinical communications. They told the Inquiry: '*it may not be perceived by the hospital as an important thing to have the parents involved because the care is in their hands, but actually for us to be present and so heavily involved I think it would have helped if everybody, the nurses and doctors, were there at the time.*' **[T/23.09.24/71].**

Father J also observed that electronic media could and should be used to facilitate regular and inclusive communications between parents, surgical centres, and district hospitals.

228. Child J had a stoma and a Broviac line, a central line, which needed to be kept clean. They had been advised that if the Broviac line became contaminated it might cause Child J to develop an infection, which they understood could have serious consequences for her. Mother J recalled that she went into Nursery 2 on 15th November 2015 and found Child J in the cot with just a small towel over her and her stoma bag detached. She was covered in faeces. This disgusted and concerned Mother J about the standard of care being provided to her daughter **[T/23.09.24/44-45]**. They later discovered that Letby was their daughter's designated nurse on that shift **[T/23.09.24/88]**.

229. When Mother and Father J complained about this incident they felt ignored and patronised by the nurse with whom they raised this and by Dr Saladi. Although they knew of PALS, they feared that raising a formal complaint might not be in the family's best interests: *'I think we felt at the time that if we had shared our concerns with PALS, that with being on the ward for such long periods of time that we were working with the nurses and if they felt criticised then we thought that that would damage the relationships further and we didn't really want to do that'* **[T/23.09.24/40].**

230. By 16th November 2015 the medical notes reflect that Child J was well; she was in air with 100% oxygen saturations and her temperature, heart rate and respiration were healthy.

231. The paediatric team held a Neonatal Mortality Meeting on 26th November 2015. Dr Brearey could not recall anyone raising concerns about the number of deaths on the NNU at the meeting and positively excluded the possibility that the issue of a connection between the deaths and Letby arose, rather the meeting focussed on learning and quality improvement in the specific cases discussed. It seems that pressure of time precluded the clinicians from considering the case of Child E. The meeting did, however, result in the decision for "*SB to take case to neonatal network and surgical case review*" **[INQ0103121]** which resulted in the "tabletop" meeting at Alder Hey on 26th February 2016. Given the weight of evidence as to concerns being expressed by this date both in respect of the rise in neonatal mortality and Letby's presence during the relevant events it is perhaps surprising that nobody mentioned it during the meeting. In not considering the case of Child E there was a lost opportunity to challenge the erroneous diagnosis of NEC or consider whether common features might have explained the unexpected collapse suffered by his brother, Child F, shortly afterwards. Even a superficial assessment of Child F's medical records would have revealed the suspicious insulin blood test results and directed the meeting towards the suspicion that he had been poisoned with insulin. It is plausible that the way in which the meeting was conducted directed those present away from the question of whether there were suspicious or concerning features surrounding the collapses and deaths or did not provide a proper environment in which suspicions or concerns could be aired. If that were the case, then it highlights the inadequacy of systems in place within the hospital to review child death and examine safeguarding

issues. If those issues were not mentioned or considered it would suggest that those conducting the meeting applied a cursory or superficial analysis of the issues and failed to engage with concerns that must, by then, have been embedded in the minds of those working on the NNU.

232. Child J, who had been doing well until that point and improving suffered a series of unexplained collapses in the early hours of 27th November 2015. She would also suffer further collapses on 17th December 2015. On both occasions Letby was her designated nurse, responsible for caring for her during the night shift.

233. The events on 27th November 2015 involved Child J suffering two sudden and unexpected desaturations which required her to be resuscitated. The second desaturation caused her to suffer seizures. She had not suffered seizures before and these collapses were at odds with her condition in the period that preceded them. She had previously presented as a lively, alert, engaging baby, almost ready to go home. The collapse was unexpected and had no obvious cause. The collapses occurred because Letby attempted to murder Child J. Although the jury trying the case could not reach a verdict on this issue, Child J's parents have no doubt that this is what occurred.

234. Dr Jayaram recalled in his evidence before the Inquiry that from November 2015 onwards he had several informal 'corridor conversations' with Dr Brearey and with his other consultant colleagues about their concerns regarding the association with Letby and the events: "The thematic review had not identified any themes in terms of clinical practice that could have explained the increased rate of deaths and as time went on without any clear explanation for these events, I felt that I had to escalate our concerns around the association with Letby even in the absence of direct evidence. I cannot give any specific dates or times of all of the discussions" **[INQ0107962§347]**. [RR: This has already been discussed in paragraph 219. Should only keep one?]

235. Dr Brigham's report (above) was presented at the Quality, Safety and Patient Experience Committee (QSPEC) meeting on 14 December 2015. No neonatal doctors or nurses were invited to the review. Dr Brearey was unaware that the review had taken place and only received the report when prompted to request a copy having been approached by Dr Jo Davies (Consultant Obstetrician and Gynaecologist) in a corridor in December 2015. Dr Davies suggested that the neonatal team undertake a similar neonatal review. It is submitted that the exclusion of the paediatricians from the process, for whatever reason, inevitably meant that the review would fail in its stated purpose to 'independently review all of the cases to identify any common themes, trends and lessons to be learnt.' **[INQ0003589]**. It probably also significantly contributed to the delay in undertaking any review of the neonatal care of the babies who died during 2015 and may have given the false impression that a more comprehensive review had been undertaken.

236. On 18th December 2015, the Child Death Overview Panel met to discuss Child E. The Panel concluded that; "*Cause of death: Prematurity, Necrotising Entrecholitis (gut infection)*" and "*This*

was an expected death category 8, with no modifiable factors being identified". No recommendations were made **[INQ0012189]**. The panel do not appear to have applied any critical thought to the question of whether the diagnosis of NEC was correct, nor taken into account the apparently rapid and unexpected deterioration in Child E's condition. A more in depth analysis of the case would have revealed that the diagnosis of NEC was erroneous (see above), which would have prompted, it is hoped, a more reflective analysis of the events leading up to his death. As Child E was a twin, it is plausible that a more critical review of Child E's cause of death might have encompassed a review of Child F's medical records, providing a further opportunity to identify his unexplained hypoglycaemia and suspicious blood test results.

237. It is axiomatic that, had a post-mortem examination been performed on Child E, the cause of death identified by the panel would have been excluded.

238. The 18th December 2015 review is a further example, within a long chronology, of missed opportunities to identify that the rise in mortality in the NNU was the product of deliberate harm by Letby. It enabled Letby to continue to harm babies in 2016.

239. An inquest into the death of Child A was opened and adjourned on 23 December 2015 **[INQ0008927/5]**.

240. Nicholas Rheinberg, Senior Coroner for Cheshire, wrote to Mother D and Father D's solicitors on 11 January 2016 confirming that he intended to hold a full inquest into the death of Child D. The Family of Child D will say that this decision was prompted by their applications to him in writing, raising concerns about the standard of care provided to Child D. It was not initiated by information passed to the Coroner by the CoCH. Indeed, CoCH continued to maintain that Child D died from natural causes and that there were no concerns surrounding the care provided to her.

241. On 19th January 2016, Dr Brearey received an amended version of the tabular schedule entitled 'Neonatal Mortality January 2015-January 2016' attached to an email from Eirian Powell. The table contained details of 9 deaths including purported '*Cause of death*' and the identity of the corresponding designated nurse ('*Staff allocated*') and other nurses present within the Unit at the time of death ('*Staff on duty')* **[INQ0001933]**.

242. On 6th February 2016, a neonatal 'Thematic Review' meeting was held with the stated aim of reviewing the '*cases again as a multidisciplinary team with an external reviewer and tertiary level neonatologist to assess: • Were all action points completed? • Any new areas of care improvement • **Any possible common themes***?' (emphasis added).

243. In his oral evidence before the Inquiry, Dr Brearey explained that he had an increasing level of concern about mortality and the association between sudden collapses and Letby's presence. He

thought that there was a need for some external objectivity to provide a 'sense check' hence the involvement of Dr Subhedar **[T/19.11.24/108]**. He did not tell Dr Subhedar about his suspicions or concerns about Letby, although according to his evidence, he already had them by this time and had discussed them with Eirian Powell.

244. The local clinical staff were represented at that meeting by Dr Brearey and Dr V and joined by Doctor Subhedar from the Liverpool Women's Hospital. The nursing staff were represented by Eirian Powell, Anne Murphy (Lead nurse Children's services) and Nurse Laura Eagles. Debbie Peacock attended in the role Quality Improvement Facilitator. The pharmacist Dr Christopher Green, who was later to feature in Letby's Grievance Proceedings, was invited but did not attend. Although it has not been confirmed, an invitation may have been extended to Dr Green because of concerns raised by Dr Brearey regarding the role of the pharmacy in providing appropriate and timely antibiotic therapy to Child D. It was suggested that this formed the basis of a dispute between Dr Brearey and Dr Green and led to a degree of animosity between them (see below).

245. The review noted that 6 of the babies considered had suffered cardiac arrests in the period between midnight and 0400hrs. In his evidence before the Inquiry, Dr Brearey explained that the timing of the collapses appeared to him to be significant: *"because if babies had collapsed due to natural causes then this would be expected to occur at any time of day or night"* **[INQ0103104§199]**. If correct this can only mean that the timing of the collapses raised in Dr Brearey's mind the suspicion that the collapses had an unnatural cause. It is difficult to see this as anything other than a suggestion that the collapses were caused by human intervention.

246. It was determined that Dr Brearey and Eirian Powell would '*review all the cases focusing on nursing observations in the 4 hours before the arrests… to identify if unwell babies could have been identified earlier [and]* ***Identify any medical or nursing staff association with these cases****.*'(emphasis added) **[INQ0003217]**. Dr Brearey recalled that they hoped that this would provide reassurance that nothing important had been missed by staff. The plan was to complete the report as a matter of urgency and send it to Alison Kelly and Ian Harvey alongside a request for an urgent meeting **[INQ0103104§200]**.

247. Dr Brearey recalled that he provided a copy of the draft report to Dr Subhedar who suggested that they include within it the theme that a higher than expected proportion of babies experienced sudden and unexpected deteriorations **[INQ0103104§199]**.

248. A team of consultant and junior paediatricians attended a Neonatal Perinatal Morbidity and Mortality meeting relating to Child C (and another baby) on 11th February 2016 to consider, amongst other things, Dr Kokai's identification of the cause of Child C's death. Although the minutes do not evidence any challenge to Dr Kokai's conclusions, Dr Gibbs told the Inquiry that he was '*sceptical about that as the cause of collapse*' (see above). It is unclear whether any discussion

took place at the meeting regarding concerns as to Dr Kokai's conclusions. The Families would question the purpose of the meeting if it did not lead to any critical discussion regarding the validity of Dr Kokai's conclusion of the cause of death for Child C. Given that the meeting took place within the context of the thematic review that was by then almost complete and, obvious suspicions regarding Letby's role in the deaths, it is also surprising that the issue never came up. It may be that the consultants were unwilling to share concerns with junior doctors and the junior doctors, if they had concerns, were unwilling to speak up. If either or both are true the meeting would have been a surreal exercise with no credible purpose.

249. The review document was emailed to Ian Harvey on 15th February 2016. Dr Brearey described this as an escalation and told the Inquiry that at this juncture he had collated what he regarded as '*quite convincing circumstantial evidence and, you know, we needed help with it. So that's -- that's why we -- we asked for that support and advice*' **[T.19.11.24/227]**

250. Dr Brearey's email to Ian Harvey enclosing the review appears to have been prompted by an email from Ian Harvey sent during the morning of 15th February 2016. His email enclosing the review does not refer to Letby or to any suspicions that the rise in mortality might be caused by deliberate actions **[INQ0038966]**. His evidence before the Inquiry suggests that he requested a meeting with Alison Kelly and with Ian Harvey at the same time, although this is not referred to in his email to Ian Harvey. The Inquiry will have to consider whether Dr Brearey did, in fact, request a meeting with Ian Harvey and Alison Kelly. If he did request a meeting then, given the subject matter of his email to Mr Harvey he could have expected a prompt response and the opportunity to discuss his concerns in person. If he did not request a meeting he failed to appropriately escalate his concerns. This was the clear plan documented at the time of the earlier thematic review meeting. If Dr Brearey is genuine in describing the concerns being expressed by him and his colleagues by February 2016, urgent safeguarding action was required. If he did not have concerns, he should have done, given the weight of material in his possession by this time.

251. When considering this issue it is important to note that Dr Brearey suggested at various times that some of the emails that he sent during the period between 8th and 15th February 2016 were deleted from his system and could not be retrieved. This evidence should not be viewed in isolation. It was the evidence of Dr Gilby that she also found that important emails had been deleted from her system and could not be retrieved **[T/24.02.25/115 onwards]**. In Dr Gilby's case this fact was subsequently proven at an Employment Tribunal. The Inquiry might take this evidence as corroborating Dr Brearey's account.

252. Child K was born in February 2016 after her mother went into labour at 24 weeks and six days gestation. Mother K would normally have been expected to be admitted to a tertiary centre (level 3) such as Liverpool Women's Hospital or Arrowe Park Hospital. At the time that she went into labour the nearest available tertiary bed was a huge distance away. Given the risk that she might

deliver an extremely premature baby during an ambulance transfer it was determined that admitting her to CoCH was the only reasonable alternative. Child K was born at 25 weeks gestation with Dr Jayaram present at the birth.

253. Although Child K was extremely premature, her clinical condition following birth was essentially normal, in fact good. Her mother received corticosteroids prior to delivery and Child K received surfactant, a drug to protect and improve lung function in premature babies and was commenced on an intravenous dextrose infusion. After an hour she was considered stable and in as good a condition as a baby of that age could be. She was intubated using an endotracheal tube and ventilated before being placed in an incubator in Nursery 1. Letby was the nurse responsible for her care on admission to the NNU, effectively booking her into the unit.

254. Mother and Father K were able to visit their daughter. They were obviously aware that she was tiny. Father K recalls that her whole hand could sit on his thumb, but they were reassured when told that she was 'stable and doing really well' **[T.23.09.24/153]**

255. Lucy Letby attempted to murder Child K by dislodging her breathing tube when she was less than two hours old. Letby was the only nurse in Nursery 1 and was alone with Child K. Dr Jayaram was sitting outside of Nursery 1 writing his notes when he became aware that Letby was alone in the room with her. By this time, he was experiencing significant discomfort about Letby's connection with previous collapses and felt uncomfortable with the idea that she as alone in the room with Child K. To allay his concerns, he decided to go into the room. In evidence before the Inquiry he said: "I didn't walk in to see anything happening, What I walked in was to find a baby clearly deteriorating and then when I went to assess Baby K, the endotracheal tube was dislodged but importantly, the nurse looking after the baby, who I believe ordinarily by this stage would have flagged up this deterioration, because in a baby of this gestation whose oxygen saturations are dropping, the first thing you do is look at the baby, its likely it's a tube problem, not responding at all" **[T/13.11.24/37-38]**. In effect, Dr Jayaram saw Letby standing by whilst Child K's oxygen saturations dropped to a dangerously low level. The alarms on the ventilator were not sounding, having been turned off, and Letby was making no effort to assess or assist Child K or call for help.

256. The endotracheal tube was found to have been pushed down by more than 20%, over 1cm, a substantial distance given the size and fragility of Child K. Lucy Letby interfered with Child K's endotracheal tube on two further occasions on 17th February 2016, at 06.15 hours and at 07.25 hours. Child K was shortly afterwards transferred to Arrowe Park Hospital.

257. Child K died in February 2016 when she was a little over three days old. Mother and Father K are grateful for the compassion extended to them at Arrowe Park Hospital but they observe that bereaved parents may benefit from guidance in the immediate aftermath of their loss. Mother K spoke of the value of spending time with her deceased baby and reflected: *'to have somebody*

maybe say; "You've got the time, don't rush, you haven't got to rush" would help……. Emphasise that time is on your side; that you haven't got a time limit with your baby. There's no pre-conceptions of what you should be doing.' **[T/ 23.09.24/125]**

258. Although Letby was originally charged with the murder of Child K there was insufficient evidence to establish that her attempts to murder Child K resulted in her death. Child K's parents will however always believe that Letby murdered their daughter and took away any chance that she had of surviving.

259. Child K's short time at the CoCH coincided with an inspection of the hospital conducted by the Care Quality Commission between 16th and 19th February 2016. The impending inspection appears to have been a factor in motivating Dr Brearey to provide Mr Harvey with a copy of the thematic review before it had been fully completed **[INQ0103104§210]**.

260. The quality of the evidence of the inspection received by the Inquiry was diminished by the Commission's failure to retain and provide a significant quantity of the documentary material generated in preparation for and at the inspection. The Families are dismayed by this and by the lack of any reasonable explanation for the failure. Letby's crimes were as a matter of fact identified in the public eye within a relatively short time after the inspection took place, and certainly within a timeframe when one would expect an organisation such as the CQC to have retained records. It is impossible to conceive of a reason why an organisation with the responsibilities towards public safety and scrutiny expected of the CQC would not have taken special care to preserve and retain documentation relating to its inspection, given the timing and the magnitude of the crimes subsequently alleged.

261. The Families will say that the CQC failed to discover, let alone address, the causes of harm to infant patients within the NNU in the 8 months that preceded the CQC visit and, remarkably, even during the visit. At the time of the inspection, the CQC had not identified the CoCH as a statistical outlier for the number of annual deaths, in part, because of a time-lag in data collection. It is submitted that this flaw is readily susceptible to remedy. The CQC failed to appreciate or investigate the concerns being expressed by senior consultants within the NNU or indeed even become aware of them. It is staggering to think that an inspection, apparently directed towards understanding whether a hospital was providing adequate and safe care to its patients, would miss such an obvious issue. If the CQC was deliberately misled by the CoCH, or by the individuals working there, that would represent a catastrophic and repugnant failure on the part of the CoCH and highlight the inadequacies in the inspecting body.

262. Helen Caine (CQC, Acute Hospitals Inspector) led the inspection of the Children and Young People's Services at the CoCH in February 2016 and explained that the CQC would expect to have been informed of unexpected or unexplained neonatal deaths through both documentary

advance disclosure and during the on-site inspection interviews, but the CQC were **not** informed of any concerns or suspicions about the events that had been occurred on the NNU at CoCH. Ms Caine was not provided with Dr Brigham's (Obstetrics and Gynaecology) "Review of neonatal deaths and still births at Countess of Chester Hospital – January 2015 to November 2015" or Dr Brearey's Thematic Review or spreadsheets of 'patient harm events' submitted by the Trust to the National Reporting and Learning System and the Strategic Executive Information System. **[T/14.11.24/25-38]**

263. Anne Ford (CQC, Head of Hospital Inspection) assured the Inquiry, that notwithstanding the disclosure failure described by Ms Caine, the hospital staff would have been afforded an opportunity to share concerns with the inspectorate and it was standard practice for all interviewees to be asked: "*Is there anything else that you would like to tell us? Is there anything that we have missed? Is there anything you want to share with us?*" **[T/15.11.24/6]** This evidence was corroborated by Elizabeth Childs (CQC, Specialist Adviser) who reviewed the transcripts of the CQC's interviews with the paediatricians, nurses and unit managers of the Children's and Young People's Services and '*nowhere could I find a comment or the words "Concern", "unexplained", "unexpected" in those notes*.' **[T/14.11.24/149]** It was emphasised, however, that the Commission's objective was to ensure that 'Mortality and Morbidity' processes were properly observed rather than investigating '*individual examples of incidents*'. **[T/14.11.24/33]** The Families have some difficulty in reconciling this statement with the reality of the CQC's role. It is not, or should not be, an organisation concerned only with assessing the merits of administrative exercises. It should have a focus on ensuring that hospitals maintain reasonable patient safety standards. In any event, the exercise of ensuring that processes are properly observed axiomatically involves consideration of the incidents that prompt those processes. That it continues to fail to recognise the dichotomy created by Ms Child's statement is not to the organisation's credit.

264. On 2nd March 2024 Dr Brearey acted on a suggestion made by Dr Subhedar and amended the Thematic Review schedule by adding the theme of '*cases involving babies that suddenly and unexpectedly deteriorate and in whom there was no clear cause for the deterioration/death identified at postmortem'.* Interestingly, although Dr Subhedar had plainly analysed and considered the Thematic Review schedule, he told the Inquiry that, at the time, he did not attach any significance to the inclusion of the '*Staff allocated'* or '*Staff on duty'* elements of the document. When asked what ought to have been done in February 2016, Dr Subhedar stated ' *I think that [I] would escalate the level of concern, had I been Dr Brearey, for example, that the level of concern in my own mind about my concern about the care that is being provided, whether intentionally or unintentionally, that that staff member was providing for the babies at the time*.' **[T/20.11.24/34]**

265. Dr Brearey emailed Eirian Powell on the same date, copying in Dr Jayaram saying: "*I think we still need to talk about Lucy – maybe when you are back and free the three of us can meet to talk about it?"* **[INQ0003114]**. This email provides support for the inference, which can be drawn from other

documents, that issues and concerns regarding Letby were being discussed more explicitly behind the scenes rather than being documented in official emails. It is perhaps understandable that individuals would prefer to discuss serious allegations between themselves, rather than record them in formal emails or documents. This observation however says more about the culture of the CoCH than what should have been done. If concerns were being expressed about the possibility that Letby could be deliberately harming patients, as seems likely by this point in time, this should have triggered a formal safeguarding response. It should not have been left to informal discussions.

266. If a meeting took place following this email it was not attended by Dr Jayaram **[INQ0107962§346]**.

267. On 17th March 2016, having earlier amended the schedule to include the identities of doctors present at the time of the collapses, Eirian Powell invited Alison Kelly to convene a meeting to discuss the Thematic Review. Her email to Alison Kelly does not repeat her earlier comments about the babies or their conditions (see above). It suggests that Alison Kelly was already aware of the review. It highlights commonality with regard to Letby's presence "leading up to or during" the collapses/deaths **[INQ0003089/2]**. In her evidence, Alison Kelly was vague as to when she first became aware of the thematic review. The Families will suggest, from the tone of her email to Alison Kelly on 17th March 2016, that Eirian Powell understood that she was already aware of the review. Alison Kelly undoubtedly received a copy of Dr Brearey's email dated 15th February 2016, which was forwarded to her on the same day by Ian Harvey **[INQ0107704§207]**. The Families will submit that Alison Kelly's evidence with regard to her state of knowledge about the thematic review was unsatisfactory. It is likely that she was aware of the thematic review prior to March 2016 and had discussed it with Eirian Powell. The issue may have been discussed but not documented in the various meetings attended by Alison Kelly in January or February 2016. In her oral evidence, Alison Kelly accepted that she had conversations with Eirian Powell, which were not always documented **[T/25.11.24/218]**. It is submitted that this should guide the Inquiry when considering Eirian Powell's approach to Alison Kelly on 17th March 2016 and the implication that she was not bringing the thematic review to her for the first time.

268. Eirian Powell does not recall contacting Alison Kelly prior to 17th March 2016 but observed in her witness statement that other senior nurses, including Debbie Peacock, Anne Murphy, Karen Rees and Ruth Millward were aware of the concerns being discussed within the thematic review meetings and would have expected them to escalate to Alison Kelly **[INQ0108000§172]**. If this was an assumption on Eirian Powell's part it may have been an unsafe one, as the minutes of the thematic review meeting for 6th February 2016 indicate that Eirian Powell had been tasked with communicating the findings to Alison Kelly (see above). There would be no good reason to wait six weeks before informing Alison Kelly that the thematic review was underway.

269. Letby was taken off the standard mixed night and day shift nursing rota on 7th April 2016 and placed on day shifts only. It was said that this was for '*mentoring reasons and support*'. **[T/19.11.24/127].** Whatever spin was placed on this decision, it is submitted it must have been a consequence of inferences drawn from the thematic review. The decision is consistent with Dr Brearey's recollection that he was struck by the fact that the events occurred during nightshifts when Letby was on duty, which appeared to him to be significant and suspicious (see above). The decision, and the circumstances in which it was taken, are not explicitly documented and therefore obscured. It will be necessary for the Inquiry to draw inferences as to the true reasons. The Families will suggest that the inference to be drawn is obvious, it adds credibility to Dr Brearey's account, calls into question Eirian Powell's account and suggests that discussions behind the scenes of the thematic review were more explicitly directed towards the possibility of deliberate harm than the words recorded within it would suggest. The Families would say that it is likely that a conversation had occurred by this time, prompted by Dr Brearey's earlier email that "we still need to talk about Lucy…" and had led to an informal decision to remove her from working nightshifts and instead move her to dayshifts, where she could be more closely observed.

270. Two days later, on the day shift on 9th April 2016, Letby attempted to murder the twins Child L and Child M.

271. Alison Kelly accepted in oral evidence that the issues arising from the Thematic Review were probably discussed between her and Ian Harvey during their one-to-one meeting on 18th April 2016 **[INQ0003385]** and **[T/25.11.24/232-235]**. The Families note that the record of this conversation references staffing and the need to contact Hill Dickinson Solicitors, a firm who handled litigation claims for clinical incidents rather than employment issues. The Families will say that the logical construction of this note is that Alison Kelly and Ian Harvey were discussing the legal implications of the thematic review highlighting that a single member of staff had been linked to the series of unexpected collapses and deaths. The Families would observe that this does not necessarily mean that Ian Harvey and Alison Kelly appreciated that there was an allegation of deliberate harm but that they did at least appreciate that a connection was being made.

272. Alison Kelly received an email from Dr Brearey on 3rd May 2016, following an email from Alison Kelly cancelling a planned meeting to discuss the Thematic Review. Dr Brearey emailed her again on 4th May 2016 saying: "There is a nurse on the unit who has been present for quite a few of the deaths and other arrests. Eirian has sensibly put her on day shifts only at the moment, but can't do this indefinitely, It would be helpful to meet before she is due to go back on night shifts…" Alison Kelly sent an email to Karen Rees four minutes later saying: "Can you please look into this with Anne M/Eirian – if there is a staff trend here and we have already changed her shift patterns because of this, then this is potentially very serious… I did not notice there was a staff trend!!". She sent a further email to Karen Rees around two hours later saying: "Please see attached (not sure you will have had previous sight of this) Lucy Letby is highlighted in red!! I have not noticed this

when I first reviewed. Can you please look into this as per my previous email…" Karen Rees responded the following morning (5th May 2016) advising Alison Kelly that she would be meeting with Eirian Powell the next day and would discuss it with her then **[INQ0003138]**.

273. Karen Rees met Eirian Powell and Anne Murphy to discuss the Thematic Review. No medical staff attended this meeting. In consequence, Eirian Powell produced a document entitled '*Neonatal Review 2015-16*'. The opening line of the document boldly asserts '*There is no evidence whatsoever against LL other than coincidence*.' [INQ0003243] The document could serve as a Defence Case Statement for Letby and emphasises the point made earlier that divisions had been formed between doctors and nurses on NNU which were actively affecting the objectivity of the investigation and impairing what should have been a straightforward safeguarding assessment.

274. When describing his response to this document Dr Brearey told the Inquiry 'It did concern me, and it did show a lack of objectivity and I was concerned that she had developed this document for assurance with Karen Rees with her lack of neonatal expertise and without discussion with any of the Consultants and the -- the arguments and the summary of this report was essentially what was used in the meeting that we had with Alison Kelly and Ian Harvey the following week on 11 May at which point I did obviously have a chance to argue the case in terms of why I wasn't reassured by any of these items' [**T/19.11.24/126]**

275. Eirian Powell's bias towards Letby undoubtedly affected Alison Kelly's approach to the issue as can be seen from her email exchange with Ian Harvey on 4 May 2016, communicating the news that Letby had been moved her from night shifts to days: "Please see Steve's comments below which alarmed me!!! Since receiving this, I have asked Karen Rees to liaise with Eirian regarding this particular nurse (Eirian further review is attached for info), I am currently reassured that there are no issues but I think this is worthy of a wider review hence our planned meeting" **[INQ0003087**]. Alison Kelly failed to discuss the issues with Dr Brearey and obtain his perspective on things, despite the fact that he had been the one to contact her directly about the issue. Again, this demonstrates that tribal divisions between doctors and nurses affected Ms Kelly's perspective on what should have been an obvious safeguarding or patient safety issue. She appears to have accepted Eirian Powell's reassurances/defence of Letby without applying a broader analysis.

276. On 11th May 2016, Dr Brearey, Eirian Powell and Anne Murphy met with Ian Harvey (Medical Director), Alison Kelly (Director of Nursing) to discuss the sudden, unexpected collapses and deaths within the Unit and Letby's association with the events. In addition to the facts contained within the Thematic Review, Dr Brearey informed the meeting that there had been no collapses or deaths at night since the beginning of April when Letby was moved to day shifts **[T/19.11.24/127]**. The Inquiry heard conflicting accounts of the tone and terms of the discussion. Dr Brearey recalled that he highlighted that the number of deaths that had occurred in 2015 and 2016 were 'exceptional' and that he saw the fact that six of the nine deaths occurred between midnight and

04.00 hours was ‘unusual’. He reported that there seemed to be a disproportionately high number of sudden unexpected collapses on the unit and having reviewed the care provided on multiple occasions, including with the input of an external neonatologist, the only common theme that was apparent was the association with Letby. He recalled making clear that these concerns were shared by his colleagues and were not his in isolation **[INQ0103104§229]**. He recalled that Anne Murphy and Eirian Powell countered the concerns ‘forcibly and with great emotion’ **[INQ0103104§230]**.

277. Anne Murphy had no clear recollection about the meeting when she prepared her Inquiry witness statement in 2024 **[INQ0101325§33]**.

278. Eirian Powell denies that she was ‘defensive’ and suggests that whilst she did not think that Letby was harming babies she could not be certain that she wasn’t and welcomed further reviews. Although an account from Eirian Powell’s perspective and probably not reflective of how others would perceive the way in which she expressed herself, Eirian Powell’s evidence on this point does provide the Inquiry with an insight into the issues being discussed at the meeting. Her account is clear in stating that she felt that she was responding to an allegation that Letby was “harming babies”. The Inquiry should see this as a significant insight into the issues being discussed **[INQ0108000§200]**

279. Alison Kelly provides some support for Dr Brearey’s account, describing Eirian Powell as being ‘vociferous’ in her support of Letby at the meeting **[T/17.10.24/134]]**.

280. The Families submit that Dr Brearey’s account is likely to be accurate, insofar as it is consistent with the tone of Eirian Powell’s recent communications with Karen Rees and Alison Kelly. Significantly, the notes of the meeting include the comments “absolute no issues with nurse” and “circumstantial” **[INQ0003181; INQ0015537]**. These accord with language used by Eirian Powell in her review document (see above) and according to the evidence of Dr Brearey were direct quotes from Anne Murphy and Eirian Powell **[INQ0103104§230]**.

281. Dr Brearey recalled that Alison Kelly and Ian Harvey appeared quite passive at the meeting and that no decisive action was recommended, save for the suggestion that they might meet again before Letby recommenced her night shifts **[INQ0103104§232]**. This is consistent with the action plan formulated following the meeting. Given the evidence of their previous exchanges and meetings between Alison Kelly and Karen Rees, it is likely that Alison Kelly and Ian Harvey had prejudged the issue and the action that they planned to take before hearing Dr Brearey’s concerns. Their approach is not consistent with a reasonable safeguarding approach, which should have prompted more decisive action in response. Both should have been open-minded to the concerns being raised by Dr Brearey. As things stood it is likely that they were influenced by Eirian Powell’s strident defence of Letby, supported by Anne Murphy.

282. The Families, especially the Family of Child O and Child P will say that this meeting was a missed opportunity to take decisive action to prevent Letby causing further harm. Properly conducted, the meeting should have adopted safeguarding and patient safety as its priority. The issues that had been raised were clearly directed towards the possibility that Letby was the cause of the spate of sudden collapses and deaths on the unit. Having been raised, the appropriate response to this issue should have been to take decisive action to protect patients on the unit from further harm. This should not have involved a decision to 'wait and see' or a plan to arrange for further discussion in the future. Letby should have been removed from the unit whilst investigations were conducted. The decision should not have been swayed by emotion but Ian Harvey and Alison Kelly should have recognised that, whatever the status of the evidence at that time, the possibility of deliberate harm could not be ruled out without further investigation. Given the primacy that should have been accorded to patient safety, the *possibility* of deliberate harm of vulnerable babies should have mandated immediate action and removal of the common denominator. The Families will say that it should have been obvious that the only way to manage risk whilst that process was undertaken would be to ensure that Letby did not have further patient contact.

283. On 16th May 2016, Dr Brearey emailed his paediatric consultant colleagues (copying in Eirian Powell and Anne Murphy) urging '*If you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on NNU, please could you let me and Eirian know. We will keep a record of these cases and review them as soon as practicable.*' **[INQ0005721]**.

284. Dr Jayaram recalled in his evidence to the Inquiry that he is certain that Dr Brearey, Dr ZA and Dr Gibbs shared his concerns about the link between Letby and the deaths but did not think that the whole consultant body had yet appreciated that the connection was a significant one **[INQ0107962§381]**.

285. Dr Jayaram believed that there were discussions amongst the consultants at this time about the possibility of involving the police in investigations but that the consensus was that without executive support and in the absence of direct evidence they would not be believed **[INQ0107962§383]**.

286. The Families will say that the content of Dr Brearey's email is consistent with the inference that the conclusion reached by Ian Harvey and Alison Kelly at the meeting on 11th May 2016 was to take no further action until more evidence came to light. If this was the decision made at the meeting, it was to have tragic consequences.

287. It is notable that Eirian Powell did not send a corresponding email to the nursing staff working on the NNU, despite being copied into Dr Brearey's email. The absence of such an email contrasts with her suggestion that she was keeping an open mind on events and would be open to considering further evidence.

288. Child N was born at the CoCH in June 2016 and admitted to the NNU **[INQ0000579/4]**. Letby attacked and attempted to murder Child N on 3rd June 2016, causing a prolonged period of distress and a profound desaturation **[INQ0000579/15]**. Twelve days later, on 15th June 2016, Child N suffered two further serious desaturations **[INQ0000579/35 & 40]**. These events were discussed with Dr Saladi on the ward round on the same day **[INQ0000579/36]**.

289. Child N is represented by a different Family Group. However, the Families would note that these were exactly the circumstances that were communicated by Dr Brearey in his email three weeks earlier. None of Child N's episodes were reported to Dr Brearey prior to the deaths of Children O and P, although he did attend a resuscitation on 15th June 2016. All of this despite the fact that Letby was noted to be behaving strangely around the time of Child N's collapses demonstrating: "strange behaviour for an experienced neonatal nurse'. She was "agitated" when staff arrived from other departments to assist with intubation and kept repeating "who are all these people? Who are all these people?" **[INQ0000643/3]**. The prospect that these events could have been highlighted to Dr Brearey and potentially allow for safeguarding measures to be put in place represents the final missed opportunity to prevent Letby from causing harm to Child O.

290. Child P was born by caesarean section in June 2016, he was the oldest of three triplets, being delivered first. He was noted to have been born in 'good condition' and 'cried immediately' albeit he initially had poor tone, which improved by five minutes of age. His heart rate and respiratory rate were normal. When assessed shortly after his birth he was noted to be entirely normal on examination. His abdomen was noted to be full but not distended, soft and non-tender. He had active bowel sounds and no enlargement of his internal organs. He was treated initially with prophylactic antibiotics, but these were stopped after a short time and on the day after his birth he was able to begin to feed on expressed breast milk provided through a nasogastric tube. He was in good condition and stable for the first few days. He required little by way of respiratory support. Everything about his condition appeared reassuring and positive and his parents were advised that, like his brothers, he was doing well **[INQ0001453/8-10]**.

291. Child O was born by caesarean section in June 2016. His delivery notes record that he was "born in good condition" and "cried immediately". His Apgar scores were normal. He was a good weight for his gestation (33+2 weeks) and maintained a good tone, colour and respiratory effort with a strong heart rate. An examination by Dr V shortly after his delivery revealed that he had a normal, soft abdomen. No complications were recorded or observed surrounding his delivery **[INQ0001344/8-10]**. An examination the following day revealed that he was 'settled, asleep but rousable' with normal tone and movements, and well perfused. His respiratory rate was normal, as was his heart rate. His abdomen seemed full but not distended and was soft and non tender with active bowel sounds, no masses and no swelling in his internal organs. He was well enough to receive expressed breast milk from birth **[INQ0001344/10-11]**.

292. Insofar as those caring for them were concerned the triplets were doing well, were healthy and thriving. In his evidence before the Inquiry, Dr Brearey explained that survival would be expected to be in excess of 99% for babies of that gestation who, like the triplets, had been perfectly well **[INQ0001390]**

293. Letby was abroad until the 22nd June 2016. No events occurred on the unit during the eight days between her attempt to murder Child N and the collapse of Child O, which occurred on the first day of her return from holiday. Facebook messages passed between Letby and Doctor U asking about the triplets **{INQ0000569/5]**. They were initially in the intensive care room and Letby sent messages saying she felt most at home with ITU and the girls knew she was happy to be in Nursery 1. When she commenced her shift the following day however the children had been moved to Nursery 2, where they were doing well and were stable. She was child O and child P's designated nurse and she was alone with them in nursery room 2 for extended periods of time.

294. Child O collapsed on 23rd June 2016, Letby's first day back after her holiday, The jury at her criminal trial determined that she had injected air into Child O's bloodstream and into his stomach via his nasogastric tube. She also caused him to sustain an injury to his liver, described by Dr Marnerides, a forensic pathologist who gave evidence at her trial, as the sort of injury that he would associate with a serious accident, such as a road traffic collision, or fall from height, or an assault. Only a few hours before his death, Dr Hew Mayberry had assessed Child O's abdomen, as his designated nurse thought it appeared slightly distended. Dr Mayberry told the Inquiry that he '*could feel that his abdomen was soft although it was slightly distended, **he wasn't uncomfortable.** This would be a common finding in a child on high flow nasal cannula oxygen and **I wasn't particularly concerned about him***.' **[T/2.10.24/126]**

295. The perception of all of those involved in the care provided to Child O was that he was stable and thriving. His collapse came out of the blue.

296. Child O's resuscitation was attended by Dr Gibbs and Dr Brearey. An unusual skin discolouration was observed on Child O during the course of his resuscitation, on the right side of his chest but with otherwise normal perfusion. The rash had disappeared when Dr Brearey returned to assist with a subsequent resuscitation of Child O. Dr Brearey recalled the issue of skin discolouration having been raised in connection with previous collapses and ensured that it was documented in the clinical notes **[INQ0103104§238]**.

297. Following Child O's death, Dr Brearey described how he was "…very worried… My intention was to discuss with Eirian Powell as soon as possible, with the intention to agree to escalate to the Executives and request action to make the NNU safe…" He deeply regrets not escalating his concerns urgently on the evening of 23rd July 2016, explaining his actions by saying that he could

not conceive that Letby would be allocated to the care of the surviving triplets **[INQ0103104§239]**. This regret is shared by the Families. The events surrounding Child O's death required immediate action, not least a safeguarding exercise to ensure that Letby was removed from further patient contact whilst Child O's death could be properly investigated. This may have been the final opportunity to prevent further harm.

298. In his statement to the Inquiry, Dr Brearey recalled that he saw Letby in the period immediately following the death of Child O. In retrospect he found it striking how normal her mood and behaviour were. Many other nurses, less involved with the death, were extremely upset and anxious following the events **[INQ0103104§239]**.

299. Dr Jayaram was not working on the NNU on 23rd June 2016 as he was attending a meeting in Liverpool. He does not believe that he became aware of the death of Child O until he returned to the CoCH on the morning of 24 June 2016 **[INQ0107962§391]**.

300. Dr Jayaram had a planned meeting with Karen Townsend (Division Director for Urgent Care) on 24th June 2016, this had been planned since 21st June and was not set up in response to Child O's death. According to his evidence, this meeting was to discuss the concerns that he and his colleagues had regarding events on the NNU **[INQ0107962§393]**. Karen Townsend described the meeting as a 'routine meeting'.

301. The meeting with Karen Townsend took place at around 11.00 hours on 24 June 2016, it coincided with Letby's attacks on Child P. Karen Townsend continued to interact with Dr Jayaram during the course of the remainder of the day. Child P died that evening (see below).

302. Dr Jayaram's evidence before the Inquiry was that during the meeting he said in terms that both he and Dr Brearey felt that Letby was purposefully harming babies on the NNU; that it was not safe for her to be left unsupervised on the NNU **[T/13.11.24/55-56]** and that he was particularly concerned about 'Triplet 2' – Child P. On her evidence, Karen Townsend became immediately concerned about the risk of further harm to children on the NNU **[T/4.11.24/34]**. Other than speaking with Karen Rees following the meeting, Sue Townsend took no further steps to mitigate the risk of harm to other children on the NNU.

303. Like Child O, Child P had been stable, healthy and doing well in the days following his birth. The doctors and nurses caring for him had no concerns about him, although, following the death of Child O, his parents understandably became concerned that he might be affected by a common condition to his brother. Following Child O's death, Child P was reviewed by Dr Gibbs and Dr Cooke, who concluded that he appeared very well. Throughout that night, although he experienced one brief oxygen desaturation and episode of bradycardia the overall picture was not thought to be of any significant concern. Mother OP visited Child P in Nursery 2 at about 06.00 hours on the

morning of 24th June 2016. She was reassured by a nurse there that her boys were 'little angels' and that she had no concerns about them. She was told to go back to the maternity ward and eat breakfast, which she did. As she was showering later that morning, she was called back to the unit because Child P had collapsed.

304. Letby murdered Child P by administering air into his stomach via a nasogastric tube. He died when he was three days old. As attempts were being made to resuscitate Child P, staff at the COCH summoned Dr Rackham's Transport Team to take the baby to the Liverpool Women's Hospital. Just before they arrived Child P's blood gases had been taken and were satisfactory. Dr V was supervising the treatment and was hopeful of his prospects when Letby said to her something like "*he's not leaving here alive is he?*" These words shocked Dr V, who had never previously heard the like from any medical professional. **[T/7.10.24/133 & 134]**. After Child P had died Letby continued to behave discordantly. She attended Dr V's meeting with Child P's parents and was noted to be *"very excited and animated"* with an *"inappropriate jolliness, brightness"* which was jarring' **[T/7.10.24/135 and T/7.10.2024/161]** Dr V aid 'it was a horrible and nagging feeling that something was very wrong and not with the babies, but on the NNU.' **[INQ0102068§109]** Dr V later accepted that she could have flagged her concerns about the sequence of events leading to multiple collapses and the death of child P **[INQ0102068§148]**.

305. As the Transport Team arrived, Child P suffered another collapse and cardiac arrest. Dr Rackham took over the resuscitation but was unable to save him. Dr Rackham confirmed to the Inquiry: *'There was no identifiable cause of death at the time, so I was surprised at the collapse and death and unable to explain what happened'* **[T/26.11.24/249]**. Father OPR "begged" Dr Rackham to take Child R to LWH. Dr V silently willed that he would acquiesce and he eventually agreed. **[T/7.10.24/136 & T/26.11.24/257-261]** Child R's parents believe, with justification, that Dr Rackham's agreement to take Child R away from the CoCH saved his life, by removing him from contact with Letby. During Dr Rackham's evidence to the Inquiry, the family took the opportunity to express publicly their profound gratitude to Dr Rackham for saving the life of Child R by removing him from harm's way.

306. Dr Rackham, a Consultant Paediatrician in Neonatal medicine based at Arrowe Park Hospital recalled being aware by June 2016 that there had been 'babies coming to us who it was unexpected and unexplained why they'd had these collapses' **[T/26.11.2024/247]**. Before the death of Child O, he had been asked to transfer him, but he did not get there in time. He explained that 'babies of that gestation are normally relatively well' and 'those babies in general we would expect to do well and survive' **[T/26.11.2024/248]**. As transport consultant he received a call the following day to travel to CoCH with the intention of moving Child P but he too died before he could get there. Dr Rackham's view was that there was 'no identifiable cause of death at the time, so I was surprised at the collapse and death and unable to explain what happened.'

307. Witnesses reported it was rare for a baby to suffer a respiratory arrest or a collapse with no explanation or cause for it. Dr McGuigan in the years prior to joining CoCH couldn't remember a case of sudden unexplained collapse at his previous NNU.

308. Dr Jayaram believes that he likely left the hospital after his meeting with Karen Townsend so did not learn of the death of Child P until he returned to work on Monday 27th June 2016.

309. Dr Brearey was not directly involved in the attempts to resuscitate Child P, save for undertaking an echocardiogram, which he determined to be normal. He returned to the NNU after Child P's death and saw that Dr Rackham was holding a debrief in a side room. Dr Brearey sat next to Letby in the room and spoke with her, saying that he hoped that she would be having a good rest over the weekend. This appears to have been a pointed comment rather than a genuine wish, expressing a hope that she would not be working over the following days. Letby responded to tell him that she was due back on shift the following day **[INQ0103104/§241]**.

310. According to Karen Rees' account, having been informed about Sue Townsend's conversation with Dr Jayaram, she went to find Dr Brearey and/or Dr Jayram. She recalls finding Dr Jayaram in his office, evidence that is inconsistent with Dr Jayaram's account that he had left the unit following his meeting with Sue Townsend. The Families would observe that if Dr Jayaram had returned to the NNU following his meeting with Sue Townsend it is inconceivable that he would not have been aware of Child P's collapse. His evidence that he found out about Child P's death on Monday 27th June is therefore consistent with him not being present on the NNU during the afternoon of 24th June 2016. According to Karen Rees' account Dr Jayaram told her that he and Dr Brearey had concerns that Letby was harming babies on the unit and she asked to be directed to see Dr Brearey [**T/21.10.24/138]**. Given that Dr Jayaram was the senior clinician and had initially raised those concerns with Sue Townsend it would seem improbable that Karen Rees only had a superficial conversation with Dr Jayaram before moving off to find Dr Brearey. It is unlikely that Karen Rees is correct in her memory that she spoke with Dr Jayaram.

311. Karen Rees recalls that she found Dr Brearey and asked him why it was that he thought that Letby was deliberately harming babies. She recalled that Dr Brearey responded by saying that he had a 'gut feeling' and a 'drawer of doom'. When asked to share the contents of his drawer Dr Brearey is said to have refused but asked for Letby to be removed from the NNU saying: "I am aware that she is on this weekend" **[T/21.10.25/139]**. Karen Rees refused to remove Letby from the NNU justifying her decision by saying that there was insufficient evidence for her to do so, that she could not act on a 'gut feeling'. It is unclear whether this conversation took place. Karen Rees' recollection that Dr Brearey was concerned that Letby would be at work the following day is consistent with Dr Brearey's account of his conversation with Letby following Child P's death. As Child P died at shortly before 4pm **[INQ0001453/243]** it is unclear whether Karen Rees' recollection that the conversation happened during the course of the afternoon can be accurate. If the conversation did

happen then, given his involvement in investigating the deaths and reporting concerns to senior executives prior to this time, the Families are sceptical as to whether the only explanation that Dr Brearey would ask when questioned was that he had a 'gut feeling'. If that is what he did say he failed to articulate concerns that should have been tangible and readily explicable by that point. The Inquiry should be cautious about its approach to Karen Rees' evidence on this issue – it is ultimately self-serving in that it is intended to support a decision by her not to withdraw Letby from the NNU that evening. It was alleged that Letby attacked Child Q on 25th June 2016. Although the jury did not convict Letby in relation to that incident Karen Rees would appreciate the implication that decisions made during 24th June provided Letby with the opportunity to perpetrate further attacks on the 25th June.

312. Dr Brearey recalled that he called Karen Rees at home, via the CoCH switchboard. Dr Brearey 'let her know that all the Consultants had concerns regarding Letby and that I had just been told that Letby was going back to work the following day on the Saturday during the debrief that occurred after the death and that I wanted the neonatal unit to be safe and the only way for us to be sure that it was safe at that stage was for her not to come to work the following day.'**[T/19.11.2024/93]**. She refused. He recalled 'I said: well, if you are saying "no", does that mean that you -- that you are happy to take responsibility if anything were to happen on the following day with any further babies and override the wishes of seven Consultants? And she said "yes" to both of these'. **[T/19.11.2024/93]**

313. The location of the conversation is relevant when the Inquiry is considering its likely content. It is axiomatic that if the conversation happened by telephone, as Dr Brearey recalls, that Karen Rees could not have seen him pointing to a 'drawer of doom'. The Families would observe that the reference to a 'drawer of doom' is likely intended to belittle Dr Brearey's complaint and add support to the suggestion that he was being deliberately obtuse and secretive about his concerns, thus hindering Karen Rees' ability to make an effective decision regarding safeguarding. Her account is likely to be self-serving in this regard as it seeks to justify her decision making thereafter. Karen Rees demonstrated herself to be an ardent supporter the position adopted by the nursing staff in relation to Letby as events unfolded. The Families will suggest that it is likely that she was equally resistant to Dr Brearey's reasonable suggestion that Letby be removed from the NNU.

314. This analysis is consistent with other evidence, suggesting that Karen Rees was obstructive and difficult. Dr Brearey recalls that 'most of the meetings Karen Rees was -was attending she would normally raise her voice from across the table telling me that there was no evidence repeatedly'**[T/19.11.2024/141]**. This demonstrates a closed mind and a lack of insight into the way in which Letby's crimes were committed and an unreasonable assumption that the threshold for acting should be set as high as absolute proof of her offending. This defensive and closed-minded attitude, by now prevalent amongst a significant cohort of senior nurses, impaired the ability to raise concerns and act upon them, As Dr Gibbs explained in his evidence to the inquiry on the 1st

October 2024 it was harder when there was a concern about a nurse because they were a 'separate structure' **[T/01.10.2024/28]**.

Phase Three: 26 June 2016 – September 2016

315. On Sunday 26 June 2016 Steven Brearey invited Ian Harvey and Alison Kelly to attend the senior paediatricians meeting scheduled for midday the next day **[INQ003142].** The senior clinicians met on the 27th June 2016 at their Monday lunchtime meeting. In Dr V's statement **[INQ0012253/41]** she explained: 'it was felt that urgent action was needed to make the neonatal unit safe.' and that 'Letby should not be working on the unit until investigations had been undertaken. Both Harvey and Kelly declined to attend that meeting – despite the fact that two babies had just died unexpectedly on the NNU on consecutive days. Neither could provide any reason or competing responsibility that would have compelled them to miss it **[T/28.11.2024/149 and T/25.11.2024/132]**.

316. On the same day, Alison Kelly, Ian Harvey and Tony Chambers met with members of the CQC at a 'Quality Summit': no mention was made of the recent events [INQ0008054].

317. The failure of Alison Kelly and Ian Harvey to attend the consultants' meeting was particularly surprising since they had each been given further detail of the concerns earlier that morning at the 'Babygrow appeal meeting' which took place at 10am on the 27th June 2016 and was attended by Ian Harvey, Eirian Powell, Anne Murphy and Dr Jayaram. Alison Kelly recalls that although Eirian was adamant there were no concerns with Letby, 'there was heightened sense of concern…Dr Jayaram brought a new perspective to the situation…there had now been two further deaths and I felt that there had been a significant shift in the gravity of the situation.' **[INQ0107704§300]** There was an unfortunate symbolism in the fact that this discussion was taking place at a 'Babygrow' appeal meeting. That was of course the charitable fundraising campaign which aimed to raise finances for a new NNU. Letby had been the 'face' of that campaign and – as Simon Holden told the inquiry – it was a campaign that was already failing and could ill afford the reputational damage of negative press:

"Now, did you understand that there was a concern that if people thought less of the neonatal unit, less money could be raised by charitable means?

A. Yes, it's worth understanding the hospital has a revenue budget to run the hospital and pay the doctors and nurses and then there was a separate registered charity and within the separate registered charity, there was a neonatal appeal to lead -- to replace the neonatal unit. Nurse Letby was the face of that appeal, in effect, and when I arrived at the Trust, they'd -they had a target of £4 million to generate to build a new neonatal unit and they'd received £2 million, but the costs of running the charity were -- were exceeding the income even at that stage before any adverse publicity. So the £2 million they had raised was diminishing." **[T/3.12.24/9]**

318. No executive or director admitted that such considerations had weighed in the balance of their decision making in the aftermath of two of the triplets' deaths, but from the outset there was a failure to confront the extent of the clinical concerns that were being raised, and to respect the expertise of those who were raising them. The Families are understandably suspicious that the potential impact on reputation and in particular the flow of funds into the Babygrow Appeal influenced the approach of the CoCH with regard to the allegations. It is not difficult to imagine the potential reputational harm to the Appeal of the revelation that its 'poster girl' was the subject of accusations of murder and attempted murder. These features should not have influenced decision making in any organisation that adopted an appropriate patient safety focused approach, but it provides an important signpost towards the potential impact of human and organisational factors and their influence upon safeguarding.

319. Having decided to miss the consultants' midday meeting, Ian Harvey and Alison Kelly next decided to meet at 16:30 to decide how to respond to the concerns Dr Jayaram had reiterated to them. They invited Letby's nursing manager and chief defender Eirian Powell to that meeting but excluded Dr Jayaram, Dr Brearey and all of the paediatricians who had been raising concerns for the safety of the NNU. Eirian Powell had been present at the 'Babygrow' meeting earlier in the day and had been recorded to be "adamant" that there were "no concerns" with Letby **[INQ0015537]**. At the 16:30 meeting the 'action plan' that emerged had several items designed to protect Letby ("extra support required"; "debrief (oc health)"; "review nurse competencies") but not the measures that the consultants had collectively agreed was necessary to protect the NNU, and telephoned through to Ian Harvey that afternoon, that Letby be removed from patient contact **[INQ0005727]**. In evidence, Alison Kelly conceded that she was not even aware (and had taken no steps to determine) whether Letby was still at work and able to access the NNU unsupervised **[T/25.11.24/135]**. In the absence of the clinicians, they agreed a series of actions and entirely contrary to the consultants' request they agreed to provide 'LL extra support [required]'. This does not and would not 'prioritise the safety of the babies of the NNU' as suggested by Alison Kelly but in fact continued to expose them to the risk. As the Inquiry heard, Letby was permitted to work unsupervised on the NNU on the 27, 28, 29 and 30 June 2016 before she left for a period of annual leave.

320. When it was put to Alison Kelly that in arranging this meeting she had ignored concerns raised by "extremely credible, knowledgeable expert people" in the form of the paediatric consultants she responded simply, "*I think at the time I was relying on my senior nursing team to give me assurances on Letby, particularly Eirian Powell, who knew her the best.'* This answer highlights in stark focus the tribalism in Alison Kelly's approach, a characteristic that was by no means uncommon within the CoCH at the time. The consultants were effectively sidelined, and the executive response was instead orientated towards the gut instinct of senior nurses. Within the context of an organisation of the size of the CoCH and having regard to the severity of the

allegations, this was entirely inappropriate. Alison Kelly, and indeed Eirian Powell, should have appreciated that it was simply not possible for individuals to provide reassurances about Letby's probity. History is littered with accounts of individuals whose violent or criminal tendencies came as a complete surprise to their friends and colleagues when they were revealed. Similar assurances would no doubt have been given about Harold Shipman before his crimes were discovered. One lesson that should be learned from this case is that serial killers, whether operating within a healthcare setting or otherwise are capable of appearing entirely normal, even banal, in the eyes of those who interact with them. The discordance between how they present and what they do is often so profound that their friends or colleagues will continue to disbelieve that it is possible that they could have done what they were accused of until absolute proof is provided. If systems orientated around safeguarding set as their threshold the need for proof sufficient to satisfy even the most doubting of minds, they will prove entirely ineffective.

321. No doubt with a sense that his concerns were being ignored by the executives, Dr Brearey sent an email to Karen Townsend and others on the 28th June 2016 **[INQ0005749/3]** emphasising there were significant concerns about the increased mortality on the NNU and that there had '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. We felt on the basis of ensuring patient safety on NNU this member of staff should not have any further patient contact'. When rebuffed, Dr Brearey tried again with a further email asking 'Just to confirm you are happy for LL to work on the NNU in the same capacity as last week despite the paediatric Consultant body expressing our concerns this may not be safe and that we would prefer her not to have further patient contact.'

322. On the 28th June 2016 Ian Harvey emailed the RCPCH enquiring about an independent review, a strategy that the Families say was done with a view to pacifying the consultants rather than thoroughly examining the allegations (see below). It is of note that the first contact with the RCPCH was made before the consultants had even been spoken to.

323. There were then a series of meetings and exchanges on 29th June 2016 that set the course of the management response to the Letby crisis away from candour with parents and notification of the police and towards 'protection' of the Trust's reputation and management of the message.

324. The first meeting that day was timed at 08:15. It is clear that the potential need to contact the police was firmly on the minds of the attendees Ian Harvey and Stephen Cross. Mr Cross' note of the meeting records **[INQ0003360]** that there was a *"sufficient level of concern that* [there had been] *illegal activity in the neo-natal unit"* and *"Advice: Police need to be involved now"*. There is a conflict of evidence as to whom precisely had been the source of that advice: in his written evidence Mr Cross asserted he had given 'pragmatic' advice to that effect **[INQ0107707§47]**; whereas Mr Harvey asserted the advice to have stemmed from an *"Email this morning from further consultant."*

Whoever's opinion was recorded in the note, it was the correct one and it should have been followed.

325. The email referred to had been sent at 08:16 by Dr Saladi to Ian Harvey (together with many other) as his meeting was progressing with Mr Cross **[INQ0003112/8]**. The clarity with which Dr Saladi had summarised the issues and identified the way forward are worth repeating here:

" We have investigated these deaths as much as we can, which included seeking clinical input from outside. The only thing which came out of it (as I understand) is one member of staff was working in the unit (not necessarily with the baby who passed away in each incident, but might have cared the baby during the staff breaks) at the time of all these deaths.

This is highly unreliable information and further outside clinical input is unlikely to help shed more light on the relevance of this information…

We have moved this particular staff member from night shifts to day shifts and from ITU care to HDU I SCBU care. When the pattern of the deaths changed, we are becoming (at least those who dealt with the babies during the resuscitation and those who participated in the investigation till now & aware of the outcome) are becoming even more worried about patient safety and their own mental wellbeing. This is affecting all of us in one way or other. This is unfair to the staff under suspicion, unfair to parents and other staff who are unaware of the situation and unfair to the staff who are aware of the situation but worried about how things are progressing?

I believe we need help from outside agencies, who can deal with suspicion. At the moment we are all under suspicion and the only agency who can investigate all of us I believe is the police. That is the only agency who can know our past history and our life outside the hospital, which might shed more light. I think we should pro-actively seek their help before we are forced because of further deaths."

326. Dr Saladi's email should be viewed within the context of his oral evidence before the Inquiry **[T/3.10.2024/90]**:

(a) Unexpected deaths are very rare within paediatric and neonatal practice. This was certainly the experience of those working at the CoCH prior to the index events.

(b) Unexpected deaths in a district hospital are extremely rare and 'that's why we usually discuss all of them with Coroner because the usual condition is -- for unexpected deaths is some unrecognised kind of anomalies, cardiac anomaly and that's where we might ask for a Coroner's postmortem or they might say, well, suggest to parents and if they are interested, go for hospital postmortem so that we find out the cause.

(c) Unexpected deaths which were unexplained even after investigations. They are extremely rare…unexpected deaths which remain unexplained in a district-- in a district general hospital a paediatrician might see only a couple in their career and I already seen one that year and during that meeting when I am hearing that there are lots more unexpected deaths'.

327. Alison Kelly separately forwarded Dr Saladi's email to Ian Harvey, shortly after it had been sent, and the two of them discussed it on a separate thread. It is assumed that this discussion took place shortly after Mr Harvey's meeting with Stephen Cross must have concluded **[INQ0047571]**: each expressed the view privately to each other that the police would have to be called.

328. Meanwhile, Dr Saladi's email had also been received by the other consultants who were separately reflecting upon it and responding in a separate thread that included Dr Jayaram and Ian Harvey. Ian Harvey's response to those emails was rather more peremptory:

" Ravi - this is absolutely being treated with the same degree of urgency - it has already been discussed and action is being taken. All emails cease forthwith." **[INQ0003112/5]**

329. Ian Harvey's response demonstrates a level of irritability with the paediatric consultants, that would grow. It demonstrates an unnecessary degree of condescension towards a group who were, after all, drawing a serious patient safety issue to the attention of the executives. It would be unsurprising if the consultants felt that they were being addressed as errant schoolchildren rather than professionals.

330. Sir Gordon Messenger addressed the issue of leadership in the NHS explaining that what should happen is the 'first recourse to things going wrong or things happening that are unexpected are to rally around amongst the team that you work with in order to see what to fix it in state of transparency and sort of shoulder to the wheel in order to get it done. If that collective spirit doesn't exist, if the leadership that drives that teamwork doesn't exist then people don't feel valued, respected, able to voice their concerns within their immediate colleagues. **[T/8.01.25/161]**' The Families will say that Tony Chambers and Ian Harvey operated a 'Federation' that was more autocratic than collaborative. The collective spirit did not exist at CoCH.

331. The next meeting on that day was at 10:00 hours, when the executive team meeting was attended by Tony Chambers, Simon Holden, Lorraine Burnett, Debbie O'Neill, Ian Harvey, Linda Williams, Stephen Cross and Alison Kelly. The minutes of this meeting **[INQ0003364]** document that there was to be a Neonatal update at 1:00pm. A comment attributed to Tony Chambers also notes that CQC report was to be published the following day and that surprisingly – given the anticipated positive report - there was to be *"no publicity at this stage".*

332. At around the time of this meeting, Alison Kelly recorded in her diary that she telephoned Bridget Lees at the CQC and that *"high level reasons* [were] *expressed"* **[INQ0015537/5]**. In evidence she confirmed that to mean that she had communicated only that there had been an increase in infant mortality, but nothing of the concerns that the consultants had raised **[T/25.11.24/83]**. Given the context and timing, that omission must have been deliberate and calculated.

333. The 13.00 hours Neonatal update was attended by Ian Harvey, Alison Kelly, Tony Chambers, Stephen Cross and Ruth Millward. Steve Cross' note of that meeting recorded that the executives in attendance appreciated that the concerns included *"some babies did not respond to resuscitation as [Eirian Powell] expected"* and that the theme of the deaths of concern was *"stable, unexpected deterioration incident, crash, death"* **[INQ0106816/6]** There was also discussion of Letby in particular (although she is not named in the minutes). Ruth Millward was *"concerned witchhunt for nurse";* whereas Alison Kelly confirmed there was *"nothing personal between* [Steven Brearey] *and nurse"* **[INQ0106816/7]**.

334. Perhaps most significant was the contribution that Tony Chambers made to the meeting. From their correspondence that morning, Alison Kelly and Ian Harvey both seemingly felt that the police would have to be called. Tony Chambers poured cold water on that idea. His concern was with the *"press"*; calling the police was *"absolute';* and he wanted to explore *"other options".* After his intervention, the meeting concluded with the following summary [INQ0106816/7]:

"David S, Ravi, Steve B, Murthy Saladi all say yes to police.
If police: unit closed, forensic examination, interview of all staff, <u>arrest of nurse</u>
<u>Reputational issues for trust – link to CQC report"</u> <u>(emphasis added)</u>

335. The Families will say that this record is clear and unambiguous. The Executives were aware, and were recording in their private meeting, that the paediatric consultants together considered that calling the police was the necessary next step. The Families consider that this was the obvious and appropriate action, and indeed the only effective step that could be taken having regard to the need to safeguard patients. This proposal was weighed against the perceived sequalae of a police investigation and reputational damage for the trust. The Families will say that any attempt to balance safeguarding duties against the potential reputational harm arising from those duties was woefully inappropriate.

336. It was in that context that the senior leaders finally met with the consultants in the evening of 29 June2016 **[INQ0003371]**. The consultants again set out their concerns with clarity and objectivity: "*babies were stable and then deteriorated", "did not respond as they should, "7 out of 9 deteriorations were between 12* [midnight] *and 4am and since change none".* It was *"more than just an association with this nurse"* and there *"unquestionably something going on at the COCH"* although the precise mechanism was unclear **[INQ0003371/1-2]**. Dr Saladi again set out that

‘Preterm babies two steps forward one step back don't suddenly deteriorate, these babies are relatively stable sudden deteriorate and collapse’.

337. All of this expertise fell on stony ground. In evidence, Mr Chambers was given several opportunities to accept that the consultants had provided him with expert opinion but chose to prevaricate **[T/28.11.24/16,17-19,25]**. At that meeting, his contribution had been to tell the consultants that they were ‘very lucky to have Stephen Cross involved because of his experience as head of CID in Chester.’ He overemphasised the disruption that a police investigation would cause and lost sight of the fact that this is what was required **[T/27.11.24/22]**. The record suggests that his intervention was then followed up by Mr Harvey suggesting the alternatives of either an ‘RCN’ or a ‘College’ review. Mr Chambers wanted to *“explore more before the police”.* Faced with those views, the consultants wilted; and the strategy of avoiding the police rather than seeking their expert assistance was set. Mr Chamber’s motivations and sympathies are apparent in the summation he provided at the end of the meeting: *‘balance was needed’* but the *‘nurse cannot be excluded’;* and the imperative that the expert child safety concerns that had been raised *‘must not define our future’*. **[INQ0003371/3]** Shortly after the meeting Alison Kelly emailed Ann Ford at the CQC, copying in Mr Chambers **[INQ0017411/1]**. Again, any mention of the consultants’ concerns or their triangulation around Letby was entirely absent, as was any mention that calling the police was, or continued to be, an issue under consideration. It was an entirely misleading and reputation-focused impression have given to the regulator of the unfolding situation at the CoCH.

338. The Families have not had the opportunity to hear from Stephen Cross. The role of Stephen Cross as ‘Head of Legal’ at the CoCH is one of significant interest to the Families. Dr Brearey explained how the consultants knew some of Stephen Cross’ history in that he had been ‘demoted from the rank of Chief Inspector to Police Constable.’ and as having ‘risen quite quickly’ from a junior position in the Trust. This issue has not been explored further in evidence but has not been refuted by those representing Mr Cross. Little more is known about Mr Cross and his experience (if any) of working in a healthcare setting.

339. Dr Brearey candidly acknowledged that he should have gone to the police. This was a recurring theme, the clinicians recognised they should have done more, earlier. But what of the Executives? In their opening they ‘offered their sincere apologies for the poor communication that took place.’ Even in 2024, after many years of hindsight, they fail to recognise that the boundaries of their culpability go no further than ‘poor communication’. The Families are astounded by this lack of reflection or understanding. As starting point, the Executives should acknowledge that they obstructed a decision to call the police following the deaths of Child O and Child P. Their actions during this period afforded Letby the opportunity to cause further harm and delayed justice to her victims.

340. The Families will say that the Executives stage-managed the consultants' meeting on the evening of 29th June. The direction of the Trust's response had already been set at the earlier executive meetings from which they had been excluded, and the RCPCH had already been contacted about undertaking a review. Most inexplicably, the executives positively decided to allow Letby to continue to access the NNU unmonitored throughout the period. Stephen Cross at that meeting painted a worrying picture of what would happen to the unit if the police were called; 'the unit would be closed, it would be made a crime scene, there would be arrests, there would be people called for questioning, and it would be very upsetting for the Families and a disaster for the Trust's reputation.'

341. The Families were not consulted with regard to whether they would support calling the police or not, so referencing their feelings in support of a decision to not contact the police was at best patronising. The Families believe that the main purpose of not contacting the Police was to protect the reputation of the Trust and the executive body. It was disingenuous to co-opt the need to protect the sensibilities of the Families in making that decision. As things stand, they have been more profoundly harmed by the discovery that their role in these events was hidden from them. They suffered more from being deliberately deceived.

342. The inquiry has discovered that the Executives and in particular Ian Harvey and Tony Chambers did not want to go to the police, and the impression Dr Brearey formed was they had already made up their mind, something Dr Saladi also referred to following the meeting on the 29th June 2016. This is despite them being told (as is accepted in their opening statement) at the end of June 2016 that there were concerns Letby was directly involved with the deaths.

343. Nurse T recalls feeling the neonatal deaths were unusual in June 2016. Nurse T recalls that after Letby was moved to the Risk team she said that 'some of the doctors were accusing her of murdering and harming babies and she had been moved to the office job because of that' when asked if she had told Letby she already knew she said about her 'she was okay about it'. One might consider that to be an unusual response.

344. The following day, the Chairman Sir Duncan Nichol was to be briefed and to meet with the consultants and hear their concerns. Yet again however, the meeting was stage managed. It had been preceded by an executives-only briefing at which the option of commissioning an 'in depth review' had been advocated and decided upon **[INQ0003661]**. At that meeting Dee Appleton-Cairns (Deputy HR Director) was said to have reviewed Letby's HR file and there was nothing of note in there and it was reported that Letby was 'introverted and quiet' **[INQ0107704§357]**. This analysis appeared to ignore earlier reports of administering an overdose of morphine to a baby and an attempt to administer Gentamicin when it had not been prescribed. The note of the meeting records discussion that 30th June was Letby's 'last day' before annual leave **[INQ0003361/1]** and suggests that it was Sir Duncan who reversed the executives' decision of the previous night that

Letby would *"have to be redeployed"* and moved away from the NNU during the period of the 'in depth review.'

345. Dee Appleton-Cairns explained in evidence that the purpose of that meeting was to consider the spike in deaths and she understood from that meeting that 'there was a commonality between her being on the unit when some babies had died'. She recalled that two significant points were discussed during the meeting on the 30th June 2016:

    (a) Downgrading the unit, although some of the clinicians pointed out that downgrading the unit did not address the specific concerns.
    (b) Asking the RCPCH to undertake a limited review.

346. The analysis of events at that meeting remained flawed. The concerns raised by the consultants went beyond a pure commonality between Letby and deaths on the unit but also focused on the sudden, unexpected and unexplained nature of their collapses and deaths. It is plausible that Dee Appleton-Cairns lacked the insight to appreciate the nuances in what was being reported, however, it is notable that senior nurses giving evidence to the Inquiry categorised the nature of the complaint as being based purely upon coincidence rather than by reference to what was actually being complained about. This superficial understanding, in part contributed to by a failure on the part of the executives to properly engage with the issues being raised by the consultants, diverted the narrative and diminished the seriousness of the concerns.

347. There was a meeting with the consultants later that day (at 3pm) **[INQ0003362]**. By then the direction of travel had been set: the police would not be informed, in favour of an 'in depth' RCPCH investigation. Alison Kelly said 'I agreed with Dr Brearey and Dr Jayaram about not feeling confident about the safety of the NNU. **[INQ0107704§368]**'

348. On the 4th July 2016 downgrading the unit was discussed **[INQ0004314]** and this was put into place shortly thereafter. On the 5th July 2016 a mortality review meeting led by Dr Brearey considered the collapses and deaths of Child O and Child P. Dr ZA recalled that at that meeting Letby's associations with the deaths was made clear. Sian Williams stood in for Ruth Millward on that day and she accepted in evidence that she 'didn't have access to a lot of the record-keeping because they have different systems in the neonatal unit' **[T/5.11.24/33]**.

349. At that meeting Ms Williams recalled the clinicians confirming they had retained a bag of fluids one of the babies had been fed with because of concerns about that child's death. Ms Williams had made contact with Mr Cross who had confirmed that where there were 'suspicions of foul play, [she] should ensure [the bags] were kept' **[T/5.11.24/35]**. This underlines the seriousness of the concerns and the need for the involvement of the police.

350. Instead of contacting the police, on the 5th July 2016 Dee Appleton-Cairns contacted external employment solicitors to discuss the organisational ramifications, if any, of removing Letby from the NNU. Once again, the reputation of the hospital was being prioritised. When asked about this she told the inquiry **[T/5.11.24/196]**:

(a) 'The Medical Director, Ian Harvey, Alison Kelly, all the clinical team had been to look at, had been through this and they had given me those assurances that there was no- it wasn't malicious.'

(b) When asked about 'a large number of unexplained, unexpected deaths on the neonatal unit?' she responded 'At that point it wasn't that, it wasn't that many'. This is a shocking statement. There had been 13 deaths in little over a year, not something one would ever expect to be referred to in that way.

(c) 'There was no commonality on the -- on the spreadsheets'. As we know, this was not true.

(d) 'The only Consultant that I knew of that was expressing any kind of concern for a long, long time was Dr Brearey'. Again, this was not true.

(e) 'So for me there was -- there was nothing here other than Dr Brearey saying he had some concerns about a nurse, a specific nurse'. Knowing about Beverly Allitt as she accepted she did, why wouldn't she seek to safeguard the patients in the hospital?

351. The fact that Ms Appleton-Cairns was able to dismiss the Head of the Neonatal Units concerns with such ease is astonishing.

352. Ms Appleton-Cairns continued **[T/5.11.24/199]**;

'But the other thing that bothers me though is regardless of what you think I think, the fact is Lucy Letby was removed from the unit but those -- and those Consultants didn't do anything. So it was like: Well, yes, she's a baby killer but now she's gone, well, we're just not going to do anything. They didn't do anything for months.'

353. It is right to say the consultants did not do enough but the crass dismissal of the concerns raised by Dr Brearey demonstrates a wholescale lack of curiosity and laziness on the part of Ms Appleton-Cairns.

354. The Families would highlight Dee Appleton-Cairns as a particularly unimpressive witness. Her evidence demonstrated a dangerous combination of arrogance and an inability, or lack of willingness, to engage with the issues being raised. On the one hand she criticised the consultants for not pressing the issue more strongly but on the other demonstrated total resistance to the idea that there was anything of significance in the issue being raised. Her approach to the consultants correlated with the response typical of senior executives, namely that it was the responsibility of the consultants to provide absolute proof that crimes had been committed before safeguarding

action could be taken. For some, this approach probably arose from a natural reluctance to take any steps that might expose the CoCH to adverse publicity until a notional, but unrealistically high, threshold was passed. It is unclear whether this motivated Dee Appleton-Cairns, or whether her approach stemmed from her inability to understand the medical issues and her ignorance of safeguarding and patient safety priorities. In any event, her approach, as with executives, led to a loss of momentum amongst the consultants and their acquiescence to following the wrong plan.

355. A position paper was compiled in July 2016 which was said to provide the Executive team with 'key mortality data and narrative.' This recorded a 'step change in mortality levels in the NNU since June 2015.' This document was produced following 'silver command' **[INQ000188/11 §4].**

Silver command

356. In the UK 'silver command' is usually a structure adopted by emergency services as a framework for the command and control of major incidents. It is usually used to provide a framework for delivering a strategic, tactical and operational response to incidents. In this case it failed to achieve any operational response. Stephen Cross chaired the investigation that took place between the 6th and the 8th July 2016, which involved data analysis and case review. This was completed while Letby was away. The investigation does not appear to have reached any conclusion.

357. Silver command excluded Drs Brearey and Jayaram. Dr Brearey flagged this to Mr Harvey and as the neonatal lead he felt he 'had most of it at hand on my computer, and it just felt ridiculous actually and I had expressed to him concerns that he trained as an orthopaedic surgeon and he was taking on a review of these -- this very complex case with hardly any neonatal experience… he just didn't have that insight or perspective that you would have if you had been in neonates for a year or two.' **[T.19.11.24/148]**

358. Ms Appleton-Cairns was involved in reviewing HR files as part of silver command. She gave the following uncomfortable evidence:

(a) Drugs error…they happen quite often in a hospital **[T/5.11.24/207–208]**

(b) Drugs errors by staff would go to the clinical governance department and that record 'I wouldn't see this, this wouldn't necessarily come to HR'. Why wouldn't these records find their way to the HR file?

359. On 11th July 2016, Sian Williams and Julie Fogarty completed a staffing analysis **[T/5.11.24/38]**. She confirmed that she and Ms Fogarty were reviewing the cases the doctors had already looked at. The Families have some difficulty understanding why a nurse with no paediatric experience would be better placed than a paediatrician to review individual cases. In any event Ms Williams

confirmed she flagged with Ian Harvey the case of one baby (Child I) who had collapsed 3 times during successive nights, seemingly well during the day only to collapse suddenly again during the night shift when Letby was on duty. When she saw this in the records she found it chilling. Ms Williams recalls she considered that 'they needed to consider the police. I did tell them I spoke to Alison Kelly on a number of occasions, one I remember with Karen Rees in my office saying that you need to go to the police and she said "I have taken advice" and that was it and she wouldn't listen' **[T/5.11.24/44]**. Ms Williams' evidence before the Inquiry is notable. If nothing else, her feeling of concern in reading the records should have provided a sense check to the executives and her observation regarding police involvement should have been listened to.

360. In a meeting on the 13th July 2016, Mr Chambers asked what would be done if the concerns were about a doctor and Dr Jayaram confirmed that the doctor would have been suspended.

361. On the 14th July 2016, the day Letby returned to work, an extraordinary board meeting took place during which Ian Harvey gave a PowerPoint presentation in which he sought to pacify the consultants by suggesting the increase in deaths was not as a result of anything beyond an increase in the acuity or younger gestation age of the babies who were being cared for **[INQ0004216]**. Mr Harvey by specialism was an orthopaedic surgeon. He failed to draw up any of the expertise of the neonatology team when compiling this presentation and he was clearly dealing with matters far outside his area of expertise. At that meeting Dr Jayaram recalled that he 'explicitly stated the concern about Letby' **[T/13.11.24/119]** but asked that it was not minuted because '… there seemed to be a pattern emerging that they didn't want to listen and I was already becoming concerned that this, if minuted, could potentially come back and -- and bite me on the backside and be used against me'.

362. Dr Brearey told those at the meeting there was a 'considerable amount of discomfort regarding the member of staff, it was felt that this was dragging on and this would not solve the problem.' Alison Kelly recalled that Dr Brearey was concerned the RCPCH review might not explain the deaths and having Letby supervised on the unit would cause anxiety and further impact on the low morale **[INQ0107704§451]**.' She goes on in her statement to say that Tony Chambers explained 'if the Trust felt conclusively about one issue then we would take absolute action.' This statement, if correct, demonstrates a fundamental misunderstanding of the necessary threshold for taking action in response to safeguarding issues. It would be consistent with the suggestion, expressed elsewhere, that the executives set the threshold for safeguarding action at an unreasonably high level as a means of avoiding reputational harm (see above).

363. Mr Wilkie, a Non Executive Director (NED) in his evidence to the inquiry **[T/2.12.24/203]** said 'people in that room should have known to go to the police…the people that were dealing with safeguarding issues on a day-to-day basis.' He recalled the medical director being an influential person and that had they had a NED who was medically qualified it would have made it easier to

challenge and pushback. He confirmed it was in his opinion an ‘unnecessary risk and an avoidable risk to have her continue to be on the unit.’

364. On her return to work Letby was told by Eirian Powell and Sian Williams that she would remain on the NNU subject to clinical supervision. This was a fanciful suggestion with no resources to support it. Dr V recalled at paragraph 132 of her statement that ‘shortly following the death of child O and child P…I was leading the team…Letby was supposed to be working under supervision and was not meant to undertake any work independently. I had asked for a fluid bolus for one of the babies and Letby appeared in front of me and said “I will get that for you”…I …just stood there staring at her not able to say anything…I felt “completely helpless” **[INQ0102068]**.’

365. On 18th July 2016 Letby received correspondence **[INQ0006495/4]** ‘this temporary redeployment has taken as a neutral act and has been taken in the best interest of all parties and in the interests of patient care, pending completion of the external review.’

366. On 19th July 2016 Dr Jayaram emailed Alison Kelly and Ian Harvey **[INQ0003143]** suggesting that the neonatal network should be involved in future work; they of course would offer specialism and independent oversight. Had Ian Harvey truly wanted to investigate and get to the bottom of the high mortality rate he would have said yes but he refused suggesting that the neonatal network had little data and the RCPCH would determine the scope of their review. There is no evidence to suggest that he had investigated the extent of the neonatal network data.

367. An executives meeting on the 20th July 2016 referred to the TPN bags that had been kept following the deaths of child O and child P and Ian Harvey subsequently asked Alison Kelly to store them safely **[INQ0006890§278].** It is unclear for what purpose the bags were being stored, unless Mr Harvey and Ms Kelly accepted that there was a potential need for them to be examined forensically. Neither Mr Harvey nor Ms Kelly sought any advice as to how the bags should be stored or whether further delays would lead to the risk that any forensic evidence would be lost. It is astonishing that an informal decision would be taken without the input of the police, to store potentially relevant evidence in a murder case with a view to that being made available to the police at some uncertain date in the future. If it was thought necessary to store evidence, it should have been obvious that the police should be called.

368. Dr Jayaram considered that by the 21st July 2016 the consultants concerns had been formally escalated **[T/13.11.24/90]** but he explained that he ‘was working on the naive assumption that the people who run the hospital would all be pulling in the same direction in terms of patient care and patient safety: ‘And of course what I am hearing is that it just didn't seem quite right, but I have no reason not to trust these people because they should be pulling in the same direction and, you know, they are wise, they are paid higher -- large amounts of money to run hospitals and if they are suggesting this is the right thing, and it couldn't be that, it couldn't be that, I just I guess I

accepted it. I -- I -- I was, I -- I was too trusting with a ---- well, I was appropriately trusting, why shouldn't I trust the people who run the organisation in which I work?' **[T/13.11.24/109]**

369. In July 2016 Kathryn De-Beger, a nurse and occupational health manager started visiting the unit. She reported that she first attended the unit to see how the staff were 'managing and coping…because there was an increase in deaths on the unit and that was under investigation.' **[T/9.10.24/46]** Over the 15 months that followed Ms De-Beger developed an inappropriate relationship with Letby and they exchanged in the region of 750 messages. In her statement she confirmed 'that being part of a WhatsApp group to provide support for a member of staff was not a usual thing' but she prioritised Letby. The Families will say that it is a common theme that Letby would co-opt and manipulate others into promoting her own victimhood as a means of diverting attention away from the allegations being made against her, to exert pressure on the executives (i.e. bullying up), and ultimately, to manipulate the direction of decision-making in her favour. With the benefit of hindsight it is clear that she was in regular contact with a significant number of individuals, all of whom believed that they were her only source of support. In some cases, such as with Ms De-Berger and with Dr U, she was able to use these relationships to obtain information about the investigations.

370. Dr Brearey considered that Eirian Powell with the backing and support of Karen Rees amplified the breakdown in the nurse vs doctors relationship. This embedded the groups into opposing battlelines, rather than encouraging them to work together towards a common safeguarding priority: 'I think the combination of Karen Rees' behaviours and Eirian Powell's denials created certainly what we felt was a nurse v the Consultant body relationship' **[T/19.11.24/86].**

371. There was 'Cultural entrapment' in Dr Brearey's opinion, which occurs 'if somebody is raising concern and that concern is so significant that the hearer the receiver of that information can't believe it and -- and it creates this credibility gap and that hearer has got that entrapment and can't move on and that's obviously made worse by denial' **[T/19.11.24/22]**

The RCPCH

372. Sue Eardley was given the task of developing the invited review service at that RCPCH in 2012 **[T/7.11.24/97]**. By 2016 the review process was reasonably well established and organised. It was governed by a handbook **[INQ0012822]** and a publicly available guide **[INQ0010214]**. Those documents made clear that the purpose of a service review was *"to visit and comment upon a current service. …. The terms of reference will usually be rooted in the quality, safety and efficiency of that service"* **[INQ0010214/4]**. Investigations likely to consider individual "*behaviour or misconduct issues"* were expressly excluded **[INQ0010214/8]**. As should have been apparent to all: it was not – and had not been designed to be – an appropriate process for the investigation whether an individual clinician was deliberately harming and killing babies.

373. Ian Harvey had first contacted Ms Eardley by email on the 28 June 2016 **[INQ0009615/5]** and then followed up with a telephone call of which he had kept no notes. Ms Eardley's clear recollection is that the consultants' concerns were not relayed to her in that call: she was told only that there was a 'correlation' between an individual being on death and some of the deaths occurring, information that was not suggested to be of 'significant importance' **[T/7.11.24/136]**. A briefing sheet filled in at the time recorded that at the time Mr Harvey had first mentioned the 'correlation' he had told Ms Eardley that there was *"no pattern"* to the deaths **[INQ0009590 and T/7.11.24/143]**. The Families will say that this was deliberately misleading given that the decision to request an RCPCH review had been made as a direct alternative to contacting the police in response to concerns about deliberate harm being caused to patients on the NNU. This interaction emphasises amongst a number of other examples, Mr Harvey's tendency to deliberately mislead those outside of the hospital about the nature of the allegations being raised in relation to Letby and mirrors his subsequent interactions with Families. The obvious implication is that he withheld information from the RCPCH to minimise the risk that they would decline to undertake the review and would instead suggest contacting the police. The Families will suggest that he also appreciated the potential benefit that could be obtained from a partial review by the RCPCH in suppressing the concerns raised by the consultants and providing the CoCH with an insurance policy against future allegations that it had failed to properly investigate the claims. Nevertheless, even on that scant and misleading picture provided to them by Mr Harvey the RCPCH ought to have proceeded no further in their investigation: something Ms Eardly candidly conceded in her evidence **[T/7.11.24/140]**.

374. In their subsequent email correspondence setting the terms and arrangements for the review Ms. Eardley asked whether the children's parents would be expecting to meet the reviewers and stated that she needed confirmation *"that the duty of candour arrangements are all in place"* **[INQ0009615/2]**. Mr Harvey replies*, "we made every effort to contact the parents of every baby who had died during the increased incidence period before the story was in the local paper — address and phone number changes meant we couldn't contact all."*

375. That was flatly untrue. The only parent that had been spoken to by Trust personnel about the RCPCH review had been Mother C, and only after she had found out about it in the local press and turned up unannounced at the CoCH Bereavement Office **[T/16.09.24/80 and T/16.09.24/82]**. On that occasion a meeting with Alison Kelly and Sian Williams had been hastily arranged. She was advised "that the investigation was just a formality to check staffing levels because there had been a small increase in the number of deaths but they didn't think it was significant. They said there was nothing more to say at that stage and they would find out more when the report was done." In evidence, Sian Williams accepted that was an untrue and misleading picture to have been given, but told the Inquiry that the executives had given her instructions about the limits of what she could say **[T/5.11.24/97-98]**. As was put to her, Mother C was being given those words

of reassurance at the same time that Sian Williams herself considered that the police should be called in. This was cover up in the name of kindness **[T/5.11.24/99-100]**. Alison Kelly's evidence was simply that she could not recall the meeting **[T/24.11.24/247]**. She offered no explanation or excuse beyond her 'reflection' that "we didn't get the communication right with Families and we didn't get the balance right". **[T/25.11.24/249]** These words of apology, if they can be construed as such, are inadequate.

376. In response to questions from Ms Blackwell KC, Alison Kelly told the Inquiry that she had no recollection of attending an impromptu meeting with Mother C. This meeting is likely to have been memorable, Mother C was heavily pregnant, distressed and anxious. A bereaved mother demanding answers about a sensitive subject, and one that Ms Kelly would inevitably have regarded as highly sensitive insofar as the Trust were concerned. When asked about why she had not taken notes of the meeting she responded '*As part of my role, I would very often meet with families on the back of complaints or if they had any concerns. I would religiously take notes of those meetings and if there was anything that was of concern that needed follow up I would usually reflect that back in a letter……. I have no evidence of any of those notes that may have been taken at that meeting with Mother C. So I can only assume, I'm not saying it didn't happen, but I can assume that I wasn't there'* **[T/25.11.24/292]**. Mother C's evidence was clear and unambiguous regarding Ms Kelly's presence at that meeting. If corroboration of her account is required it can be found in her letter to Ian Harvey dated 7 February 2017, referred to in her evidence at **[T/16.09.24/91-94]**. "*I met with Sian Williams and Alison Kelly when I turned up at the Bereavement Office really quite distressed following this publication."* How would Mother C have identified Sian Williams and Alison Kelly by name when writing to Ian Harvey if she had not met them as she recalls that she did?

377. If the Inquiry accepts Mother C's evidence it should ask itself why Ms Kelly chose not to take notes of the meeting, given that this was her usual practice. The Families will say that she did not take notes of the meeting for the same reason that Ian Harvey did not take notes of his meetings with Mother C. Because it was intended that that there should not be any permanent record of the meeting, or of the issues discussed. It would provide opportunity to deny that the meeting occurred or that she was involved in it. Indeed, as she sought to do in response to direct questions on the issue from her counsel. The Families, and Mother C in particular, would say that the evidence of Alison Kelly on this point was disingenuous and false.

378. Ian Harvey seems to have introduced the topic of the consultants' concerns at some point later in the process of commissioning the RCPCH report; and to have done so indirectly and in a way that minimised their significance. By 7th July 2016 Mr Harvey had responded to the RCPCH proposed terms of review **[INQ0009595]** with a counterproposal **[INQ0010256]** that added into the draft terms of reference, *"Are there any identifiable common factors or failings that might in part, or in whole. explain the apparent increase in mortality in 2015 and 2016?"* without any explanation as

to why that was thought necessary, or how it changed the scope of the initial terms **[T/7.11.24/154 and T/7.11.24/325]**. Once those amendments were accepted by the RCPCH, Ian Harvey confirmed their instruction on the same day.

379. In his communication with the RCPCH Ian Harvey had applied the qualifier "*apparent"* to the increased mortality rate on the NNU on 7th July 2016. The next day he finalised his internal CoCH document "*Analysis of NNY Mortality Rates"* within which he had concluded to the contrary that there had been *"a step change in mortality levels in NNU since June 2015"*. Just why Mr Harvey had so inconsistently characterised the NNU mortality rate was never adequately explained, but the executives' preoccupation with the reputation of the Trust continued over this period: it was on the 11th July 2016 that the entry *"Potential Damage to reputation of Neonatal Service and Wider Trust due to Apparent Increased Mortality within the Neonatal Unit"* was added to the Hospital's Urgent Care Risk Register. The Families will say that this notation encapsulates the tendency of the CoCH to prioritise reputational management over patient safety whilst simultaneously trying to withhold information about the nature of the concerns being raised. It is objectionable in the extreme.

380. The RCPCH invited review team scheduled their service review visit for 1st September 2026. The lead reviewer was to be David Milligan. In the lead up to the visit Mr Milligan had reviewed material provided by the CoCH. On 26 August 2016 he emailed Ms Eardley to report that a number of questions had arisen from what he had read, *"not least that one individual seems to have been present for all but one"* of the deaths **[INQ0012748/3]**. By the time the email had been sent, Ms Eardley agreed that Mr Harvey must have made her aware of the consultants' suspicions about Letby but she did not pass them onto the review team, even when the lead reviewer had independently identified the very source of their concern **[T/7.11.24/162]**.

381. The first meeting of the visit was with Ian Harvey and Alison Kelly. At the very outset the lead reviewer, David Milligan set out in clear terms to Ian Harvey and Alison Kelly on the first day of inspection that the RCPCH 'may not be able to explore the detail of the deaths' **[INQ0010124/1]**; that they were there to do a service – rather than a case note - review. This caused the executives no apparent surprise or alarm. Instead, Ian Harvey warmed to a familiar theme of watering-down the consultants' concerns - they *"want to see the worst – but nothing else is pointing that way"* – and justified the decision not to call the police by burnishing of Mr Cross' credential: he *"was DCI before he retired[1]"*. As with all other investigations into Letby the executives sought to control the direction and message, rather than following the evidence.

382. Sue Eardley's letter to Mr Harvey dated 5th September 2016 **[INQ0003120]** confirms that the investigating team were not aware until they met him on 1st September 2016 that Letby had been

[1] On a technical level, untrue.

removed from the NNU on the basis of allegations that had been made: "by one member of medical staff, supported by his colleagues". The tone of the letter suggests that it was repeating complaints that had been made to the team by Letby about the nature of her removal from the unit and misstated the nature of the complaints being raised against her by suggesting that they emanated from one individual rather than from the consultant body as a whole. This letter reflects both the misinformation that had been provided to the RCPCH by Ian Harvey and also Letby's tendency to deflect from those allegations by promoting her own victimhood. The only appropriate response from the RCPCH should have been to terminate the investigation immediately and recommend contacting the police.

383. For their part, the RCPCH reviewers were not able to see past the improper 'steer' they were being given by Mr Harvey, nor to objectively reassess whether they ought to have proceeded at all. How they ever thought it appropriate to interview a potential murder suspect about the circumstances of that suspicion is hard to fathom. Part of the answer appears to have arisen from a misapprehension about the expertise of a non-practicing barrister that may have been allowed to persist, but that cannot be the entire answer **[T/11.11.24/7-11]**.

384. On the evening after she had been interviewed, Letby contacted Dr U in instant messages **[INQ0000569]** that the reviewers had *"'off the record' told me they think an investigation into the deaths will be a recommendation & I need to prepare myself that as I would play a big part in that over due to being a common factor & it could take several months"*. Both of those involved in the meeting– Clare McLaughlan the Lay Reviewer, and Alex Mancini the nursing reviewer - deny giving Letby that information. Whether they in fact did so, or alternatively whether the message to Dr U was part of Letby's web of fantasy and self-aggrandisement may not be entirely certain.

385. On the second day of the review, the reviewers met again with Mr Harvey and Ms Kelly. The notes of that meeting **[INQ0014605]** record that the two were told in terms: that the reviewers had concerns about the propriety of continuing and had considered aborting; they had continued only because their terms would allow the background to be established; there needed to be an independent case note review of all deaths by two independent experts; and an HR process needed to be started to formalise Letby's position. Neither could have been left in any doubt that the RCPCH report to come would not determine the issue of Letby's potential culpability. Any claims they subsequently made to the contrary were in bad faith.

386. Mr McCormack in his evidence explained that 'the expertise of the Royal College of Physicians I understood, having had previous obstetric reviews, it was all about manpower and about your guidelines and about how you address risk. It -- it wasn't going, I didn't think, to give us information that was going to help us address the issue of intentional harm, and that's why I asked them [Ian Harvey]: "Do they know about the nurse concern?" And he said quite clearly, "Yes, the issues have been highlighted and including the nurse issue."' Clearly he was misled by Ian Harvey as to the

parameters of the instruction and what would be investigated.

387. Professor Fletcher, current President of the RCPCH agreed that the terms of reference should never have been agreed. Professor Fletcher confirmed that the guidelines for review were not followed, namely that the terms of reference were not agreed and that clinicians should be involved in the decision to review. Professor Fletcher said that ‘when the Review Team arrived for example if they heard advice that would suggest that there had been misbehaviour then yes, I think -- yes, the -- the review should have been halted then **[T/12.12.24/83]**. That was a missed opportunity to stop the review’.

388. In fact, the opening statement of the RCPCH confirms that ‘the aims of a review process are in general to provide an expert examination of the workings and functioning of hospitals or other forms of paediatric service (such as community paediatric service) – to either advise on steps for improvement or to recommend changes to the design of a neonatal or paediatric service within a hospital or region’. This was not the necessary level of review required, as Mr McCormack feared, they could not carry out the job they were there to do.

389. Sue Eardley in her evidence to the inquiry on 7th November 2024 confirmed she had never previously been asked as part of a service review to consider why a death rate had increased but nonetheless, they added Letby to the list of people to speak to. She agreed that this was inappropriate because of the risk it may muddy or confuse other investigations, and it is entirely unclear as to what prompted this in the first instance. Ms Eardley accepted it was entirely inappropriate for the RCPCH to conduct a review in the circumstances that existed at that time and risked providing false reassurance **[T/7.11.24/132]**.

390. Dr V recalls ‘relaying my grave concerns regarding the circumstances that Child O and P died in and how unexpected their collapses were and the failed efforts at resuscitations of previously completely well babies…My other colleagues shared their concerns…The reviewers sat and listened in silence.’ **[INQ0102068§142]**

391. We know now that the RCPCH review team considered medical records, minutes from the morbidity and mortality meetings and post-mortem reports for several children. The families of those children knew nothing about these reviews and they were not invited to contribute to the process. This led to the omission of important evidence, including the evidence that would have been provided by Mother E as to her experiences surrounding Letby. It would have permitted her to uncover the fact that Letby had falsified records surrounding the time leading up to her son’s death. It may have led to the investigators discovering that her other son had become seriously unwell at the same time and led to a review of his records, this would have revealed that he had been administered unprescribed exogenous insulin.

392. On its completion two copies of the RCPCH report were made available – the first was a full copy that was provided to only one person; Ian Harvey. The second was the 'modified' copy omitting any reference to Letby. Dr Brearey wrote to the RCPCH on the 5th February 2018 **[INQ0012734]** that he had " a number of concerns regarding the way the college responded to our concerns, particularly after the invited review report was submitted to the Trust. The modified report, which did not include any of our concerns, was utilised by the Trust to follow a plan that gave us all considerable patient safety concerns and was a stressful time for all of us. It is quite possible that if the college had intervened at that stage and provided support to its members (the consultant body)... then the police investigation might have started earlier'.

393. In their opening statement it is accepted by the RCPCH that 'its actions in undertaking the review commissioned by CoCH did not directly assist in uncovering the causes of death and recognise that this contributed to the uncertainty and lack of clarity that bedevilled the response. It also apologised that it was not sufficiently supportive to paediatricians'. The RCPCH holds a position of privilege with over 23,000 members. They say their aims are to advance the teaching and practice of paediatric medicine, to improve the health of children and improve standards of care, alongside educating and examining those who train in this speciality. On this occasion they failed. Insofar as the Families are concerned, that failure not only encompassed a failure to identify Letby as a source of harm to babies on the NNU but also permitted their report to be used by the CoCH as an active shield against the concerns raised by the paediatricians and as a means of misleading families as to the true nature of events.

394. The RCPCH met with some of the consultants on the 1st September 2016. Dr Saladi was disappointed that they had not been instructed to examine the individual deaths. Sue Eardley confirmed that she had been told ahead of the review visit that there were concerns about the association of a member of staff and the deaths at the hospital. However, she failed to share that information with her review colleagues. It has been accepted whether in their opening or in the evidence from Professor Fletcher that:

(a) The review team should not have interviewed Letby and they should not have had 'off the record' discussions with her.
(b) A recommendation should have been that the hospital report the concerns to the police or the RCPCH should have reported the concerns to the police.
(c) It was wrong to recommend an HR investigation into allegations of murder.

395. By September 2016 Dr Brearey said that the paediatricians as a group felt they were being excluded, and that the trust was taking a different agenda. He felt as though they were suggesting the paediatricians had something against Letby and that the clinicians were behaving abnormally.

396. On 9th September 2016 Dr Jayaram met with Ian Harvey and he subsequently emailed a summary of the discussion to his colleagues **[INQ0103167/3]**. He was reassured that there would be a forensic detailed independent review by two different sources. Between September and December there was a clear lack of communication between the clinicians and the Executives, a period of time that Dr Brearey refers to as 'extremely frustrating'.

397. Eventually, only two doctors were shown a redacted copy of the RCPCH report and were then only given 1 hour to read it. To adopt Dr Brearey's words as set out in his email sent later in 2018 **[INQ0103159]** '"Fundamentally, the Execs treated the service review as a review of mortality and treated the Hawdon report as a robust review which it wasn't at her own admission then used the grievance procedure as evidence suggested or triangulated in IH's words. This was all very incompetent and misleading'. The Families would echo those sentiments.

398. The service review itself was helpful to a point and identified that there were gaps in medical and nursing rotas, investigating neonatal deaths should be strengthened 'appear to be reported at several different meetings but unclear at which the resulting actions are monitored. Despite sound structures, there seems to be disconnection between the neonatal leadership and the Trust's governance and risk management processes. Reviews highlighted examples of poor decision making, delays in seeking advice and delayed retrieval of infants to tertiary units.' **[INQ0001954/5]** Other issues identified included:

(a) Paragraph 3.9 'the MBRRACE-UK report published in May 2016 provides historical analysis of neonatal mortality and morbidity for births during 2014 and does not show the Trust as an outlier for that period, which makes the recent prevalence more curious.

(b) Paragraph 3.11 'the consultants note that several of the infants had collapsed unexpectedly and had been surprisingly unresponsive to resuscitation, despite the staff following standard protocols in each case.'

(c) Paragraph 4.4.23 not all of the cluster of deaths were reported to the Child Overview Panel (CDOP) as some were resident in Wales and at least some of those deaths should have had a rapid response meeting.

(d) Paragraph 4.3.7 Leadership at senior Trust level appeared to be somewhat remote from the day to day issues taking place in the unit

(e) Para 4.4.5 it is not clear who is responsible for Datix entry

(f) Para 4.4.6 until early 2016 there was a risk and Patient Safety Lead, it is worth noting that this role was filled by Debbie Peacock, a lawyer, who had a good relationship with the NNU. The role was vacant for a substantial period until filled in May 2015 by a Risk Midwife who was new to the job, difficult to work with and didn't do things she was asked to do. Dr Brearey told her he was 'underwhelmed with her service' and David Semple, her successor described in an email on the 16th June 2017 **[INQ0006771]** that 'to put it mildly we have inherited a mess.'

(g) Para 4.4.11 Nurses complete daily summary on Badger but use paper notes until discharge. Concerns were expressed that different system for care, incident and death reporting do not communicate and data differs between them.

(h) Para 4.4.12 The review team were concerned that it was only when the data was formally reviewed by the analyst did management realise how busy the unit was

(i) Para 4.4.13 Not all of the cases underwent a post mortem despite this being recommended by BAPM 2011.

(j) Para 4.4.25 The RCPCH review team were concerned that CDOP did not appear to be alert to the cluster of neonatal deaths and for at least some there should have been a rapid response meeting within 5 working days of notification.

399. An independent case review was required.

400. There is a somewhat telling sentence at paragraph 4.3.1 in which it was said ‘the senior nurses were very strong as a team and provided appropriate challenge to the medical staff and support to nursing colleagues.’ Their challenge was so great in 2015/2016 they simply drowned the clinicians out.

Dr Hawdon

401. Dr Jane Hawdon received a telephone call from Sue Eardley in September 2016 during which she confirmed she was happy for her name to be put forward for a case note review. Thereafter Dr Hawdon received instructions from Ian Harvey. As with the RCPCH review, Ian Harvey limited the information provided in the instructions. The Families will say that this was deliberate and cynical. There was no mention of Letby nor of the clinicians’ concerns about an individual nurse in her original letter of instruction **[INQ0014365]**; and nor was she provided with the letter from the RCPCH to Mr Harvey that had prompted her instruction and set out the actions taken to remove Letby from the NNU **[INQ0003120]**.

402. Insofar as the Families are concerned, Mr Harvey’s instruction of Dr Hawdon paid no more than lip service to the terms of what RCPCH had advised was necessary in their 5th September letter: only one expert had been instructed rather than two; there was no forensic paediatric pathology; no fully systematic chronology; and no consideration of the wider circumstantial evidence, and in particular no details of the staff who had access to the NNU at the material time.

403. The RCPCH had also specified that the records that Dr Hawdon was to be provided should be *“paginated to facilitate reference and triangulation”.* To the contrary, the limited records that she was sent by Ian Harvey were incomplete and in disarray. This was an irregular experience for her, and something that was never explained **[T/12.11.24/12]**. Dr Hawdon wrote to Mr Harvey on the 29th October 2016 and said ‘having worked through box 1 and reporting on the files therein, I was

a little taken aback to find loose records for these cases bundled together in envelopes in box 2 rather than inserted into each file…there were also loose print outs for 1 patient who did not have a file and for whom medical records were not supplied'. If Mr Harvey considered that Dr Hawdon's report should be a serious and forensic investigation into potential crimes, then the care taken in instructing Dr Hawdon and providing her with the material necessary to undertake that task provided no assistance in achieving that goal. The Families will say that the exercise was never intended to investigate the paediatricians' concerns. From the perspective of the executives at the CoCH it was intended to provide evidence that they had followed the recommendations of the RCPCH, whilst minimising the risk that the allegations would be revealed beyond the confines of the hospital.

404. As to the process of her report, Dr Hawdon told the Inquiry that she had emailed Ian Harvey to check that the parents of the children who had died had consented to her investigation **[T/12.11.24/42]**. His reply to her on the subject is contained within the disclosure and contains the assertion, "*Re parental consent, we had informed parent ahead of the review that it was occurring*" **[INQ0003123]**. As with his reassurance to Susan Eardley that consent was in place for the RCPCH review, Mr Harvey's assertion was misleading and untrue. This was another significant failing in candour and care from an experienced, senior clinician. As Dr Hawdon explained,

"Q. Why would that be important to you, to know whether that had been given?
A. It's -- it's vital that no -- no parent should know that the care of their baby is being reviewed by an external person without them being informed.
Q. It may seem obvious, but why?
A. The baby is their baby and all matters related to their baby are important to them." **[T/12.11.24/44]**

405. Dr Hawdon reported her findings under cover of a letter to Ian Harvey dated 29th October 2016 **[INQ0003358]**. She told him in terms that she had not fulfilled the terms of reference that the RCPCH had set. Nevertheless, even on the strength of the 'synopses' she had been able to create, she concluded that at least 5 of the deaths remained unexpected and unexplained and recommended that further and broader forensic reviews be undertaken, taking account of all of the circumstances.

406. Dr Hawdon's expectation was that receipt of such a report by a person who was aware that Letby had been present at the relevant unexplained events should have triggered an immediate safeguarding referral, and through those professionals onwards referral to the police **[T/12.11.24/24-25]**.

407. In giving evidence before the Inquiry Dr Hawdon was taken through her conclusions as to the causes of death recorded by her within her report and whether the list of those deaths that should

be regarded as unexplained remained accurate. She candidly accepted the limitations of a casenote review: it did not involve any discussions with the treating clinicians, or with the parents of the babies who were the subject of the review. It was, she agreed, an essentially superficial exercise **[T/12.11.24/52]**. She was unaware, for example, that Child E had a twin brother who had also collapsed unexpectedly. Had she known this, she would have found this concerning. She would have sought out Child F's records and if she had seen blood test results showing a very high level of insulin and an unrecordable level of c-peptide she would have been "extremely" and "without a doubt" concerned that exogenous insulin had been given to the baby **[T/12.11.24/59-60]**. As each case was explored in more detail, and information was added that could have been made available to her, or indeed to some extent was available to her through the records, she moved other cases from the column of explained deaths, to the column of unexpected and unexplained deaths. By the end of her evidence she had recategorised: Child C, Child D, Child E, Child O and Child P as unexpected and unexplained.

408. As things stood, though, her report gave the incorrect impression that deaths that were in fact the product of murder, were explained or expected. This continued to blur and obscure the picture that was available to the consultants, and subsequently to the parents. There were substantial delays in providing the report to paediatricians or to parents (see below). Dr Brearey confirmed that, when he eventually saw it, the case note review he saw 'wasn't much different to what we'd done…but it was something external'. The version provided to the parents and to the paediatricians was however truncated and had been edited. Various versions of the report appear amongst the disclosure.

409. On the 26th January 2017 the Consultants attended a meeting expecting to review the reports but they were confronted with the entire Board and the BMA representative for the Consultants, Sean Tighe **[INQ0003523]**. Dr Tighe described the meeting as 'pretty shocking really…it was extremely one-sided **[T/08.10.24/197]**. The paediatricians hardly had any opportunity to say anything and in fact hardly did say anything…the Chief Executive, whose tone was dictatorial, somewhat regimental, demanding that the board had made their decision, that this was final and that the paediatricians were to draw a line under the whole thing and were to accept Miss Letby back to work and were to apologise to her for the derogatory remarks…that had been alleged they had made.' Dr Brearey recalled Karen Rees reading out a statement from Letby 'Ms Rees was quite dramatic in her reading of it. We were all quite stunned, really. As a sort of synopsis of Executive behaviour, I can't imagine there's an example of anything more incompetent in the history of the NHS. How you can start a meeting saying you followed Speak Out Safely practices and then tell seven Consultants who all have significant concerns like this that they are to apologise to the person and that she would be going back to work or else there will be consequences, was quite -- quite striking and surprising and quite upsetting for -- for most people there' **[T/19.11.24/170]**.

410. Dr Tighe met with Dr Jayaram and Dr Brearey in the corridor outside the meeting 'to express my surprise and shock as to what we had both just witnessed and my deep concern for them and the position they were in.' As their union representative he said he was 'extremely disturbed by the pressure you are being put under…what I saw as a direct threat to them if they didn't do as they were told by the Chief Executive…I think he even said there will be consequences **[T/8.10.24/201]**.'

411. Dr Tighe told the inquiry about the 'element of distrust between consultant paediatricians, senior nurses and senior managers as a result of the allegations made by the former… all the professional people on the Board other than the Medical Director were from the nursing profession…the nursing profession and their views of the nursing profession were overwhelming on the executive board. The accused was from the nursing profession. Would it not, therefore, be natural for the nurses to defend their own?' **[T/8.10.24/213-214]** He went on to say 'it was clearly inappropriate for the MD to mount his own internal investigation and to analyse this himself, with no input from his own paediatric experts. **[T/8.10.24/215-216]**'

412. On 31st January 2017 Letby sent all of the NNU staff an email saying 'all allegations were unfounded and untrue and I have therefore been fully exonerated. I have received a full apology from the Trust.' Investigations had not been concluded and the investigations undertaken thus far had fallen short of adequately exploring, let alone reaching conclusions on the question of whether crimes had been committed. Either the email is the product of game playing on Letby's part, or it was based upon assurances given to her by senior executives, or a combination of the two. It would have been entirely incompetent for a professional to regard either the RCPCH report, or Dr Hawdon's report, as exonerating Letby and allowing a conclusion to be reached that she was safe to return to patient contact.

413. On 2nd February 2017 the Consultants requested sight of the case note review and Dr Brearey recalls Ian Harvey advising him that 'the coroner wasn't aware of the deleted paragraphs in the report or our concerns at that time.' On the 3rd February Dr Brearey obtained a copy of the case note review and he took it to Nim Subhedar who after review considered there were 7 babies that required further review.

414. Under cover of correspondence from Ian Harvey dated 8th February 2017 CoCH sent families A, C and D the redacted copy of the RCPCH report. This correspondence suggests the external assessment was also from the Royal College of Nursing; it was not. The letter goes on to say 'it describes no single cause or factor to explain the increase we have seen in our mortality numbers.' It failed to acknowledge that this was redacted. Mother A & B spoke to Sian Williams on the 13th February 2017 and was told that the independent review was 90 to 95% complete but the medical director was 'in the process of formatting the report so the information can be understood.'

415. It was not until 28th February 2017 the consultants were finally given the opportunity to read Jane Hawdon's report. At that time the parents had not been told. Dr Hawdon accepted in her evidence **[T/12.11.24/50]** that 'it is a serious omission that I did not say: and results should be shared with Families. But as far as I'm concerned that's a given.'

416. On 3rd March 2017 Ian Harvey wrote to Mother D 'within the Review that one of the recommendations was that a separate independent review of the care of each of the babies should be carried out…indicated that a small number of areas of investigation are required.' This was of course contrary to the public statement Mr Harvey had given to the BBC that the Trust had 'acted swiftly' and that the Reviews had been completed, which was given on the 8th February 2017. It would seem Mr Harvey continued to weave his own narrative.

417. Dr S Holt was asked about her recollections and she set out in her oral evidence that 'I put faith that the leaders within the organisation, the Medical Director, the Chief Executive, would know and understand how to, I don't know, process our concerns and apply due diligence to scrutinise, you know, and look into our worries. I don't think that is what happened and I felt one of the -- one of the senses I got was that it was protecting their own reputation and being concerned about negative publicity for the hospital' **[T/3.10.24/137]**. The executives' concern for the reputation of the hospital was a recurring theme through the evidence, both documentary and oral evidence. Dr Benneyworth confirmed that in her opinion, 'the NHS in particular has a poor reputation for transparency'.

418. And what of the parents, some of them we know received the doctored report in January 2017. It was not until the criminal trial that a number of the families discovered what had really happened. The lack of accountability, curiosity and a willingness to learn and improve enabled the Trust, specifically Ian Harvey, Tony Chambers and Alison Kelly to perpetuate the lie.

419. Hayley Griffiths (the Freedom to Speak-up officer)worked in the Risk and Patient Safety department. This was the unit to which Letby was moved, where she was given access and oversight to all records, reviews, investigations and assessments carried out by that department. A wholly inappropriate redeployment. In this department, without any supervision, she had access to numerous records, documents and internal communications relating to her actions.

420. Hayley Griffiths met Letby on the 1st September 2016. Hayley Griffiths advised Letby to take out a grievance against the doctors. Hayley Griffiths confirmed that the Speak out Safely policy set out that '"Concern must be based on a reasonable belief that you can justify but you do not need hard evidence that wrongdoing is happening'. As Dr Brearey told the inquiry **[T/19.11.24/216]** 'the evidence was quite clearly and it was all in the Thematic Review: the evidence of Letby's association; the sudden and unexpected nature of the collapses; the timings of the collapses; the numbers of the collapses; the fact there was no other explanation for this, that was the evidence'.

Phase Four – From September 2016 onwards

421. When considering events in this phase it is helpful to do so thematically rather than strictly chronologically. The Families will submit that this period is typified by efforts on the part of the senior management at CoCH to suppress the release of information regarding the concerns expressed by the consultants, by an abject failure to be candid and open with family members and by the direct and dishonest suppression of the facts. As time progresses the actions of the CoCH and the senior executives towards the consultants become more hostile and extreme. Throughout the period Letby, with the support of senior nursing staff, promotes the narrative of her own victimhood. She seeks to manipulate various individuals to support her and discredit those who raised concerns. This narrative is adopted by senior management at the CoCH, who use the hospital's grievance process as a mechanism to suppress the concerns being raised by the consultants and ultimately to threaten and bully them. This is done in order to suppress the concerns raised by them regarding Letby, The CoCH and its senior management were motivated throughout by a desire to protect the hospital's reputation, and therefore their own reputations. They ultimately did so at the expense of promoting patient safety.

The Inquest into the death of Child A

422. The circumstances pertaining to the death of Child A and the investigations into his death will be addressed in detail by Family Group 1. His case is referred to here as it provides an insight into the culture and practices at CoCH, which are relevant to the Families' submissions, and in particular when considering the CoCH's approach to transparency and candour with the affected families, and when considering its approach to the inquest into the death of Child D.

423. Having been opened and adjourned on 23 December 2015 **[INQ0002042/18]** and following an earlier postponement, Child A's inquest was finally heard before Nicholas Rheinberg on 10 October 2016. Ian Harvey had been sighted on the Trust's preparation for this inquest since at least 7 March 2016 when Sarah-Harper Lea had emailed him, attaching Dr Brearey's 'Thematic Review', summarising the Coroner's requirements for provision of further evidence from CoCH and noting "In order to prepare for the Inquest we need to consider duty of candour which Steve Brearey has advised Dr Saladi would be best placed to do" **[INQ0008927/5]**

424. By the June of 2016 and in the aftermath of two of the triplets' deaths the executives continued to take personal oversight of the upcoming inquest into Child A's death and in the evidence that was to be given at it. At the Executive directors meeting on 3 August 2016, it was minuted, in the context of a discussion of executive scrutiny of the management of the NNU concerns (the 'neonatal dashboard'), that Alison Kelly and Ian Harvey were to 'review' the statements prepared for the

inquest **[INQ0007197/140-142]**. That they would take such an interest in an inquest was an irregular occurrence **[T/28.11.24/80]** for which Ian Harvey offered the Inquiry no explanation, beyond failure of memory **[T/28.11.24/125]**. The Families would submit that this oversight over the inquest and the evidence that would be adduced before the Coroner demonstrates a desire by Ian Harvey and Alison Kelly to maintain control over the information coming into the public domain regarding events at the CoCH and Letby's involvement. It is part of a pattern of controlling the narrative and supressing information.

425. There was further linkage between Letby and executive engagement in Child A's inquest in the minutes of a subsequent executive meeting on 8 September 2016. The discussion then had centred on a strategy to deal with Letby's grievance **[INQ0006265]**. It was minuted that those present (including Ian Harvey, Alison Kelly and Tony Chambers) agreed that the "Nurse remains on unit". That was so despite Alison Kelly being recorded as having recognised the tension between "care / safety of the unit" on the one hand and "treatment of Lucy" on the other; but suggested that the two needed to be "balanced". No individual is recorded as having challenged this analysis. Amongst the actions to be taken and matters to consider in relation to that issue the endorsement "Plus Inquest Child A disclosure" has been made to the manuscript minutes.

426. There can be little doubt that the Child A inquest statements were sent to and reviewed by the executives, and that despite Mr Harvey's claim to forgetfulness, he was keeping the closest watch over the preparations for the inquest. On 27 September 2016 (the week before the rescheduled final inquest was to take place) Joshua Swash forwarded to Ian Harvey the email he had that day sent to instructed counsel Louis Browne. He did so at the request of Stephen Cross **[INQ0052593]** - with the explanation,

"Stephen Cross has asked me to forward this email to you which I have today sent to counsel regarding the above inquest, and as you will note that the nurse that has recently been moved out of the neonatal unit was involved in the care of baby [Child A]. You will also note that Stephen is going to speak with counsel about disclosure to the Coroner on this matter."

427. It is clear from context that Mr Harvey required no explanation as to who "the nurse" was, nor of the fact that Mr Cross was to intercede directly with counsel in relation to "disclosure to the Coroner on this matter". Although in evidence Mr Harvey relied upon another failure of recollection and stated that he 'refutes' **[T/28.11.24/177]** any suggestion that his involvement in this exercise was to ensure that concerns about Letby were not disclosed to the Coroner, no other credible explanation has ever been provided. The Families submit that his interventions in this regard should be seen alongside his conduct in relation to other issues. They will say that he demonstrated a profound lack of openness throughout.

428. The 'counsel' referred to in Mr Swash's email was Louis Browne (now – but not then – KC) and he had advised specifically in relation to the need to disclose the concerns about Letby to the Coroner. At a pre-inquest meeting with the Trust's inquest witnesses on 8th September 2016 Mr Swash had noted Mr Browne's advice that if it transpired that Letby had been involved in the care of Child A, then that fact and the fact of the spike in deaths had to be disclosed to the family. Mr Swash had then considered the underlying medical notes **[INQ0108406/5-6]** and determined that Letby had been involved in Child A's care. His email provided that information to counsel and in so doing removed any uncertainty from the advice that he had given -– disclosure had to be made to the Coroner and to the family.

429. In evidence, Mr Browne's account was that: he had instructed such disclosure to be made in conference; he understood that disclosure had been made; he did not understand why it had not been; and that responsibility for that failure rested with Mr Cross for not following his advice **[T/4.12.24/50]**. That account raises questions as to how in then subsequently conducting the inquest proceedings experienced counsel would not have come to realise such disclosure had not been made. It is curious to say the least that he would not have appreciated that such significant information would have been a source of interest and questioning from both the Coroner and the legally represented family? The resolution of this particular issue may not be for this Inquiry, but it may have relevance to the evaluation of Mr Browne's wider account.

430. What is clear from the evidence is that after the conference and Mr Swash's research an intercession took place that countermanded the advice that Mr Browne had given that disclosure about Letby should be made. Each of those involved in the decision to supress disclosure– Browne, Harvey and Cross – disclaim responsibility. Each claims failure of memory. Mr Browne also claims that he is sure he was not told there was any suspicion that Letby had deliberately harmed babies on the NNU; and asserts that he would have immediately advised the Trust to make referrals to Safeguarding and the police had he been so informed **[T/4.12.24/9]**. He does accept that he must have been told that there was a "consistency" of Letby's presence coinciding with the neonatal collapses **[T/4.12.24/13]** and accepted Mr Swash's contemporaneous note that he formally advised the CoCH that fact must be disclosed to Family A if she had been involved in Child A's care.

431. It might be inferred from the contemporaneous records that the discussion referred to in Mr Swash's email between Mr Cross and Mr Browne (and under the superintendence of Mr Harvey) took place; and that Mr Browne was ultimately persuaded that disclosure need not be made. It is regrettable that none of those three witnesses have assisted the Inquiry with a description of those discussions nor an explanation of their thinking at the time. Any suggestion that involvement in the making of such a significant decision has fallen from memory **[T/4.12.24/27]** – particularly in the light of everything that followed with the arrest, prosecution and conviction of Letby – is in the Families' view, unconvincing. What is incontrovertible is that Ian Harvey and Stephen Cross either

ignored Mr Browne's advice or persuaded him to change it. Either alternative was reprehensible and a perversion of proper approach to child protection and the coronial jurisdiction.

432. The failure to make disclosure at Child A's inquest was compounded when neither of the CoCH Trust witnesses made mention of their suspicions when giving evidence. In his pre-inquest meeting with Louis Browne Dr Jayaram had told his counsel that he "still to this day … doesn't know why this happened. 27 years in paediatrics, never seen this kind of situation" **[INQ0108046/9 and T/13.11.24/59]** Within that conference the discussion included ""Review Royal College of Paediatrics, pattern of deaths appear unusual, further inquiry required, forensic review"?" and the advice, ""If review is outside of the remit of your knowledge, then say so." was recorded **[T/13.11.24/59]**.

433. Advice not to 'speculate' or 'guess' might frequently be given to witnesses in all sorts of proceedings, but it had a particularly chilling impact on these facts where the clinicians were repeatedly being told that their concerns were speculative. Dr Jayaram had his 'hot debrief' in relation to the RCPCH review with Ian Harvey on 8th September 2016 at which he had been told "that they hadn't identified any significant issues with clinical practices, that there were a number of recommendations around team working and leadership although he didn't specifically say what areas, and that they had recommended a forensic -- full forensic Casenote Review" **[T/13.11.24/60]**

434. It was in that context that Dr Jayaram was instructed not to say anything outside of his knowledge – including the review – and not to speculate in his evidence **[INQ0003118 and T/13.11.24/63]**. Importantly, the Coroner had been given the directly contradictory impression. Mr Cross wrote to Mr Rheinberg to tell him "The Review Team have indicated they were entirely satisfied with the care within the neonatal unit and raised no concerns. However, they recommended that a detailed forensic Casenote Review of each of the deaths from July 2015 should be undertaken, so consequently this is still a work in progress." Then: "I have instructed Louis Browne ... counsel in the matter and is fully aware of the review and Dr Jayaram as the Lead Consultant is fully aware of this matter." **[T/13.11.24/64 and INQ0107964/24]**

435. The impact of the advice not to speculate had was most clearly spelled out by Dr Saladi in his evidence to the Inquiry

" 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." **[T/3.10.24/30]**

436. None of the foregoing serves to excuse the failure of Dr Jayaram and Dr Saladi to disclose their suspicions to the Family and the Coroner at Child A's inquest. They each accepted that failure, something the Coroner was to quantify as extremely disappointing and a complete failure **[T/6.12.24/60-61].** In his evidence Dr Jayaram explained that at the inquest he had made an 'oblique' reference to Letby when recalled before the Coroner **[T/13.11.24/244]** and 'threw breadcrumbs' but in his own words 'didn't have the courage' to be candid and open and identify his concerns about Letby directly and specifically **[T/13.11.24/25]**. Dr Jayaram must answer for those particular failures in his duty, but the Families encourage the Inquiry to look at those failures within the context of the pervading culture and the pressure that appears to have been applied from senior management.

437. Mr Harvey's involvement with the Coroner did not cease with Child A's inquest. He and Stephen Cross met with Nicholas Rheinberg on 8th February 2017 to advise him that "no theme has emerged from the in depth investigations" into the neonatal deaths at the Countess of Chester **[T/28.11.24/186]**.

438. Put together, it is submitted that scrutiny of Child A's inquest proceedings and the CoCH's wider engagement with the coroner permits no other inference than attempts were being made at the highest levels to prevent coronial scrutiny of the concerns about Letby or the unusual increase in neonatal mortality at the CoCH that began with Child A's death.

The impact of tribalism and Letby's manipulation.

439. On 9th September 2016 – and at a time before Dr Hawdon has even been instructed to undertake the "detailed forensic casenote review of each of the deaths since July 2015" that the RCPCH had recommended be urgently undertaken - Karen Rees emailed Alison Kelly with the purpose given as "to explain how I feel". Ms Rees goes on to make an emotional intercession on Letby's behalf characterising the decision to redeploy her from the NNU as "wrong and immoral" and based "on a senior Clinician having a 'gut feeling' with no evidence (except that LL has been present at a number of these neonatal deaths)". The doctors versus nurses tribalism is patent in the terms of Ms Rees' complaint. She concludes her email in these terms:

"There is also the impact, not only for the NNU but for the rest of the organisation and the message that this sends out - **a Clinician is being listened to and supported, with potential devastating consequences for a nurse. How are the nurses on the NNU going to react?** I have already witnessed that senior nurses on that unit, do not even want to answer the telephone to that particular Consultant, who is making these allegations and making clear of his personal view.

It was a sad day for me yesterday. The frustration and emotion of not being able to change the decisions that have been made, compounded by the unfairness of it all, makes me sad to think

that we still appear to hold Clinicians in high regard...the same not afforded to nurses." (emphasis added)

440. This is frank tribalism and part of a pattern of behaviour by senior nurses and nurse managers that entirely ignores the seriousness of the concerns raised and the concomitant need to safeguard patient safety. It resonates with Eirian Powell's disparaging comments in her oral evidence about doctors **[T/17.20.24/22-23 and T/17.20.24/211]** and suggests a deeper and more historical animosity that might be said to have been created by these events. The Families will be dismayed to read this communication and its contents, which appear to reduce what should be a forensic and circumspect investigation into the prospect that their children had been attacked and murdered into the politics of the playground. It shows no insight or professionalism. It demonstrates a profound lack of leadership, an abject failure to promote a patient safety orientated culture and an attitude, that if prevalent in other units and allowed to continue, will lead to further harm to patients. No better words describe it than pathetic and childish.

441. The evidence before the Inquiry demonstrates that this toxic tribalism was endemic throughout the nursing hierarchy within the CoCH. The (perhaps unintended) impact of Alison Kelly examination before the Inquiry demonstrated that her instinct was always to listen to nurses, rather than doctors; and that was so irrespective of their respective competencies to express an opinion on the point at issue:

"Q. If in those circumstances you had said to Dr Brearey: do you think she might be causing harm deliberately and he had said yes, what would you have done?
A. We -- I probably would have took different action but that conversation never took place.
Q. Now, had you treated it as a safeguarding issue, would you have spoken to the named doctor, Dr Isaac, immediately following that meeting?
A. I would have probably gone to my safeguarding team, as in the nursing team first, Dr Isaac was based on the unit. So I probably would have gone to my corporate nursing team first.
Q. Isn't this a matter for the named doctor?
A. It -- it is but the first place I would have gone would have been my team, which are the safeguarding team" **[T/25.11.24/11]**

And

"Q. So you have there, we have just been through, four expressions of expert opinion [from Doctors] plus a fact which is consistent with the concerns that you are being told about?
A. Yes.
Q. That is an adequate basis for action, isn't it?
A. Yes. But we were balancing that with the nursing view of her practice and of how highly she was thought of on the unit as well.

Q. Which is irrelevant, is it not, to the issue of whether she is doing this deliberately?

A. Well, we needed to get -- we needed to get more facts, we needed to pull things together to see what the fuller picture was at the time." **[T/25.11.24/18]**

442. The instinct to tribalism is particularly dangerous where – as here – the individual at issue is manipulative and pandered to. Letby and her parents were provided with a direct meeting with the nursing senior managers and executives (Tony Chambers, Alison Kelly and Karen Rees) on 22nd December 2016. The minutes of the meeting begin with Letby's parents reading out a statement of their feelings about events and the impact on them and their daughter. The statement by them has the feel of a victim impact statement, of the sort that would subsequently be submitted by the Families. Thereafter Tony Chambers gave his overview of the investigations that had been carried out into the increase in mortality rates on the NNU: the claims of the link between Letby and the deaths were "unsubstantiated" and "never accepted" by the executives. John Letby stated Drs Jayaram and Brearey should be "instantly dismissed"; and Mr Chambers stated that at the upcoming meeting with the consultants: "We will discuss the recommendations of the Royal College review, behaviours we expect to see will be clearly described, and then disciplinary action may follow if not followed" **[INQ0003463/1/3-5]**. In evidence **[T/27.11.24/103-104]** Mr Chambers denied the clear meaning of the words he said in that meeting but – it is submitted – to the contrary, both his meaning and the focus of his sympathies are apparent from the note.

443. The meeting on 22nd December 2016 also contains the first recorded use of phrase "draw a line". This phrase would subsequently appear within different contexts, in particular used as a direct threat against the consultants and references to it being used were common threads throughout their evidence. When giving evidence, Mr Chambers refused to accept the clear meaning and import of the words of the record:

"Part of this sharing is us as an organisation drawing a line. Anyone steps over that, full disciplinary policy may be used." So what Letby is being told in this meeting is now the report has been shared, a line is being drawn and if anybody continues to talk about this, disciplinary process.

A. No.

Q. Isn't that what that means?

A. No, not at all" [T/27.11.24/105]

444. This factionalism – the setting off of the 'victim' Letby against the 'aggressor' consultants continues throughout the period under scrutiny and indeed continues in different fora to this day. There is little doubt that Letby herself strongly promoted this narrative of victimhood and used it to distract and divert attention away from the allegations levelled against her. On 10th January 2017 Letby was given a personal briefing by Tony Chambers, Alison Kelly and Karen Rees (all nurses as well as senior executives) on the Board meeting that has taken place the same day. The minute of that meeting contains the following extract **[INQ0003471/2]**,

“Mr Chambers advised you that the Board were absolutely clear in their support for you to return to the Neonatal Unit, in the requirement of the Doctors to make an apology to you and in supporting the recommendations of your grievance. Mr Chambers advised that if the doctors didn't make an apology, there would be other elements to consider”.

445. By 31st January 2017, Letby had been permitted to send an email to all NNU staff stating, inaccurately, that she has been “fully exonerated” since all the “distressing allegations of a personal and professional nature made by some members of the medical team” have been found to be “unfounded and untrue” **[INQ0058624].** This was so despite all members of the executive team being aware that there had been no such evaluation of Letby’s conduct and that the long series of NNU deaths and collapses remained unexpected and unexplained by any of the investigations that had taken place. This email provides further proof of Letby’s tendency to promote herself as the victim, which if not actively supported by the executives and managers, was condoned by them through inaction.

446. No doubt emboldened by the assurances that he had given to her, when Letby met Tony Chambers again on 6th February 2017 **[INQ0014279]** she demanded that she “expects four apologies” from the consultants. Mr Chambers responded to this by telling her they all support her return and that he will also obtain an apology from Jim McCormack. Letby was told in terms by Mr Chambers: “Lucy don’t worry we have got your back”. This was not “clumsy language” **[T/27.11.24/120]** as he tried to explain it away, but an accurate description of his continuing mindset and approach. It is entirely consistent with Tony Chamber’s conduct as recorded in contemporaneous documents and accords with the perception of the consultants that their attempts to highlight Letby’s crimes had resulted in them becoming the focus for criticism and persecution. It demonstrates clearly that Tony Chambers had lost all perspective on the seriousness of the issues that were being raised and the need to ensure that appropriate safeguarding responses were put in place. He had descended into simple-minded tribalism, losing all situational awareness and demonstrating a profound failure of leadership. Were there ever a situation where it was necessary for the leader of an organisation to be circumspect, reflective and forensic, this was it. Had a robust patient safety orientated culture existed within the CoCH at the time it would have sought to ensure that the issues raised were properly investigated with the involvement of the police, following a proper safeguarding route whilst at the same time ensuring that Letby was supported through the process until such time as a proper conclusion could be reached as to her involvement in events. As it was, under Tony Chamber’s leadership, tribalism and emotion were allowed to distort the process leading to a chaotic, febrile and tribal environment where the need to safeguard patient safety was quickly forgotten.

The Grievance

447. The Families would observe that the evidence heard by the Inquiry indicates that the senior management at the CoCH never engaged in any robust or coherent internal investigation into the concerns raised against Letby, whether disciplinary, or by reference to her competence, even when specifically advised to do so by the RCPCH. They did however investigate and criticise the conduct of those who had raised the concerns in the first place by a subversion of the proper grievance process.

448. The grievance had first been raised by Letby on 7th September 2016 **[INQ0002749]**. The day before, Sue Eardley wrote to Ian Harvey informing him that the RCPCH team were recommending both: "that the Trust takes immediate steps to formalise the actions you are taking with the nurse. Our understanding is that an allegation has been made and therefore a process of investigations needs to be put in place which sets out the nature of the allegation and the process you will follow to investigate it" and that "a detailed forensic case note review of each of the deaths since July 2015 should be undertaken". This advice should have been clearly understood by the senior management at CoCH to mean that the allegations directed towards Letby should be investigated through a proper forensic review of the deaths occurring within the NNU since July 2015.

449. The recommendation/advice offered by the RCPCH was not followed and no formal forensic investigation was instituted. On one analysis, the decision to commence a grievance process in place of a forensic review reveals the biases and operating assumptions in place amongst the senior management – that they had concluded that the allegations were false or baseless. Given the evidence available to them at the time there was no reasonable basis upon which they could reach that decision. If that was the basis for the decision it was based upon ill-constructed judgements biased by tribal loyalty combined with the desire to protect reputations and an unwillingness to contemplate the potential truth of the allegations.

450. An alternative analysis of the decision is that it was motivated purely by the desire to protect the reputation of the Trust and its senior managers, perhaps influenced by the potential embarrassment that would arise from a high-profile nurse being the subject of an accusation of murder. Either explanation would involve a serious deviation from the conduct that should be expected of an NHS Trust with a solid patient safety focus.

451. Whatever the underlying motivation for selecting the grievance process as a means of addressing the allegations made, that choice would, perhaps inevitably, bring about the outcome that would eventually ensue. It would categorise Letby as a victim, and the whistleblowers as the wrongdoers. It would shift the focus of the investigation onto the perceived harm that had been caused to Letby, distracting attention away from the issues that led to her removal from the NNU in the first place.

452. If the decision to follow the grievance route was motivated by a belief that the CoCH would owe a potential liability to Letby under employment law, it was misguided, and the executives should have

been quickly disabused of the notion. On 5th July 2016 Dee Appleton-Cairns had telephoned Ian Pace of DAC Beechcroft for advice. As his note **[INQ0101934]** and account of that call set out, his advice was that the employment aspects “paled into insignificance compared to the patient safety risks concerned” **[T/21.11.24/73]** an issue that he considered she had not recognised **[T/21.11.24/75]**. Advice was also provided repeatedly that the consultants’ concerns needed to be dealt with under the Trust’s ‘Speak out Safely’ policy **[T/21.11.24/96]**, something which did not happen until after the police had finally been contacted nearly a year later and with which we deal in more detail below. The Families will submit that this advice was correct. In any context patient safety, and the adjunct protection for whistleblowers should take priority. It would be absurd if a situation were allowed to exist whereby ensuring the well-being of an individual accused of harming patients should take priority over ensuring patient safety.

453. This advice was not heeded. Once a grievance has been raised it may not have been unreasonable to progress it, but it was obviously lopsided and prejudicial to investigate the propriety of whistle-blowers raising concerns, and not the substantive safeguarding and safety concerns that they had raised.

454. On the day after Letby had raised her grievance, she felt empowered to send a copy of it through her union representative Hayley Cooper to both the CEO and the Chair of the Trust on 8th September 2016 **[INQ0002748]**. There then followed a meeting of the executive team on that day **[INQ0006265]** that considered Sue Hodkinson’s Neonatal Unit Options Appraisal **[INQ0004660]**. That document included as an option the undertaking of a disciplinary investigation against Letby to regularise the procedural position which must seemingly to have been rejected, although no insight as to the reasons for that rejection has ever been offered. Instead, the meeting determined that the attendees agreed Letby should remain “on unit”. As the chronology shows, this was the consistent executive plan almost until the moment the police were called. It was agreed at a time before the forensic case note review had even been commissioned let alone reported (Dr Hawdon was first approached by Ian Harvey later in 8th September but she was not formally instructed until 5th October 2016).

455. Ian Harvey appears to have set the direction of the grievance before it began by telling Dr Green that the number of neonatal deaths was “not out of the normal range but it was high” and also that the RCPCH had “found some concerns around medical leadership on the unit and around clinical decision-making and the care of individual babies” **[T/6.11.24/168]**. These observations either deliberately distorted the evidence that had been presented to him by that stage or demonstrate an incompetent and/or superficial understanding. In either case they should not have formed the foundations for the grievance process.

456. For his part, Dr Green seemed to have accepted Ian Harvey’s assertions without any checking, and to have proceeded accordingly. This may not be unreasonable, given that he was a Pharmacist

with little relevant clinical experience. From his first interview it should have been apparent that the process ought to have proceeded no further: her claims to 'bullying' were without detail or substance; and the need to first investigate the safety and safeguarding concerns that had been made was again underlined from her union representative's first opening salvo,

"Professional responsibilities. What is the Trust doing about it? What evidence does the Trust have? Is there to be an investigation into a practice? What are the grounds? Does she have to undertake supervised practice? Who else has to undertake it? No one else, why not? Why she's been singled out? When can she return?...

There is [sic] serious allegations. Why hasn't this been reported to the police? Why is the organisation sitting on something like this? Has the organisation challenged this evidence?" **[T/6.11.24/178-179]**

457. The shortcomings in the process and outcomes of the grievance were covered in detail in the evidence. The process lacked any forensic structure and failed to adhere to even basic evidential safeguards. Rumour was allowed to stand as evidence, facts and allegations were not properly tested or analysed and conclusions appeared to have been based upon instinct or personal bias rather than evidence. The term "witch hunt" is overused in the context of the Letby case and features in the language of Letby's supporters through the grievance process. It is misused in that context. It would be more appropriate to describe the grievance process as a witch trial. It started from the premise that the allegations made against her were unfounded and, perhaps inevitably, criticised those who made them. This distortion of the process was either cynical and deliberate, or utterly incompetent, in any event it allowed Letby's complaints about her own victimhood to manipulate the discussion away from the issues raised in the allegations, which it never considered. The Families do not accept the assurances of Dee Appleton Cairns that the process was conducted objectively and fairly. They will say that she presented as a particularly egregious witness upon whose credibility little or no weight should be placed. The obvious implication from the evidence is that she successfully sought to influence the outcome of the process and that the judgment was prepared subject approval and editing by the senior nursing managers.

458. Although it cannot be said that the grievance process provided Letby with the opportunity to cause further harm, it undoubtedly delayed justice for the Families, diverting as it did attention away from the need to investigate her actions and contact the police. Although Dee Appleton Cairns appeared arrogantly unrepentant when presented with that suggestion, the Families believe strongly that the process was misused, permitted Letby to retain her liberty for longer than otherwise would have been the case and came close to restoring her to a position whereby she could resume causing harm.

459. Mr Lythgoe, Director of Operations for the HCSA on the 5th December 2024 explained the disciplinary framework for doctors, MHPS (Maintaining High Professional Standards) where he said it was not common to find an impartial or fair investigation but it was common to find victimisation of doctors. He highlighted that those investigating were often asked to investigate complex issues without the necessary access to draw attention to cases and without access to the Executive leaving an inability to be ineffective.

Evasion of Board Accountability

460. The executive directors met on 7th December 2016 **[INQ0004366]**. An "in depth conversation" on the neonatal service reviews is recorded in the minutes, together with a plan to update the board in January 2017 and a resolution that Ian Harvey lead on external communications. Up until that juncture, the dissemination of the contents of the commissioned reviews had been both extremely limited and tightly controlled and the nature of the ultimate report to the board is illuminated by considering what had come before.

461. On 8th September 2016 the executives resolved that it was their intention to ensure Letby returned to the unit **[INQ0006265]**; and on 19th October 2016 they had further agreed that distribution of the RCPCH report would be limited to them **[INQ003202 and INQ0003370]**. The only external consideration of it before the report to the board in January 2017 had been the very limited opportunity afforded to Drs Brearey and Jayaram to read (but not take away) the redacted version on 10th November 2016 **[INQ0003111]**. By then, Ian Harvey had been sent both Dr Hawdon's report and her covering letter that stated she had been unable to carry out the full extent of her instructions **[INQ0006862 and INQ0003358]**. Neither document was shared with the consultants.

462. Dr Brearey was asked to attend a meeting two weeks later on 24th November 2106. He was forbidden from discussing what he had read with anyone else (later formalised in a letter dated 13th December 2016) since "To do anything other than this is in direct contravention to an instruction from myself as noted by Sue [Hodgkinson]" That letter was itself dishonest. It asserted "you had the opportunity to review a draft [of the RCPCH] report. We do not know that the final report will correspond closely with this draft; therefore, it would be inappropriate, if not irresponsible, to discuss any findings with those that haven't seen it". In fact, the final RCPCH 'close out' letter enclosing the two versions of the report had been received by Ian Harvey three weeks before it was sent on 24th November 2016. **[INQ0009617, INQ0009618, INQ0009619 and INQ0009620]**

463. In that context, the carefully controlled management and misleading redaction of the information provided to the CoCH board can be seen to be deliberate policy, rather than oversight or mistake. In advance of that disclosure, it was minuted at a further meeting of the executives' group on 30th

November 2016 that Ian Harvey was to talk with Sir Duncan Nichol about the next steps ahead of the meeting.

464. That meeting took place on 30th December 2016. Sir Duncan Nichol, Tony Chambers, Ian Harvey, Lorraine Burnett and Stephen Cross met. A handwritten note of the meeting recorded that Ian Harvey gave a summary update and there was discussion of what should be done with the unredacted version of the Royal College of Paediatrics and Child Health report. The notes recorded a decision to endorse the transition of Letby back onto the Neonatal Unit **[INQ0004299]**. Although various executives, including Tony Chambers, denied that the process was underway prior to the police being contacted, this is the clear implication from the contemporaneous documents and indeed Tony Chambers' assertions to Letby (see above).

465. That carefully coordinated meeting finally took place on 10th January 2017. **[INQ0003518]** was Harvey's brief/recommendation to the board; [INQ003237] are the minutes. The Board were provided with the 'dissemination copy' of the RCPCH report. They were not provided with the unredacted copy, nor even told of its existence. They were not provided with the Hawdon report, nor were they told that she considered she had been unable to fulfil her instructions. None of the consultants were invited to the meeting, and neither were their concerns summarised or explained.

466. The tone of Mr Chambers' address to the meeting provides further evidence of his bias towards Letby and lack of objectivity. He told the meeting, "there is an important set of consequences for people and for one individual. There's an unsubstantiated claim that the issue is down to one individual's actions and behaviours. We did explore supervised practice for the individual but this was not supported by clinical colleagues." **[INQ003237/2]** His assertion that the concerns against Letby had been found to be "unsubstantiated" was immediately followed by a dramatic reading of a statement from Letby by Sue Hodkinson or Karen Rees. The result was Sir Duncan Nichol's statement that the Board supported Letby returning to the Neonatal Unit. The assertion that the allegations were unsubstantiated was either dishonest or displayed a staggering lack of insight, knowledge or intelligence. Mr Chambers should have realised that the allegations had not been investigated let alone subject to proper analysis or testing. They might be described as 'unproven' at that stage but that should not have been to suggest that they were unfounded. The Families would prefer to categorise Mr Chambers' statement to the non-executive board as deliberate and cynical, motivated by a desire to suppress the concerns raised by the whistleblowers.

467. In his evidence to the Inquiry Sir Duncan Nicol accepted that he should not have allowed the information to be stage managed in this way, and that it was a failure of his not to ensure that the consultants were present at the meeting **[T/2.12.24/75]**. His view that he and his fellow board members had been misled by the executives was accurate **[T/2.12.24/78]**

"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…

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."

468. Even in retrospect and in the face of the evidence, Mr Chambers refused to accept that he had misled the board when he told them that the RCPCH report had made no immediate recommendations when it plainly had **[T/27.11.24/94-95]**. That part of his examination was an exchange which we submit was revelatory of his whole approach to his evidence and to the work of the Inquiry. It was stated that only one cause of death had been found to be unascertained (dismissed – without evidence – as 'not uncommon') when in fact Dr Hawdon had by that stage placed 4 deaths in that category; and the outcomes and conclusions were also misrepresented. Again, Mr Chambers would not accept that this was an attempt to discredit the consultants to the board; and he vacillated and became combative and obstructive when pressed on the point by CTI **[T/27.11.24/96-98]**. This exchange alongside others demonstrates that Mr Chambers was an utterly unreliable witness of fact. His evidence was disingenuous, self-serving and arrogant.

469. Beyond the particular terms used, the entire approach and presentation of the RCPCH report (both to the board and elsewhere) was misleading. As Ian Harvey was ultimately obliged to accept in evidence to the Inquiry **[T/28.11.24/198]** a casenote review by a specialist forensic pathologist would have been necessary to evaluate whether there were suspicious circumstances in each of the individual deaths, not the RCPCH service review he had commissioned and received (something the College had told him in terms) **[T/28.11.24/198]**. The following exchange in his evidence was also instructive:

"But just to be clear, the report that was produced as a result of that review could not be relied on to exclude the possibility that the children had been harmed?
A. No.
Q. The same really must apply to Dr Hawdon's examination and Dr McPartland's examination, because first of all, Dr Hawdon, in respect of five of the deaths -- or four, and I am sure you will be asked about why that may have changed -- couldn't find an explanation. So, by definition, she hadn't found a crime or excluded a crime. She was in the same position, really, as Child A's pathologist was: it was unascertained. So that had not excluded Lucy Letby harming them?
A. No."

470. Nevertheless, the report was presented as having answered the consultants' concerns which had – in truth – never been investigated. But then that had been the Mr Harvey's approach from the outset.

"it was irresponsible and dangerous to return Lucy Letby to the unit because you could not be confident, as the Medical Director of the hospital responsible for patient safety at the Countess of Chester, that Lucy Letby would not harm children again?

A. I would have to accept that, with retrospect, yes, it would have been a risk -- well, more than a risk for her to have gone back on to the unit.
Q. One which should never have been countenanced?
A. Looking at this no." **[T/28.11.24/208]**

471. Another particularly egregious aspect to the presentation to the non-executive board was the emotion that was brought into the meeting through the reading of what amounted to Letby's victim impact statement. This provided Letby the chance to communicate to the top of the organisation and use her complaints of unfair treatment as a weapon to influence the board and to manipulate the hospital's handling of the consultants' concerns.

Applying pressure to the consultants

472. The extent and impact of the pressure applied to silence and control the consultant paediatricians was apparent from the evidence they gave to the Inquiry. Dr Suzie Holt put it in this way **[T/3.10.24/170]**,

"It was -- it was a pretty astonishing time. The challenge we had was that all of us feel very passionately about our service and I say that even though I don't work there any more, we all felt passionately about our service and wanting to be able to continue to offer a service and we were providing an amazing service to the paediatric patients as well as the redesignated neonatal unit and eating disorder service and training the next generation of doctors. I think we all felt that working with our board was going to be better for the population than all of us ending up on gardening leave, which felt like was the insinuation from that January meeting, that if we didn't toe the line then we wouldn't be remaining in our jobs and I think it's important to remember at this point that there was already talk of her returning to the neonatal unit and we still didn't think sufficient investigation had taken place. So there was a degree of thinking actually we need to also keep our voice and not be silenced to prevent that happening."

473. One stark example of the executive attempts to silence the consultants' continuing concerns is provided by the 'draw a line' meeting of 26th January 2017 at which Tony Chambers banged the table and threatened consequences against any who dared challenge the narrative he had set

down **[INQ0003523]**. Looked at objectively, it was inexcusable that experts who had raised good faith patient safety concerns came to be treated in such a manner. It is notable that by the time of that meeting the RCPCH and Hawdon reports were still being withheld from the consultants and had yet to be considered by any expert paediatrician within the hospital. The meeting – and the attempts to silence further safety concerns - proceeded without any expert analysis of the outcome and sufficiency of investigations that had been undertaken.

474. Dr Saladi described Tony Chamber's conduct at this meeting in forthright terms. Mr Chambers was 'red faced' banging on the table and speaking forcefully. He stood whilst speaking, told the attendees that the investigations were complete and that the executives were 'drawing a line' under it. He emphasised this point by banging his fist on the table. **[T/3.10.24/109-110]**

475. It is notable that Tony Chambers asserted in this meeting that the consultants' concerns had been managed under the Trust's 'speak out safely' policy **[INQ0003523/2]**. This was simply untrue. Active pursuit of detriment and punishment against the consultants was the central tactic deployed to achieve the strategy of controlling the message and suppressing concerns. In her evidence, Alison Kelly accepted that Mr Chambers' statement had been untrue but could offer no explanation as to why neither she nor any of the other executives present had done anything to challenge it **[T25.11.24/57-59]**.

476. Following on from the meeting, on 20th February 2017 the committee responsible for 'speak out safely' made an active decision not to log the consultants' concerns under the policy, and thereby to deprive them of its protections **[INQ0098375/3]**. Instead, when Dr Jayaram raised concerns at being forced into mediation with Letby he received an email from Ian Harvey instructing him to engage or risk a referral to the GMC **[INQ0003119]**. It is also clear that the making of a regulatory referral against the consultants continued to be part of the options Mr Chambers considered deploying: at a meeting of the executives on 16th March 2017 he is noted to have said "part of me says ring police and GMC" **[INQ0003344/3]**

477. Unedifyingly, once contact with the police had been raised, there was then an apparent attempt to obscure and reverse the earlier decision to refuse to recognise and protect the consultants' concerns. In a series of minutes the committee sought to go back and rewrite history (and their records) to obscure the fact that an active decision not to formally record the concerns had been made **[INQ0098434, INQ0098376 and INQ0098458]**.

Dissemination of the RCPCH report and misleading communication with External Bodies

478. Having minimised and obscured the true nature of the concerns about Letby and the neonatal deaths and collapses to the Coroner and the board, the executives set about an identical strategy in their communication with external agencies and with the Families. They repeatedly misled those

who would have been able to provide guidance and accountability, and squandered opportunities to progress the investigation and bring Letby to justice.

479. On 22nd December 2016 the Care Quality Commission held an engagement meeting with the Hospital. The hospital was represented by Ian Harvey, Alison Kelly, Sian Williams and Ruth Millward from the Hospital and Julie Hughes and Debs Lindley from the Care Quality Commission. The agenda for the meeting noted neonatal services to be a key risk area under the heading "Strategic Update from Trust" **[INQ0017298]**. There was discussion of the RCPCH report but it was not disclosed to the CQC. There was no mention of Letby nor of the consultants' concerns (which mirrored the approach taken by Alison Kelly when first reporting the fact of the RCPCH review on 30th June 2016 **[INQ0017411]**). The CQC were not informed that Dr Hawdon had been instructed to conduct the forensic case note review, let alone that she had reported that she had been unable to fulfil her instructions **[T/15.11.24/77]**.

480. Grotesquely, the first person outside of the CoCH directorship to be shown the final (redacted 'dissemination') version of the RCPCH report was Letby herself on 31 January 2017 **[INQ0003471/5]**. On the day before she was given that special treatment the consultants had taken the opportunity of reiterating their requests to be shown both the RCPCH report and Dr Hawden's report in their compelled correspondence in which they agreed they would send a letter of apology to Letby **[INQ0003095]**. Again, Tony Chambers refused to accept that delay in communicating and implementing the RCPCH immediate recommendations put patient safety at risk, even when pointed out to him in evidence **[T/27.11.24/100]**.

481. There was a further engagement meeting with the CQC in on 17th February 2017. The minutes **[INQ0014405]** recorded that the picture communicated to the CQC on that occasion was that the outcome of the investigations was limited to "lessons to be learned around transport processes and in the incident reporting system" **[T/25.11.24/89-96]**. With what might be thought to be some understatement, Alison Kelly was prepared to concede "we perhaps should have shared a bit more information at that time, but we were still gathering the information internally" **[T/25.11.24/91]**. She agreed that the CQC had still been told nothing of Dr Hawdon's instruction, nor that she had reported that four of the deaths remained unexplained and required further investigation, but denied that the effect of those omissions was to mislead the CQC. On 14th February 2017 at a meeting of the executive directors three days before the CQC had visited it had been noted that having now seen the RCPCH and Hawdon reports the consultants were adopting a "firmer position" that the neonatal deaths were "not natural causes" **[INQ0003379]** yet not a hint of this was communicated to the CQC: quite the opposite.

482. Perhaps the most revealing of Ms. Kelly's answers came when it was put to her that it would have been perfectly appropriate to tell the CQC that "a Consultant neonatologist had recommended more investigation for four babies" and she replied simply "We could have told them, but we didn't

have the answers at the time so”. **[T/25.11.24/92]** In that answer there was a direct echo of the managerial culture and tone set by Mr Chambers. Since there was no pleasing PR-appropriate answer available, the problem was not disclosed. Ms Kelly displayed no reflection or understanding of the danger of that approach, even to the point of her appearance in the witness box before the Inquiry. The inappropriate culture and tone set within the CoCH under Mr Chambers’ management had become indelible.

483. It was not just the CQC that was being misled during the period. On 28th November 2017 Alison Kelly wrote to NHS England explaining why the Countess would not share the RCPCH report with them at that time **[INQ0008077]**. The terms of that letter advanced as part of the justification that the review team had assured the Trust “that there were no immediate actions or concerns”. That entirely ignored – and obscured – the fact that the report made a series of recommendations under the heading “Recommendations: Immediate.” The clear intention of the letter was to delay provision of the RCPCH report to NHS England at a time when the executives had it at hand and could easily have provided it had they chosen to. As with the CQC, Ms Kelly’s justification for that approach was that the executives collectively “wanted to make sure that we had a fuller picture” **[T/25.11.24/177]** – which can immediately be seen to be a euphemism for “we wanted to be sure we were presenting good news rather than problems”. Here as elsewhere Ms Kelly repeated her defence that the misleading of NHS England about the availability of the report ‘was not done intentionally’, an explanation that simply cannot stand in the light of the consistent and deliberate strategy to avoid scrutiny.

Dishonest Misleading of Families

484. The precipitating cause of there being any report of the completion of the RCPCH report to the Families concerned seems to have been Sunday Times press inquiry on 3rd February 2017. No parent or clinician had been shown either final version of the report before that time, despite them having been in the hands of the executives for many weeks and months by that time. That Ian Harvey’s reply to the press inquiry had been disingenuous was immediately obvious but still not something he would accept, even by the time to give evidence **[T/29.11.24/105]**:

“This was a report that we asked for and invited from The Royal College. At the time of requesting the review and in the interest of transparency we were open with our board, our governors, our staff, patients and a wide range of stakeholders including the local media. We received the final report in December 2016 and it is due to be published next week. We have carried out the additional independent reviews requested as part of this process. Medical Director at The Countess of Chester Ian Harvey said: "We have done all we can to keep parents informed and our clinical teams will be contacting them again ahead of the review being published to make sure a copy is available for them. Thirteen detailed independent case note and pathology reviews will also be shared with the families on an individual basis. Our work on this has only completed within the last

two weeks and now we have the full and accurate information to share with parents. We are sorry for any distress or upset this review may have caused. Those families affected have been through so much already."

485. The impending publication of the Sunday Times piece forced the CoCH to communicate the outcome of the RCPH service review to the parents. The Families believe that had this piece not been published they would never have learned of the existence of the report nor the substance of the complaints raised. The impact that the release of the story might have on families only appears to have been appreciated by the CoCH at the last-minute leading to late disclosure and further stress and anxiety for family members. The delivery of the letter to Mother EF by black cab 30 minutes before publication is entirely indicative of the executive management's approach to the parents and their duties of care, candour and honesty towards them **[INQ0107012/12§92]**. The claim in that letter **[INQ0008990/2]** that there had been previous attempts at contact was simply untrue. The only contact she had at all from the CoCH to that point was a repeated request to return a breast pump that had been given back before she had even left the hospital. Since then Mother EF had not been provided with any bereavement support whatsoever and nor had her consent been sought for the inclusion of her child in Dr Hawdon's case review. Neither she not any of the Families were warned of the potential impact of the RCPH report, its publication nor told of any of the concerns that had underpinned its creation. The impact of that callous approach was predicable and profound: panic, retraumatisation and significant upset **[INQ0107012§94-100 and T/18.09.24/24-27]**.

486. Of course, the version of the RCPH report that was provided to the families was the dissemination version which excised any mention of Letby, the concerns that had been raised about her, or the context of the RCPH's recommendations to investigate her. In providing limited disclosure with no further information to contextualise the material being provided to the families, the CoCH yet again sought to control the narrative and limit the impact to their reputation. This was an entirely selfish and inhumane action. It misled families.

487. The imminent publication of the Sunday Times also prompted a 'cryptic' phone call to Mother C from Sian Williams. This immediately aroused suspicion and anxiety in Mother C – "what on earth had been found [in the RCPCH investigation] that could interest such a big news organisation?" **[INQ0106954§25]**

488. Following the posting of the report, Mother C made further telephone and in person contact with Sian Williams on 6th February 2017 **[INQ0012622/5-6]**. Her questions were not answered and her concerns were explained away, despite the obvious anxiety and distress she was exhibiting.

489. Unlike the other families, Mother C had been previously notified of concerns surrounding the NNU in the summer of 2016, when her husband and been directed towards a report in the Chester

Chronicle, prompting her to attend the CoCH unannounced. She attended a meeting with Sian Williams and Alison Kelly, who told her “that the investigation was just a formality to check staffing levels because there had been a small increase in the number of deaths but they didn't think it was significant. They said there was nothing more to say at that stage and they would find out more when the report was done." In evidence, Sian Williams accepted that was an untrue and misleading picture to have been given, but told the inquiry that the executives had given her instructions about the limits of what she could say **[T/5.11.24/97-98]**. As was put to her, she was being given those words of reassurance at the same time that Sian Williams herself considered that the police should be called in. This was cover up in the name of kindness **[T/5.11.24/99-100].** Alison Kelly’s evidence was simply that she could not recall the meeting **[T/25.11.24/247]**. She offered no explanation or excuse beyond her ‘reflection’ that “we didn’t get the communication right with Families and we didn’t get the balance right” **[T/25.11.24/249]**. These words of apology are inadequate.

490. After speaking with Sian Williams on 6th February 2017, Mother C wrote to Ian Harvey by letter dated 7th February 2017 **[INQ0008969]**. She set out for him in the clearest terms just what the impact had been from the Trust’s disgracefully poor efforts to inform and update her in relation to the emergence of concerns about the NNU and the progression of the investigations. Uncomfortably for him, she had immediately recognised and set out the facts that he and the other the executives were seeking to conceal and suppress:

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

491. This was a without context reaction from a bereaved mother to the redacted version of the RCPCH report. It demonstrated immediately the obvious advantages to treating parents and families with candour and respect and as partners in the investigation of safety concerns; and on the other hand just what a self-justifying echo chamber the CoCH management had become. The approach to Mother C was essentially patronising, hoping that she would not have the intelligence to see through features missing from the redacted report and ask further questions.

492. It is the context of Mother C’s reaction to the RCPCH report that makes Ian Harvey’s subsequent correspondence and meeting conduct so egregious. His first strategy was delay. When Mother C received no reply to her letter, she telephoned the hospital on both 13th and 14th February 2017 without success, eventually successfully obtained an appointment to meet Ian Harvey a week later on 20th February 2017 **[INQ0011981/2-3]**.

493. Extraordinarily, no note of that meeting has emerged from the disclosure provided to the Inquiry by the CoCH. At odds with the normal practice, no letter was ever sent to Mother C to summarise and record the events discussed; and no contemporaneous note has ever been provided. This is

also in variance to Mr Harvey's usual practice, which is revealed through the various notes of meetings and interactions that he engaged in. Mother C set out her recall of that meeting in her statement in the following terms,

"Ian Harvey apologised to us for the poor communication. He advised us that some small areas that could be improved upon had been noted in the review of Child C's care, but nothing of concern; and there was nothing that could have been changed about his care that would have affected the outcome and prevented his death. We were relieved to hear this. This was what we wanted to hear, and we were aware that nothing ever goes perfectly so we had expected some areas of improvement to be noted. The conclusion of the investigation would allow us to move forward and not to have this investigation and uncertainty hanging over us…"

494. That statement was served on all Core Participants including the executives. It was included verbatim in the opening that was submitted on behalf of all the Families. Mother C subsequently gave evidence and affirmed the accuracy of what she was written. No question was asked – whether directly by the Executives advocate or on their behalf by CTI – to suggest that she was in any way wrong or inaccurate in her recollection. When Ian Harvey gave evidence, he stated that he could not recall the detail of the conversation **[T/29.11.24/112]**. It follows that Mother C's account has remained unchallenged and undisturbed, and the inference suggested by the Families in opening must arise,

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

495. Ian Harvey's subsequent correspondence with Mother C reinforced the misleading and dishonest approach he had taken. If his evidence is accepted on the point, by the time of his letter to Mother C on 28th April 2017 **[INQ0008973 and INQ012620]**(sent only after she had chased and implored him for a substantive response) he had reached a point where he knew the police were going to be called and an investigation undertaken but – as was put to him **[T/29.11.24/140]** - told her none of that; and gave a completely misleading impression of the state of affairs.

496. The Families were informed about the Hawdon report in April 2017. Even then, they were provided with no more than extract pages from her casenote review, sent without context or explanation. The extracts had themselves been substantively amended by Ian Harvey, a fact which he did not disclose **[T/16.9.24/107-108].** This was the first point when Mother EF saw the contents of the

records created by Letby on the night of Child E's death. Mother EF was able to appreciate for the first time that this information was wrong, and that Letby had falsified the notes. Thankfully, and by chance, she was able to obtain her mobile phone records and corroborate her own recollection. This valuable information was almost lost due to the delays in sending out the reports. Dr Hawdon was personally shocked that her report had been provided to the families in the way that it was: insufficient covering information and explanation had been provided; and it was inappropriate to share them outside of the face to face meeting, particularly in a time of grief **[T/12.11.24/41-2].**

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

Reporting to the police and further attempts to prevent investigation

498. Just whether Ian Harvey and the other executives did regard a police investigation as inevitable in April 2017 – or alternatively whether they continued to do everything they could to close down and limit such a step – is an important issue for the Inquiry to determine.

499. As March 2017 progressed, the executives showed no sign of wanting to call the police and had been pressing ahead with their long-planned objective of returning Letby to the NNU. Letby continued to hold meetings with the senior nurses throughout the period and continued her efforts to wield influence and control **[INQ0003471/2]**. Drs Brearey and Jayaram were being forced into mediation process with an individual they continued to suspect was responsible for the deaths and collapses of vulnerable infants in their care **[INQ0003104]**. When Letby found out that Dr Brearey had nevertheless refused to mediate with her, she sent an email to the executives seeking to recruit them to force him to comply; and demanded that an explanation be provided to her parents **[INQ0006221]**. This behaviour was manipulative and vengeful.

500. It was after the 27th March 2017 meeting between the executives (Tony Chambers, Ian Harvey and Sue Hodkinson) and the consultants (Dr Brearey and Dr Jayaram, supported by Dr Subhedar) that the latter's demands that the police be called could seemingly no longer be simply ignored **[INQ0003150]**. The issue was further discussed at additional executive meetings on the following days.

501. Even then – and despite appearances and claims to the contrary – the executives had clearly not given up hope of avoiding alerting the police. On 30th March 2017 in a meeting attended by Alison Kelly, Sue Hodkinson told Letby that the intention was still for her to return to the NNU the following week **[INQ0011817]**. On 3rd April 2017 Stephen Cross was preparing a document entitled 'Rationale' which opened with the phrase "In our view, there is no evidence to justify a criminal

investigation" before continuing reluctantly "However, in the spirit of openness and transparency the matter is being reported to the Police, having regard to the fact that a number of Consultant Paediatricians are not satisfied with the very thorough investigations and reviews undertaken". **[INQ0003226]**

502. The dispute around the precise purpose of Simon Medland QC's instruction may also reveal the competing motivations and priorities of the clinicians on one hand, and the executives on the other. In advance of their meeting with him on 12th April 2017 the consultants' understanding had been that the purpose was simply to advise them how to approach the police. The reality was that Mr Medland had been "well versed" in the scepticism of the senior executives and understood his instructions to be to advise whether such a report to law enforcement was justified at all **[T/3.10.24/180]**. As a criminal barrister with no experience of healthcare issues or the workings of an NHS Trust he was ill equipped for the task, as he himself conceded and reported to the CoCH at the time of his instructions. The Families will say that he was clearly not unknown to Stephen Cross and it may have been hoped that he would support the executive's position and divert attention away from calling the police. If this was the intention of the executives it was consistent with their previous conduct in arranging investigations that were ill equipped to highlight or investigate the issues at hand. Mr Medland's brief, as described within the note of his meeting with the consultants, also clearly indicated a bias towards the protection and management of the Trust's reputation, no doubt reflecting discussions that he had had with the executives prior to the meeting taking place. These submissions do not seek to suggest that Mr Medland was necessarily privy to a scheme to divert attention away from the police, indeed his actions following the meeting suggest that he probably wasn't. There is however the obvious suspicion that the executives, led on this issue by Stephen Cross, hoped that he could be counted on to follow their approach.

503. The meeting when it took place was clearly heated, as revealed by Mr Medland's note and for part of it at least attempted to steer the consultants away from their plan to call the police. Despite that scepticism, the firmness of the consultants' conviction clearly had an impact on Mr Medland, and when he reported to the Board the following day he made the suggestion of an approach to the police member of the CDOP would provide an alternative to a direct calling in – which was thought to continue to be disadvantageous **[INQ0003236]**. That he put the recommendation in those terms suggests that he was attempting to find a mediated solution between two extremes, with a continued reluctance on the part of the executives to involve the police. This is entirely at odds with Mr Chambers' assertion that Mr Medland was brought in to facilitate or organise an approach to the police. The Families will suggest that Mr Chambers' account in this respect, and others, is not honest or reliable.

504. After some further delay, the meeting with the CDOP chair and police representative was set for 27th April 2017. Nigel Wenham attended that meeting in his capacity as Cheshire Police's CDOP representative, having been invited by Hayley Frame. As a result of what he heard he returned to

his police station and briefed Assistant Chief Constable Darren Martland. That evening he sent an email to Ian Harvey, requesting that the Countess of Chester write formally to the Chief Constable "requesting that Cheshire Police conduct a forensic investigation into the circumstances surrounding the deaths" **[INQ0102293/2]**.

505. The terms of the letter that the CoCH sent to fulfil that request reveal the continuing mindset of Tony Chambers and the rest of the executives. Mr Chambers' letter in reply was dated 2nd May 2017 and concluded with the clause (emphasis added) **[INQ0102319]**,

"I am writing formally requesting that Cheshire Police conduct a forensic investigation into the circumstances surrounding the deaths **with a view to excluding any unnatural causes."** (emphasis added)

506. Mr Wenham was asked for his view on those words during his evidence. His view was that they "had no place" in the letter, since the purpose of an investigation is to determine the truth rather than to arrive at a pre-determined outcome; that this was an example of the impression he had gained as time had passed that the executives were trying to 'shut doors' on the investigation and of "trying to maybe direct a mindset" **[T/20.11.24/205]**. This evidence is consistent with the Families' analysis of the instructions to Mr Medland (see above). The priority of Tony Chambers and the other senior executives remained directed towards avoiding an investigation, avoiding a finding that crimes had been committed. It sought to suppress rather than find the truth.

507. Those efforts to close-down the investigation and direct the mindset of the police by the executives continued to be apparent in the early stages of the police investigation, and but for Mr Wenham might have succeeded in preventing it altogether. On the 5th May 2017 Tony Chambers, Ian Harvey and Stephen Cross went to the police headquarters. Mr Wenham's notes of the meeting **[INQ0102297/5-6]** show the efforts that were taken to undermine the consultants and minimise their concerns: Letby is characterised as "well regarded within the nursing team" and the reflection that the concerns raised "felt like a witch hunt" is offered, together with the fact that a "written apology from Paeds to her" had been made. The paediatricians on the other hand are dismissed as having been "operating with a collective mindset". The official minute of that meeting records that in relation to the 'Nurse' the police were told that "there is no evidence other than coincidence." **[INQ0102298/3]** The impact of those efforts was that the police investigation was nearly over before it had begun: a further meeting was planned for 12th May 2017 to make a final decision on the need for a police investigation, but the minute concluded "there are no significant concerns to suggest any unlawful acts, it appears a series of anomalies that needs to be investigated further".

508. In advance of that meeting, the consultants had been in correspondence with Mr Wenham and sent him their concerns directly, rather than trusting the executives to communicate them honestly and objectively **[INQ0102300, INQ0102301, INQ0102302 and INQ0102303]**. The summary that

they had provided was compelling and supported by two additional documents containing data analysis. The information presented was of an entirely different nature to that presented by the executives. In Mr Wenham's words,

"overall collectively these documents were incredibly powerful and important in terms of how we moved forward" **[T/20.11.24/165].**

509. On 12th May 2017, when Tony Chambers learned that the consultants had gone around him and outflanked his attempts at downplaying their concerns, he reacted with predictable fury and contempt. His review of their summary of concerns was that it "reads unbalanced… not moved on… not being allowed to be assertive" **[INQ0102305/2]**. He continued, "It is disappointing that it does feel that, as a group of clinicians, they have not moved on". Any doubt as to the impact about Mr Chambers' true feelings about these events is dispelled once his actions immediately after the police meeting are considered: he convened a meeting with Sue Hodgkinson about "the potential options for managing the two consultants" if the police did not investigate. Note records "GMC" and "action plan to manage out" were amongst the options he sought advice upon. The note explicitly refers to a plan to circumvent the speak out safely protection that would be afforded to the consultants **[INQ0015642/48]**. The meaning and implication of that note is plain and unambiguous. It is consistent with the character of Tony Chambers as revealed through his conduct up until that point and emphasised by his performance in the witness box. It was reprehensible, unbefitting of the conduct of a person holding the position of Chief Executive of an NHS Trust with the attendant status and remuneration that attaches to that role.

510. The evidence given by the final witness, Dr Susan Gilby, casts further light of Tony Chambers' mindset even after Letby had been arrested. In her evidence before the Inquiry, Dr Gilby recalls: "So there was never any – the approach that I found from – certainly from Tony at the time that we were working together, which was **this will be nothing, it will be the paediatrician's fault**…" (emphasis added) [T/24/02/25/99-100].

511. In the event, Tony Chambers was not given an opportunity to deploy those plans. On 15th May 2017 the consultants were finally given the opportunity of an objective hearing, and a full police investigation followed shortly after. The contrast between how Mr Wenham received their evidence and how it had been treated by the executives could not be more stark:

"The meeting was -- I can't describe how powerful it was. They were knowledgeable, they spoke from the points of view whereby they were dealing with these things real-time and the -- they have had -- they have had -- they have lived and are breathed these events for the last several years and I just felt for those professionals there, they had an opportunity now to just speak to someone and be listened to and believed what they were saying. And it felt as though that we weren't just going to push them away like they had been in the past or threatened or intimidated, which is what

the perception is they had. They were just very powerful in what they were saying and committed and, you know, I think we all owe them a great deal for coming forward and speaking out the way they did." **[T/20.11.24/179]**

Subsequent conduct of Tony Chambers and the attempts at rehabilitation

512. In his press release of 4th February 2018 Tony Chambers clearly and unambiguously misrepresented the consultants' attitude to the investigations undertaken prior to the approach to the police the year before in April 2017:

"We have had various enquiries, including the Royal College of Paediatrics Review, and there were just a few anything else that our clinician said: look, we think we have got 90% of the answers but there are still bits that we need to do and are sensibly clear that we have not missed anything." **[T/27.11.24/53]**

513. Even when presented with that duplicity in evidence Mr Chambers would not accept it. His response was to say that it was an "enormous regret" that the journalist he had spoken to on other topics had accurately reported his words. His attempt to explain away Dr Jayaram's entirely legitimate perspective that the release had been "insensitive and disrespectful to the clinicians and the Families" was regrettable **[T/27.11.24/54]**.

514. It may have been that press release that was the final catalyst for Mr Chambers leaving the CoCH. Shortly thereafter on 14th February 2018 the consultants wrote to Tony Chambers expressing their concerns about misleading public statements **[INQ0002935/1]**. On 16th April 2018 they met with Sir Duncan Nichol to discuss the breakdown in the relationship between the consultants and the executives under his management; and on the 30th April 2018 they provided a written document setting out their various criticism and concerns. On 3rd July 2018 the hospital was informed that Letby had been arrested on allegations of murder.

515. A vote of no confidence in Mr Chambers' leadership was scheduled to be taken by the Medical Staff Committee on 19th September 2018 but was avoided by reason of his resignation.

516. That resignation had been stage managed between Sir Duncan Nicol and Lyn Simpson of NHS improvement. The contemporaneous records show that there had been a telephone call between them that day that during which Ms Simpson had advised "it was in no-ones interest to go ahead with the vote of no confidence against the CEO and that it would be helpful if it could be prevented" and that the appropriate strategy was to seek to find an alternative post for Mr Chambers **[INQ0101357/1]**. Despite the record, neither of the parties to that telephone call accept that they sought to prevent the vote of no confidence taking place: Sir Duncan Nicol's account was that he believed the vote was still going to take place **[T/2.12.24/107]**; whereas Ms Simpson resolutely

claimed in a frankly ridiculous exchange that ‘prevent’ did not mean ‘stop’ **[T/21.11.24/29, T/21.11.24/37 and T/21.11.24/42]**.

517. Ms Simpson’s evidence lifted the rock on an arrangement whereby significant senior resource was spent obtaining a new and unadvertised senior position for Tony Chambers – to be funded from CoCH’s finite budget of precious public funds – without any due process, diligence or consideration of his fitness. The naked and expressly declared purpose of this exercise was to rehabilitate him **[T/21.11.24/39]**. Although denied by Ms Simpson, the effect of her records and her evidence seemed to be that a ‘standard rehabilitation period’ appeared to be a well-recognised and often deployed concept within NHS senior leadership. The proposition that was put to her in the light of that evidence might be considered to be mild understatement,

“Some people may be surprised that it appears that there was a safety net for Executive Directors when there were signs that their organisation had lost faith in them, that that safety net would consist of a well-paid job for which they did not need to compete and which would be good for their CV which would be found for them”. **[T.21.11.24/6-7)**

518. As for Mr Chambers, his only preoccupation was ‘maintaining his status’ through the rehabilitation exercise **[T/21.11.24/40]**. There was no reflection on the events that had led to his having left the CoCH, and no consideration of his fitness to continue to fill senior leadership positions within the NHS. In her evidence before the Inquiry, Dr Gilby recalls:

“Q: You say at paragraph 254:
“I recall Tony Chambers was made aware (presumably by Sir Duncan Nichol) of the impending request for a vote of no confidence. Tony asked me to do what I could to persuade the paediatricians against this.”
A: yes, that’s right…
…I remember sitting in Tony’s office with him, and saying – him saying to me: “I can’t have a vote of no confidence. I can’t have it. I’ve done nothing wrong.” And we had the usual conversation about the – his view of the situation in terms of the paediatricians and the way they behaved.
…I said to him, “if you really feel that everything has been done that should have been done then you have a right to a voice as well. So why don’t you go to the meeting and provide some balance and stand up for yourself?”
And he said repeatedly “I can’t have a vote of no confidence”.
And he meant that even if – or I took him to mean even if the vote of confidence is not passed. It was having that on his record seemed to be an absolute red line for him…” [T/24/02.25/94 – 96].

519. The Families will say that Mr Chambers, who compared a vote of no confidence regarding his leadership to the “Brexit vote” [T/27.11.24/186], was primarily or solely concerned for his own

reputation and future career. He has failed to show any genuinely reflection on the part that he had played in the events at the CoCH during the relevant period.

Themes and Recommendations

Opportunities to avoid harm

520. The Families' submissions with regard to the opportunities to avoid harm are set out within the body of the chronology above and will not be repeated here with the same detail. Those opportunities fall broadly into the following categories:

521. There was a failure to properly and promptly investigate the cluster of unexpected deaths that occurred in June and July 2015, and which culminated in the death of Child E in August 2015. Those deaths were sudden, unexpected and should in all cases have been regarded as unexplained. Insofar as the Families forming these groups are concerned:

521.1.1. The death of Child C was ascribed to a cardiac condition that was actively doubted by the treating clinician. The circumstances leading up to Child C's collapse and the complexities surrounding his resuscitation should have been investigated more thoroughly. His death should have been categorised as unexpected and unexplained. Care should be taken not to allow unexpected or unexplained deaths to be treated as normal. There should be a greater index of suspicion where unexpected and unexplained deaths occur in clusters.

521.1.2. The unusual features surrounding Child D's death should have been fully investigated. It should have been appreciated that it did not accord with what would ordinarily have been expected for sepsis or infection. The highly unusual episodes of transient skin discolouration noted at the time of her first collapse should have been investigated and considered alongside similar reports involving Child A and Child B. It is clear that these events were considered unusual at the time and not consistent with the signs normally seen in paediatric practice.

521.1.3. Child E's given cause of death (NEC) was not consistent with his condition prior to or following his collapse. A post-mortem should have been arranged, which would have identified that he did not have NEC. Further investigation would have revealed that his death was unexpected and unexplained. Accounts surrounding the patches of skin discolouration noted prior to his death would have correlated with skin discolouration noted in the cases of Child A, B and D. It would or should have been recognised that this transient discolouration was highly unusual and not consistent with the discolouration commonly or uncommonly seen in paediatric practice. Interactions with Mother EF would or should have led to a realisation that her account contradicted the events documented in the clinical notes, raising the suspicion that the notes had been falsified.

As was said repeatedly during the course of the Inquiry, this evidence was there to be discovered with proper enquiry and curiosity.

522. The collapse of Child F should have represented a bright line in the chronology after which no further children were harmed. There was sufficient evidence by that point to Letby as the common link between all six cases until that point. It is notable that Letby was convicted of the murders of Children A, C, D and E and the attempted murders of Children B and F.

523. The case of Beverley Allitt provided a persistent parallel throughout the evidence heard before the Inquiry. The following observations within the Clothier Report were set out within the Families' written opening, but bear repeating again here **[INQ0017497/131]**:

"We were struck throughout our Inquiry by the way in which fragments of medical evidence which, if assembled, would have pointed to Allitt as the malevolent cause of the unexpected collapses of children, lay neglected or were missed altogether. Taken in isolation these fragments of medical evidence were not all very significant nor was the failure to recognise some of them very culpable. But collectively they would have amounted to an unmistakable portrait of malevolence. The principal failure of those concerned lay in not collecting together those pieces of evidence. The initiative and the energy needed to do this were not forthcoming at GKGH. That is the true and ultimate criticism.

Civilised society has very little defence against the aimless malice of a deranged mind. Wherever we have found the slightest possibility of prevention, we have pointed to it. The tightening of standards which we have sometimes urged must be a good in itself and such small improvements may reduce the opportunities open to another Beverly Allitt."

524. A key recommendation of the Clothier Report was that the crimes of Beverley Allitt should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events. Having considered the universal revulsion to the crimes of Beverley Allitt alongside the sense of hope contained within the Clothier Report that such events should never be repeated, the Families cannot help but feel a profound sense of sadness that a little over twenty years later that recommendation had been wiped not only from the collective memory of the NHS but those who were working within the CoCH. It is a truism that as events recede into history their impact diminishes. It is also right that whilst it might be easy to learn the lessons of historical disasters it is another thing altogether to appreciate that the same events are unfolding on your doorstep. Whilst the crimes of Beverley Allitt may have appeared to be a remote event in history even twenty years later, those working at the CoCH would have had warnings from more recent and local history to remind them of the possibility that a nurse might deliberately cause harm to a patient. At the start of the relevant chronology, Victorino Chua, a nurse working in a local

Trust, was convicted of murdering two patients and attempting to cause 21 other patients grievous bodily harm with intent by poisoning them with insulin.

525. An unavoidable comparison with the case of Beverley Allitt is that her crimes were eventually detected when a blood sample reported by a laboratory was found to have high insulin levels alongside low c-peptide levels. As in the case of Child F, the laboratory contacted the Grantham and Kesteven Hospital to report the abnormal test result along with the suspicion that exogenous insulin had been administered to the child. Unlike in this case, that report would lead over a short period to Beverley Allitt's arrest and ultimate conviction, albeit not before she could cause harm to another child. Although categorised by Dr Gibbs as a collective failure on the part of the entire paediatric team most of the blame for this failure rests with Dr ZA, who ultimately decided to disregard the abnormal result. This decision had serious consequences for the victims who followed Child F.

526. Although Dr ZA's decision is ultimately a case of human error it is important to consider how such error might be avoided in the future. It is perhaps inevitable that doctors or nurses will be slow to accept the possibility that their colleagues are deliberately harming patients: cases of deliberate harm being thankfully very rare and entirely at odds with the behaviour that would ordinarily be expected of individuals working in a healthcare setting. Whilst it was helpful for the Clothier Report to highlight a need to be wary about the possibility that a colleague is causing deliberate harm this is the type of recommendation that might be quickly lost within the real world. In this case, Dr ZA was provided with direct evidence that her patient had been administered with unprescribed exogenous insulin but failed to recognise it as a possibility or act upon it. The Laboratory passing that test result onto the hospital believed that they had discharged their duty in notifying them of the result but then took no action to ensure that there was a direct dialogue between the clinical scientist and the consultant who was responsible for decision making. Had there been a mandatory requirement that the laboratory speak directly with the consultant responsible for the patient's care then the opportunity for Dr ZA to attribute the result to a lab error, if that is what she did, would have been greatly reduced.

527. The Families will say that any recommendations made mirroring the recommendation in the Clothier Report that the possibility that unexpected or unexplained deaths are caused by deliberate harm should be embedded through the creation of clearer, mandatory duties. For example, if a test result is obtained that raises the possibility of deliberate harm it should be a mandatory requirement that the person reporting that test to the hospital and the person receiving the result of that test discuss the possibility that the result represents evidence of deliberate harm and ensures that possibility is further investigated. A third check and balance might also be necessary, to counter the possibility that the individual receiving the test results might deliberately seek to suppress them.

528. Harm to the victims who followed Child F were avoidable because of the failures that preceded them. With each subsequent case further evidence accumulated that would have pointed towards the possibility of deliberate harm had it been investigated.

529. The Families will say that there is evidence to suggest that from the death of Child I onwards, individuals working on the NNU had begun to suspect deliberate harm. This was couched in rather vague terms at times, but the Families will say that the evidence was clear. By the final months of 2015, at the latest, paediatricians working at the CoCH believed that the babies who had died over the course of the preceding months had been the victims of deliberate harm. This should have acted as a trigger for immediate escalation and reporting due to the potential safeguarding implications.

530. Although Dr Jayaram was clear in his evidence that he did not consider that he caught Letby "red handed" when he witnessed her standing close by whilst Child K deteriorated, he clearly suspected that he had walked in to the immediate aftermath of an attack, or at least that she was deliberately not intervening to save Child K in the face of an obvious and serious deterioration in her condition. Those suspicions should have been a trigger for immediate escalation due to the potential safeguarding or patient safety issues that arose in either scenario.

531. The commencement of the review into neonatal deaths in October 2015 took place within the context of suspicions regarding unexpected and unexplained deaths and collapses within the NNU. These events should have triggered a more coordinated formal response. The process appears to have been undertaken informally by Dr Brearey and Eirian Powell without defined goals beyond investigating the rise in neonatal deaths. The analysis did not consistently incorporate unexpected collapses and deteriorations in children, even where the child suffering the collapse was linked to one of the deaths being investigated. For example, the investigation examined the case of Child E but did not review the records of Child F, his twin brother, who also suffered an unexpected deterioration in his condition at or about the same time.

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

533. The local Coroner was not provided with consistent evidence regarding the deaths or the suspicions arising from them. Dr Gibbs did not communicate his concerns regarding Dr Kokai's conclusion of cause of death for Child C to the Coroner, something that may have prompted further investigations. Dr ZA advised the Coroner that Child E died from NEC, when that diagnosis was poorly supported by the evidence, seemingly with a view to sparing the family the distress of a post-mortem. Child D's death was reported to the Coroner but the fact that her death had occurred amongst a group of other deaths that became linked to suspicions regarding Letby's conduct was

not reported to the Coroner and the inquest process continued on the basis that the death was natural, albeit perhaps influenced by clinical negligence until the Police investigation was triggered. Only then was the Coroner's investigation suspended. Although Child A is represented by a different family group, the Families consider that the CoCH actively misled the Coroner with regard to suspicions surrounding Letby's role in the death by withholding key information.

534. Both the SUDIC procedure and the Coronial process provided an opportunity to highlight common links between the cases and reveal suspicions regarding Letby's role in the deaths. Neither could function properly because they were not utilised, or else misleading information was fed into them. It doesn't take much imagination to conclude that either mechanism could have led to the earlier involvement of the police.

535. During the early part of 2016, the outcome of the thematic review was escalated to senior executives, namely Ian Harvey and Alison Kelly. The Families will say that it was clear, by the time that these escalations took place, that a substantial number of paediatric consultants had genuine concerns about the possibility that babies had been deliberately harmed. It is for the Inquiry to determine when those concerns were first escalated to the senior executives however there is no doubt that if those concerns existed, they should have been escalated clearly and without delay. If they were escalated at the time that the thematic review was finalised, the response from the executives was slow and inadequate, it taking until May 2016 before a face to face meeting was arranged.

536. The evidence suggests that, whether or not they had been communicated in clear terms before, the meeting on 11th May 2016 involved a discussion surrounding Letby's potential involvement in the collapses and deaths. The only appropriate response to this information was an immediate safeguarding exercise to prevent Letby causing further harm to babies on the NNU. The 'watch and wait' policy encouraged by Mr Harvey and Ms Kelly was entirely inappropriate and put further lives at risk. In the circumstances it led to the deaths of Child O and Child P.

537. There were further opportunities to avert harm. The attack(s) on Child N occurred after this meeting and involved a series of unexpected and unexplained collapses of the sort that had become typical for Letby's victims. Dr Saladi failed to notify Dr Brearey of Child N's collapses, despite having received an email from Dr Brearey asking for such events to be reported. The nursing staff involved in Child N's care had not received a similar communication from Eirian Powell and were not therefore given the opportunity to report concerns that they might have had.

538. It is clear, even through this period, that strong divisions had arisen between doctors and nurses and that these impaired the ability of the system to react to the concerns when they were raised. Eirian Powell provided a strident defence of Letby, offered assurances about her character and sought to deflect allegations made against her. This undoubtedly influenced the response of the

executives at the meeting on 11th May 2016, indeed there is evidence to suggest that lobbying by Eirian Powell and her colleagues in advance of the meeting may have led to the outcome of that meeting being a foregone conclusion before it occurred. It is axiomatic that individuals within any workplace will struggle to accept that their friends or favoured colleagues could be guilty of wrongdoing. A proper response to safeguarding issues should seek to bypass the impact of personal loyalties or 'gut instinct' decision making. These are potent forces for derailing an effective safeguarding response and should be excluded from the process. The Families will say that the key factor in determining an effective safeguarding response should be the mandatory duty to escalate and follow process once concerns have been raised. Those who might hesitate from pursuing an allegation because of the fear that it might trigger an adverse reaction from colleagues or managers could be empowered by mandatory duties. A clearly defined algorithm for response would avoid the potentially disrupting effect of emotion based human factors. Had a clear framework been in place, supported by clearly defined mandatory duties and an effective neutral response, the divisions between doctors and nurses would have been neutralised. There would have been no debate as to the process that should have been followed or the respective duties of the individuals involved in decision making. The additional benefit of mandatory duties within that scenario is that those reporting their concerns and those coordinating the response would have appreciated the potential legal or professional consequences of not following the defined procedure. A response to a defined procedure would also appear more neutral and non-judgemental with regard to the individual who was the subject of the allegation. It would involve the application of a clear framework without an apparently negative judgement on the part of the decision maker.

539. The Families will say that there were multiple opportunities to stop Letby and to prevent harm being caused to babies in her care. These opportunities continued even following the death of Child O. Prompt action by Dr Brearey following Child O's death may not have made a difference given what in fact happened following Child P's death, however, within a properly functioning patient safety orientated organisation, they should have done. Letby was not convicted of attempting to murder Child Q and so the events following the death of Child P fall outside of the scope the Inquiry. Child Q's parents, although not forming part of the family group whom we represent will undoubtedly feel, as many who we represent feel, that the tally of convictions do not tell the full story of Letby's crimes.

Reporting and Investigation Duties

540. The Families consider that there needs to be greater clarity and structure with regard to the duty to investigate sudden and unexpected death within the hospital setting. It is clear from the evidence heard by the Inquiry that the various mechanisms and structures that were in place were not followed. There was undoubtedly a point within the sequence of events where individuals suspected deliberate harm was being done to patients and yet there was no widely understood or formulated safeguarding process to be followed. The families would say that, given the well-defined

safeguarding structures that are in place in other contexts the absence of one for this type of event is bizarre.

541. The creation of a clear and unambiguous structure for the investigation of deaths within hospitals should be created that includes prompting to consider whether there is a possibility that death was due to deliberate harm on the part of anyone, including a healthcare worker. There should be a clear protocol to follow in response to identifying deliberate harm as a possibility that includes the involvement of the police at an early stage.

542. Datix reporting should be mandatory in all cases of sudden and unexplained collapse, as well as in cases of unexpected death for babies or children, that form should provide prompting with regard to the consideration of whether deliberate harm is a possible explanation for the collapse, providing a clearly defined response if that is suspected.

543. Training should be provided to all doctors and nurses to consider deliberate harm. That training should be ongoing and should include training with regard to specific safeguarding issues and responses.

544. Similarly, there should be a mandatory duty on individuals to report concerns regarding deliberate harm at the point where that concern arises. Clear training and protocols should be provided with regard to the duty to report concerns, and also a clearly defined and organised response that should be expected to be followed when concerns are reported. It should be regarded as professional misconduct to fail to report concerns, and to fail to act upon concerns once reported. The duties should be extended into the regulation of managers (see below)

Culture

545. There is little doubt that the paradigm of good culture within an NHS Trust is one that promotes patient safety as its priority. As an organisation that promote public health, provides medical treatment and cares for the vulnerable, sick and injured, it should go without saying that the NHS should not harm those who pass through its doors. High ideals, however, do not always interact smoothly with the practical realities at play within the organisation. Various reports and investigations over the years have identified examples of bad culture surrounding major healthcare failings. The Families will say that many, if not all, of the same characteristics are evident in this case. Why, if the stated aim of an NHS Trust is to promote patient safety, does that goal often become lost? Why do cultures that are toxic to patient safety continue to persist, when the hallmarks of those bad cultures have been so clearly delineated through major well publicised Public Inquiries. The primary goal for the Families in engaging with this Inquiry is to ensure that other people don’t suffer in the way that they have. This goal is not limited to preventing another healthcare professional from deliberately harming babies, although that is important to them. It also asks the NHS to take positive steps to improve culture, and in particular to protect patient

safety. In this sense the issues for this Inquiry are elided with the issues that faced other Public Inquiries into healthcare failings, most of which involved events that were far more quotidian than murder and attempted murder.

546. The Families do not propose to set out a full account of the findings and recommendations of each Inquiry or Report dealing with failings in NHS healthcare. They will however observe that patient safety failings causing harm to service users within the NHS appear to have common themes reflected in the culture of the Hospitals that were the subject of investigation. Despite successive reports and Inquiries highlighting the same issues, the NHS as an organisation appears unable to learn from its mistakes. Sir Rob Behrens, in his evidence before the Inquiry [INQ0014599], referred to the Health Ombudsman's "Broken Trust" report [INQ0014545] and a press release relating to that report dated 29 June 2023 [INQ0014599§40]:

"Every time an NHS scandal hits the front pages, leaders promise never again. But the NHS seems unable to learn from its mistakes and we see the same repeated failings time and time again. Our report looks at the reasons for the continued failures to accept mistakes and take accountability for turning learning into action. We need to see significant improvements in culture and leadership. However, the NHS itself can only go so far in improving patient safety. One of the biggest threats to saving lives is a healthcare system at breaking point."

547. In his evidence regarding the hallmarks of bad culture that he found when investigating the Mid Staffordshire NHS Foundation Trust, Sir Robert Francis KC described:

"a lack of openness to criticism, a lack of consideration for patients; defensiveness; looking inwards, not outwards; secrecy; misplaced assumptions about the judgements and actions of theirs; and acceptance of poor standards and a failure to put the patient first in everything that is done" [T/30.09.2024/156]

548. This follows closely the first recommendation made within the Francis Report that: "The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard". In explaining that recommendation within his evidence before this Inquiry he observed that: "While directed at the Trust in particular, the recommendation contained an implied requirement for the NHS as a whole. The NHS Constitution… contains a requirement to put patients at the heart of everything it does. It is also fair to point out that most staff [75.14% of respondents] think that care of patients is their organisation's top priority…" [INQ0101077/36]

549. Professor Mary Dixon-Woods, in providing her analysis of the Francis Report also highlighted the relevance of issues that caused a deviation from a proper focus on patient safety: "The Inquiry identified that a key contributor to the disaster at Mid Staffordshire was that clarity of purpose in

relation to patient safety and quality of care tended to be displaced by issues of finance and performance…" [INQ0102624/39].

550. In her view a good culture would be one that had clarity about vision, purpose, goals, values and priorities including inclusive, respectful and safe care: "The priority given to safety and quality in particular should be clear and explicit at every level, from board to ward" [INQ0102624/26].

551. In contrast, a poor culture is one where there is fragmentation, ambiguity and diffusion of responsibility: accountability for patient safety and quality of care is dispersed and poorly coordinated [INQ0102624/39].

552. The same observation was reflected in the evidence of Sir Robert Francis KC:

"…in a place where – a service in which resources are never going to be enough, we can never do everything all the time. [The leaders] need to be able to understand how to prioritise things but – and to protect patient safety and the provision of the fundamental standards and they must have those standards and the interests of the patient in the case of a hospital always at the forefront of everything they do and they must make sure that everyone in the organisation does the same… you need to make sure that your finance department has at the front of its mind the interests of the patient, what is the best thing we can do for the patient and you will tend to find that the money then follows… you need to understand how to prioritise and, you need to understand how to protect patient safety in your organisation." [T/30.09.2024/74-75]

553. The worrying suggestion that a hospital finance department might need to be reminded of the need to prioritise patient safety could also be seen in the evidence of Professor Stephen Powis:

"Q: from the position of NHS England, how important is patient safeguarding and safety?
A: Patient safety is, is the prime at the very top of NHS England's responsibilities and I would say that for every leader within the health system that is and should be the top priority. 'First do not harm' is a phrase that you will recognise. It is a phrase that clinicians, you know, live by and it's the same for organisations and senior leaders: our first duty is to 'first do not harm'." [T/17.01.25/189]

"Well, obviously it is important to acknowledge that particularly in financially challenging circumstances, senior leaders have to make a decision about where they deploy their resources. But I go back to my previous answer. At the very top of everybody's list is patient safety… we are very clear currently that the priority is not to harm and therefore I would say deploying resources to support patient safety would be at or near the top of most people's priorities." [T/17.01.25/190]

554. The words used, although superficially reassuring, suggest that there continue to be individuals working within the organisation who would not regard patient safety as the first priority when it came to the allocation of resources. This is concerning.

555. A connection between a healthy culture and one that prioritises patient safety was further emphasised within the following extract from Professor Dixon-Woods report for the Inquiry [INQ0102624/30] although this time emphasising that a healthy safety culture is one that is curious to understand poor outcomes:

"A feature of a healthy culture is one that actively seeks out weaknesses in systems and behaviours relating to quality and safety, typically using multiple techniques and sources of organisational intelligence, and that is attentive to staff and patient voice – a group of behaviours characterised by 'problem-solving'. These behaviours include actively seeking out information and views that offer challenge, disrupting any incipient risk of complacency. For example, when a particular area is identified as an outlier – e.g. it appears to be performing especially poorly compared with others, or demonstrates deterioration over time – healthy cultures have awareness at the different levels of the organisation, curiosity is demonstrated, appropriate methods are used to determine whether there is cause for concern, the factors contributing to the situation are explored, and, where needed, the appropriate actions are taken to improve. Problem-sensing behaviours also involve caution about being self-congratulatory…"

556. The opposite of this culture is a culture that is 'comfort seeking' something that is "characterised by seeking reassurance, by taking undue confidence from the data available, and by the inability or unwillingness to seek out information that might challenge the sense that all is well [INQ0102624/30].

557. Sir Robert Francis KC also highlighted transparency, honesty and openness as features of a healthy safety culture [T/30.09.24/35]:

"One of the features of the healthy culture, the safety culture, the just culture, is the need for absolute honesty and openness… if you don't have that, then you will develop unnecessary dangers in what you do. So in order to do that you have to relieve people of the fear that if they raise a concern or they are honest about a mistake they have made, that they will be punished for it… Another part of it is that you are afraid to suggest that someone else could have done something better without the fear of thinking that you will suffer adverse consequences for doing that…"

558. He identified the opposite of this as: "what Professor Kennedy said was a 'club culture' which was basically a mutual reassurance between professionals that they weren't doing anything wrong, a categorisation of whistleblower as being a maverick… [T/30.09.24/124].

559. This may be linked to Professor Dixon-Wood's observations about the propensity of the organisation to listen to issues when they arise [INQ0102624/21]:

"Other failures of voice arise because of challenges in how well organisations listen. Some organisations are culturally indisposed to hearing about problems, demonstrating 'comfort-seeking' behaviour or lack of hearer courage, so engage in denial, defensiveness, and suppression. Other issues are more practical: organisations may struggle with the sheer volume of issues raised and the forms in which they come to attention through multiple sources of data as well as soft intelligence. Further, not all concerns are well founded; systems for raising concerns, designed with the best of intensions, and mostly used in good faith, may sometimes become weaponised or used strategically to advance local or personal interests… Once an organisation has been made aware of a concern, it may (potentially inadvertently) induce 'voice futility' where people feel that there is no point in giving voice because nothing appears to change in response…"

560. Transparency may be linked to what Professor Dixon-Woods referred to as 'opacity' or 'institutional secrecy'. This was also a hallmark of a good safety culture in the eyes of Professor Dixon-Woods, or its absence is a feature of a dangerous culture: "A common theme is opacity: there may be some awareness (of different kinds) or problems in some part of the organisation, but it may take a long time for the intelligence to surface, and for action to be taken either to avert tragedy or prevent further harm." [INQ0102624/15].

561. In Professor Dixon-Woods' evidence she identified a mechanism by which organisational structures and cultures impair hazard recognition. Quoting work by the sociologist Barry Turner analysing major accidents and disasters between 1965 and 1975 and the impact of 'administrative behaviour' in contributing to that she noted [INQ0102624/16]:

a) Hazard warning of the hazard potential of particular events may be misunderstood because of erroneous assumptions. That people disregard warning signs because they are preoccupied with other matters, because they did not recognise their significance or they perceive them to be low status.
b) Hazard signs are overlooked or not responded to because of information handling difficulties, including the basic limitations of cognitive capacity, or because particular issues arise when confusing and excessive amounts of information are generated.
c) Hazard signs are overlooked because of a feeling of invulnerability. Professor Dixon Woods comments: "This observation of Turner's is less intuitively obvious, but describes how people may not feel that something will happen to them.

562. She goes on to observe that: "These behaviours and responses have a profoundly cultural character. As Carl Macrae puts it, writing in the context of NHS disasters: "Critically, it is the shared

beliefs, collective assumptions, cultural norms and patterns of communication across organisations that shape what information is attended to and how it is interpreted and communicated – and most importantly, what is overlooked, discounted and ignored" [INQ0102624/16]

563. Also significant, is Professor Dixon-Wood's account of the 'banality of organizational life' causing the 'drift in customary practices over time' [INQ0102624/19]. Daily judgements about risk are used to balance the practicalities of daily life or to accommodate the needs of others, meaning that over time, work practices and systems decline so that behaviours that promote patient safety are lost and other practices normalised: "Over time, these challenges can mean that a phenomenon known as 'normalisation of deviance', described by Diane Vaughan in the context of NASA disasters, emerges. Normalisation of deviance occurs when people within an organisation become desensitised to a deviant practice or behaviour that it is no longer recognised as deviant. It can, in Vaughan's words, 'neutralize signals of danger' enabling people to confirm to institutional and organisational mandates even when personally objecting to a line of action." [INQ0102624].

564. These human and cultural factors may provide an explanation as to why some of the paediatricians failed to recognise warning signs sooner. Despite the exhortation with the Clothier Report to consider the possibility of deliberate harm when faced with a series of sudden, unexpected and unexplained deaths within the unit the paediatricians failed to recognise the signs because they failed to recognise that this was something that could happen to them. Such factors might be seen in Dr ZA's failure to arrange a post-mortem following the death of Child E, or to recognise or understand the warning signs that came from Child F's blood test result. They are present in the senior paediatricians' response to the junior doctors' concerns about skin discolouration and the unusual nature of the collapses and deaths. These represent not only individual failings, but profound failures of culture as well. The paediatricians should have exercise greater curiosity sooner.

565. These cultural issues impeded the earlier detection of Letby's crimes but they were not operating within a microcosm. The overall culture of the CoCH and in particular its senior management was relevant when concerns began to be escalated. The elements that make up a toxic and dangerous culture were present and became more obvious within the behaviour of the senior management. Although cognitive biases against the possibility that such events could unfold within their hospital were inevitably contributory to some extent, a poor safety culture meant that they were not recognised as impediments to safety. The priority of preserving personal and institutional reputation, the prioritisation of other factors, including the sourcing and preserving of funding streams. Placing undue weight on evidence that appeared to support underlying biases or priorities, such as miscategorising the findings of the reviews by Dr Jane Hawdon and the RCPCH as exonerating Letby, deliberately or mistakenly. Rejecting the opinions of the paediatricians and

ultimately demonising and persecuting them because they opposed and contradicted that narrative. All profound failings in culture, sadly all too familiar.

566. A feature of this case, which does not appear to have been prominent within previous assessments of cultural failings and their impact on what Professor Dixon-Woods would describe as 'healthcare disasters', is the effect of tribalism between different groups within the hospital. In this instance, the conflict between doctors and nurses. The Families will say that this had a real and substantial impact on the effectiveness of processes that should have ended Letby's crimes and brought her to justice sooner. The suspicions surrounding Letby triggered a defensive reaction in the nursing body and in particular in senior nurses that created an obstacle to investigating those suspicions. The strength of this reaction appears to have caused the paediatricians at various points to falter or hesitate, to experience 'voice futility' as Professor Dixon-Woods would describe it. Ultimately the defence of Letby was weaponised by one group within the organisation and then by the organisation as a whole to suppress the voices of those who were raising the concerns.

567. It is not suggested that the nurses who supported Letby did not genuinely believe that she was innocent. Their actions were guided by cultural factors described above. They were influenced by cognitive biases, both in favour of their colleague, and driven by their tribal identity. They were simply unable to recognise the warning signs that were obvious both with regard to the nature of the events that were unfolding within the NNU and also by reference to Letby's own behaviour. Eirian Powell saw Letby as a good nurse and normalised her transgressive behaviour. She mounted a strident defence of Letby, which influenced the approach adopted by others. This typified cultural norms within the nursing body. It was too quick to run to the defence of a nurse when they were threatened and too slow to consider whether the accusations might have substance. This cultural factor inhibited what should have been a straightforward exercise in safeguarding. A different priority was allowed to obscure the need to protect patient safety and to overtake their fundamental professional duty.

568. The evidence regarding the positive safety culture was consistent in highlighting the need for the open and free discussion of patient safety issues both internally within the organisation but also externally with those who might be affected by events in the hospital. It follows that whilst the duty of candour and the duty to protect whistleblowers might be seen as distinct and free-standing obligations within the NHS, they are in fact key components of establishing or identifying good culture.

Candour (Openness and Honesty)

569. The term 'candour' has a specific and technical meaning. The Families will use it when describing the statutory duty of candour but this section will more generally address the obligations of a Trust to be open and honest with those who are affected by patient safety issues. A specific statutory

duty of candour is important but might, in its technical formulation, lead to an NHS Trust following a tick box exercise. The representatives of the CoCH conceded in their opening to the Inquiry that the Trust had failed to follow the statutory duty of candour and apologised for this. The Families will go further than that, the Trust and senior executives working there, deliberately covered up the events that formed the basis of this Inquiry. When asked by the Families for explanations about what had happened to their babies, they misled them. They deliberately lied. This represented an absolute failure of the Trust in its obligations towards patient safety. It demonstrates the essentially bad culture that was allowed to persist within the CoCH, perpetuated by the senior executives.

570. The Francis Report provided the catalyst for the creation of a statutory duty of candour. Recommendations 173 and 174 were as follows **[INQ0012277/107]**:

"Every healthcare organisation and everyone working for them must be honest, open and truthful in their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful."

"Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information. Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative)."

571. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a registered person must act in an open and transparent way with relevant persons in relation to the care and treatment provided to service users in carrying on a regulated activity. The Inquiry should consider whether the overly technical structure of the statutory duty of candour and the way in which it has been implemented within the NHS has created a duty without real meaning or substance. The Families will say that the duty of candour in its present formulation is not effective. It was entirely ignored by the senior executives at the Trust without any risk of consequence.

572. In his evidence before the Inquiry, Sir Robert Francis KC said the following about the importance of candour: At **[T/30.09.24/50]**:

"…openness, transparency and candour are in reality different aspects of the same thing, really, and I suppose openness is the overarching one and I defined it as the proactive provision of information about performance, negative as well as positive. And by that I meant proactive sharing of information internally and externally. In my view, an NHS Trust provider of healthcare is

something we all own, we should be entitled as members of the public or as patients or as parents to know what's going on inside this organisation and that information should be provided willingly and without prevarication. There are of course qualifications to that about personal data, confidentiality and so on which one might go to. But it is the willingness to provide that information. Transparency means -- and my definition was: "The provision of facilities for all interested persons and organisations to see the information they need properly to meet their own legitimate needs in assessing the performance of a provider in the provision of services."

573. At **[T/30.09.24/52]**:

“Candour became to have a technical meaning. What I meant by that was, and the definition was: ‘The volunteering of all relevant information to persons who have [and this is important] or may have been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made.’ So candour in this sense is about being proactively honest with people when something either has -- is known to have gone wrong or might have gone wrong and we don't wait to be asked or for a complaint, we are just honest about it. But that comes under the rubric of being open, it is one aspect of being open and but perhaps one of the most important ones, because it concentrates on the obligation of the organisation to be honest with its individual patients and their families of course.”

574. And at **[T/30.09.24/114]**:

“the process of the duty of candour has been treated as a defensive mechanism rather than an involvement mechanism and a resolution mechanism. The whole point of the duty of candour is to satisfy people who have been harmed or might have been harmed, giving them an opportunity to understand what has happened, and to take part in the process of improvement, to receive redress by way of apology and if necessary some money, but all without having to bother lawyers or the courts or disciplinary processes but to actually do things quickly and resolve them quickly and allow people to feel that they have been respected.”

575. In this sense Sir Robert Francis KC alluded to the principle of candour and openness in contrast with the way in which the duty was implemented and formalised. The Families will suggest that in many cases, including this one, the principle has become lost. It is either ignored or functions in an unduly technical way. The principle of candour is that NHS Trusts are honest and open with affected parties about the events and the suspicions that surround them. The technical implementation of the statutory duty of candour allows Trusts to complete a technical process which provides them with the opportunity to say that they have fulfilled their duties, without being fully open and honest with affected parties. The lack of a clear structure for enforcement of the duty and a seeming unwillingness to enforce it means that it can be ignored seemingly with impunity.

576. In September 2023, Facere Melius noted: “Communications with the families should have happened after the concerns from the paediatricians were first made… it appears the executives didn’t realise they had to do this under the NHS duty of candour.” **[INQ0003054/50]**.

577. The duty of candour had been widely publicised before and after its implementation in November 2014. Ian Trenholm of the Care Quality Commission referred to the Guidance from the Quality Care Commission ‘Guidance for providers on meeting the regulations’ published in March 2015 **[INQ0012634]**. The following points can be taken from this guidance:

Pg 40 Outcomes of investigations into incidents must be shared with the person concerned and, where relevant, their families, carers and advocates. This is in keeping with Regulation 20, Duty of candour.

Pg 79 Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level or its equivalent, such as a governing body.

• Providers should have policies and procedures in place to support a culture of openness and transparency, and ensure that all staff follow them.

• Providers should take action to tackle bullying and harassment in relation to duty of candour, and must investigate any instances where a member of staff may have obstructed another in exercising their duty of candour.

• Providers should have a system in place to identify and deal with possible breaches of the professional duty of candour by staff who are professionally registered, including the obstruction of another in their professional duty of candour. This is likely to include an investigation and escalation process that may lead to referral to their professional regulator or other relevant body.

• Providers should make all reasonable efforts to ensure that staff operating at all levels within the organisation operate within a culture of openness and transparency, understand their individual responsibilities in relation to the duty of candour.

578. The duty of candour was not followed in this case, not because the senior management of the CoCH were unaware of it or that it had not been widely publicised enough before and after its implementation. It was not followed because releasing information conflicted with other priorities that the Trust regarded as more important. In this case, the need for secrecy surrounding the allegations in order to avoid bad publicity, reputational harm and a potential impact on funding and

income streams. This type of conflict is one that would be entirely predictable - indeed it is referred to more broadly by Professor Dixon-Woods in her evidence (see above). One would expect a statutory obligation to cut through such a conflict, however, the statutory obligation was owed by the organisation and not the individuals who made the decisions. There was seemingly little prospect that the organisation's duties would be enforced externally, and little or no prospect that the individuals involved would face personal consequences for failing to adhere to their duty. It was, in those circumstances, something that was circumvented in order to protect other priorities.

579. The failures in this case went beyond a technical failure to adhere to the Health and Social Care Act Regulations. In their interactions with families, senior executives, in particular Ian Harvey and Alison Kelly, misled the Families. The account of Mother C, if preferred, demonstrates a pattern of deliberate deceit. Ian Harvey's explanations within his interactions with her did not just involve weasel words, he lied to her. She has every right to feel aggrieved at being misled.

580. The same is also true of the Trust's interactions with other families. At the Inquest into the death of Child A the Trust and its witnesses withheld key information that should have been disclosed to the Coroner and to Child A's family. If the Inquiry concludes that the witnesses were told by the Trust, or its lawyers, not to speculate, not to offer evidence regarding their suspicions and to limit their evidence to a description of the key facts as they appeared within the medical records, that was an instruction to mislead the Coroner. We do not represent the family of Child A but we recognise in that deceit similar conduct towards those who we do represent.

581. It is clear from the evidence that concerns were raised about Child D. Her parents had no choice but to pursue an inquest against resistance from the Trust and, initially at least, from the Coroner. The Trust submitted witness statements to the Coroner suggesting a natural and non-suspicious death. An impression that they continued to give even when it should have been clear to them that there were very serious suspicions regarding a potentially unnatural cause for Child D's death. Omitting to pass that information on to the Coroner or the family was deliberately misleading, it withheld information that would have been vital to both. The motivation in doing this was obvious, the Trust prioritised protecting its own reputation above a duty to be honest, open and transparent. This represented a total failure of culture.

582. Subsidiary duties exist on doctors and nurses to be open and transparent with patients who have been harmed and guidance issued by the NMC and GMC in June 2015 "Openness and honesty when things go wrong: the professional duty of candour" **[INQ0010513]** provided that: "Every healthcare professional must be open and honest with patients when something goes wrong", reflecting rules of professional conduct implemented by both the GMC and NMC.

583. The professional duties did not however survive conflict with the approach adopted by the organisation. Susan Gilby in her evidence before the Inquiry **[T/24.02.25/80]**: "So one of the things

I did learn from Dr Brearey is that the parents – and he was quite distressed about this – that the parents had not been offered candour in the way that he would normally want to use, you know, in a poor outcome."

584. It is obvious that if there is a culture of fear within an organisation that individual doctors and nurses will be reluctant to be honest and open with patients on an individual level if the institutional response conflicts with that approach. It may be unreasonable to expect individuals working within an organisation to exercise candour with patients without some concomitant protection for them akin to the protection provided to whistleblowers. Expanding the duty of candour so that it applies to individuals as well as being an organisational duty may provide further clarity.

585. It is important that in applying a duty of candour to individuals that unregulated hospital managers are held to the same obligations. Whether a breach of the duty of candour is punished on a personal level should not be left to the question of whether the manager or executive happens at the time to be regulated by the GMC or NMC.

586. The Families will contend that, for the duty to be followed and respected, it needs proper enforcement. If it can be ignored without consequences the duty will be allowed to take second place to other priorities. At present the CQC is responsible for ensuring compliance with the duty. The Families are concerned that this has not been done with sufficient force or regularity and that adherence to the duty has therefore been diluted.

587. The duty of candour should be included within any professional standards imposed on hospital managers. Failure to show proper adherence to that duty, and indeed a failure to be open, transparent and honest with affected families should be treated as professional misconduct.

Protection for Whistleblowers

588. The evidence before the Inquiry also identifies the importance of adequate protection for whistleblowers. The CoCH in its policy statement "Speak out safely (raising concerns about patient care) and whistle blowing policy" **[INQ0003325]** stated:

"The Countess of Chester NHS Foundation Trust is committed to openness, transparency and candour so that staff feel able to raise concerns and/or debate issues of concern about health care matters in a responsible way without fear of victimisation."

589. It is easy to conclude, based upon the way in which the Trust approached the issues raised by the consultants culminating in its Chief Executive declaring that they should be reported to the GMC and managed out, that the Trust's statement bore little relation to the culture in place at the time of these events.

590. The protection afforded to whistleblowers is, in the Families' view, only as effective as the culture within which it operates. A healthy patient safety culture will respect whistleblowers, paradoxically meaning that they do not require protection, whereas within an unhealthy patient safety culture they will be persecuted, bullied and 'managed out'. It is clear from the evidence that in those cases the whistleblower is unlikely to be able to rely upon their employer to protect them and will instead need to seek redress through an employment tribunal. This might provide compensation, but it will not necessarily preserve a career or reinstate the whistleblower to their previous status. It is perhaps inevitable that many potential whistleblowers decide to leave their concerns unsaid rather than risk their careers and salaries by raising concerns.

591. There is more than adequate evidence of the link between a whistleblowing culture and one that preserves patient safety. Sir Robert Francis KC clearly placed it within his paradigm of a good safety culture, alongside compliance with a duty of candour **[T/30.09.24/35]**:

"One of the features of the healthy culture, the safety culture, the just culture, is the need for absolute honesty and openness… if you don't have that, then you will develop unnecessary dangers in what you do. So in order to do that you have to relieve people of the fear that if they raise a concern or they are honest about a mistake they have made, that they will be punished for it…Another part of it is that you are afraid to suggest that someone else could have done something better without the fear of things that would will suffer adverse consequences for doing that…"

592. The 2015 report from Sir Anthony Hooper to the GMC "The handling by the GMC of cases involving whistleblowers" **[INQ0007342/2]** noted:

"8. The goal of patient safety is much more likely to be achieved if healthcare professionals raise concerns about those acts or omissions of other healthcare professionals or systemic failures which, in their view, detrimentally affect patient safety.

9. In the words of Dame Janet Smith:

"I believe that the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance or health of another could make a greater potential contribution to patient safety than any other single factor."

593. Sir Robert Francis KC in his "Freedom to speak up" report dated February 2015 said **[INQ0010493/15]**

"5.3.3 Speaking up is something that all staff need to do on a regular basis. In addition to the obligations with regard to incident reporting and the professional duty of candour, the introduction

of the statutory duty of candour for organisations means that all staff will need to ensure that their employer has the information with which to fulfil its obligations. More generally in order to ensure that patients are safe all staff need to feel free to raise concerns about the way in which they are treated, whether they perceive the cause to be due to systemic reasons or to a deficiency in the performance or ability of one or more colleagues"

594. That the persecution of whistleblowers is a hallmark of a poor safety culture was similarly highlighted by Sir Robert Francis KC (see above)..

595. The importance of whistleblowers and the need to protect them has been highlighted in various other reports, such as: The Report of the Morecambe Bay Investigations (March 2015) and The Patterson Inquiry (2022). Yet despite it seemingly being recognised that a healthy patient safety culture is one that values whistleblowers the approach that is seen as necessary is a structure of protection for them. This recognises that the inherent culture within many NHS Trusts is one that continues to see whistleblowers as troublemakers rather than saviours. Although they are critical of failures by the paediatricians to identify the crimes of Lucy Letby sooner, the Families recognise that, once they had raised those concerns, the paediatricians were not afforded proper protection by the Trust, were criticised and bullied and ultimately put their professional positions in jeopardy. It must have required considerable determination and persistence to carry on. Had they not done so, Letby would have been returned to the ward and would have continued to harm babies. Had the police not been contacted when they were, had Tony Chambers succeeded in reporting the consultants to the GMC and 'managing them out' of the Trust the consultants would likely have faced litigating through the employment tribunal with a prospect of compensation at best. It is clear that the stigma attaching to whistleblowers is such that this would have probably ended or at best seriously harmed their careers. A system that would allow that outcome is not good enough.

596. The Families would therefore suggest more robust protection for whistleblowers. The duty to protect whistleblowers should be regarded as a component of any professional standards imposed on hospital managers. It should be a matter of professional misconduct to take steps that seek to bypass proper protection for whistleblowers.

Regulation of Managers

597. The problems of executive lack of candour and the suppression of whistleblowers so apparent on the evidence of this Inquiry are sadly familiar refrains that have been heard time and again within the NHS. Identical issues had been at the heart of Sir Ian Kennedy's report into the Bristol Royal Infirmary [**INQ0017990/458]** Robert Francis' Mid-Staffordshire Inquiries; Tom Kark KC's review of the *"Fit and Proper Person Test;* and Dr Bill Kirkup's Review into Maternity and Neonatal services in East Kent, as well as many others stretching back over the decades and more recently. The managerial reflex to prioritise reputational concerns over safeguarding; and to obscure potential

shortcomings rather than disclose them to public view has proven extremely difficult to cure and is not limited to the facts under consideration here. Helene Donnelly described her identical experience from Mid Staffordshire **[T/4.12.24/184]**

"I don't just mean pulling in an independent investigator necessarily. I mean going to the police or other bodies that are appropriate and I think we could strengthen the policy and the guidance and the training to possibly be more explicit in that.
Q. Is it your experience that Trust managers, on occasion, are resistant to taking such a step?
A. Yes.
Q. Based on concerns around the reputations of either themselves or the Trust, is that a problem?
A. Yes, absolutely. I do think that this harks back to my concerns around HR practice as well, is that the focus is on the reputational damage of the organisation and protecting the organisation and not necessarily on just doing right thing and having transparency and openness to make sure that we can all be assured that either there is a problem and therefore it needs to be addressed through the appropriate routes and channels or actually there isn't a problem but we looked into it robustly and thoroughly and transparently and everybody can then be assured. And those things don't necessarily happen."

598. As the previous sections have set out, the solution to this issue is complex and will require a coordinated effort to overcome which must include measures that centralise the importance of candour and effectively protect those who seek to raise concerns. What must now be undeniable is that the solution must also include the full 'fitness to practise' regulation of those who fulfil management roles in hospitals and in particular those executives who set the tone and culture; and those in more junior management positions to whom concerns are likely to be raised at first instance. To counter the reflex to reputational preoccupation those individuals must be given a clear self-interest that aligns with patient safety and candour: achieving regulatory compliance and avoiding personal sanction. Whilst changing culture to prioritise safety cannot be achieved by regulation alone, it can play an important part.

599. As is well known, all medical, nursing and healthcare professionals are already regulated by their respective professional regulators (and whether or not those regulators would benefit from consolidation or harmonisation is beyond the scope of these submissions). Whilst each regulator presently has its own individual code, common to all are standards of probity, honesty and duties of appropriate response to safety concerns. If healthcare professionals working in a hospital breach those standards, they are liable not just to lose their job but to be removed from their profession generally and prohibited from any similar further employment elsewhere. Importantly, those standards do not just govern their behaviour whilst acting in a clinical capacity; but also in the fulfilment any managerial function they might have. That has been the case since at least 1999 when in the Privy Council in *Roylance v GMC* [2000] 1 AC 311 (which was the case referred to in

passing by Sir Robert Francis in evidence **[T/30.9.24/85]** and in which he had in fact acted for the appellant) decided that a doctor who had been Chief Executive of the Bristol Royal Infirmary was liable to be erased from the profession for failing to respond appropriately to concerns that had been raised about increased infant mortality in the performance of cardiac surgery irrespective of the fact that he had himself not performed any of the care under scrutiny.

600. Against that background, it must be incongruous managers as a class are not regulated. As Sir Robert put it in evidence **[T/30.9.24/9]**,

"the one group of people who don't appear to be subject to regulations at all are the senior managers and that has a number of consequences. One is that there is no common standard for or qualification required to be for instance the Chief Executive of a large Hospital Trust, multi-million -- billion pound operation and there is no qualification for doing that. Secondly, it means that they, of all people sitting round a board table, are the -- are not subject to a regulator as such"

601. As this inquiry and those that have preceded it have firmly established, that incongruity has a heavy human cost. When those who perform important management functions at all levels of a trust do not have the same drivers to candour and safety, whistleblower victimisation and suppression of concerns are the result.

602. The adoption of voluntary managerial standards and codes has been attempted repeatedly and failed to gain any purchase: an enforceable 'fitness to practise' standard and compulsory register for managers is what is required. That submission is proven by the fact that there has been a voluntary code of practice with patient safety as its first tenet of one type or another since 2002 **[T/7.1.25/76-80]** with no detectable impact on the instinct to poor managerial behaviour across the decades. There is nothing to suggest that the 2024 '*NHS leadership competency framework for board members*' **[INQ0108668]** will fare any better - even putting to one side some the repeated concerns raised about its terms – since it continues to lack any mechanism for enforcement. Tom Kark KC's review of the wholesale systemic non-enforcement of the '*Fit and Proper Person Test*' revealed a particularly pernicious feature that could have been written about Mr Chambers on the evidence the inquiry has heard,

"And so under the test as it was there was absolutely no way of closing that door off and also what was happening was that if, if a director had been found to have been misbehaving and they left a Trust, they would go into one of the other sections of the NHS: apparently NHS Improvement was often a welcome organisation, surprisingly. They would spend a few years in some other bit of the NHS, then they would pop out again into another Trust and I think that was thought to be extremely unattractive."

603. We would also submit that the managerial fitness to practise regulator should not be limited to regulation of board-level appointments and should govern all levels of NHS managerial role. We agree with Mary Dixon Woods that taking that approach would have the effect of levelling the playing field with clinicians and stopping the weaponisation of the threat of GMC referrals; and more positively that such a step could also serve to increase recognition of the importance of management to the delivery of safe care. Moreover, as Kenneth Jarrold articulated, it is the more junior managers who are likely to have the greatest role to play in the first line response to whistle-blowers and potential patient safety concerns **[T/7.1.25/89]**.

"Secondly, that the code should apply to all managers because let's remember that all this stuff about board managers is, is just one aspect. The people who actually manage the NHS are the ward sisters and team leaders; they are the real managers of the NHS, and it's those team leaders and ward leaders who need to be included."

604. As with almost all the witnesses asked on the subject, Mr Jarrold agreed that full fitness to practise enforcement would be necessary,

"I think that there does need to be proper investigation of breaches of the code and -which never happened before, and there needs to be a disbarring list that somebody could be placed on if the breach of the code had been judged to be sufficiently serious for that to happen."

Bereavement Support

605. The bereavement support offered to the families we represent was universally lacking. . For Mother EF the totality of support she was provided amounted to a single leaflet, handed to her whilst she was still cradling her dead son in her arms and entirely unable to take on information **[T/18.9.24/39]**. Thereafter, the only contact she received from the hospital were repeated telephone requests to return a breast pump that had been given back before the family left the hospital **[T/18.9.24/26-27]**.

606. Mother EF subsequently felt so strongly that no other parent should suffer the lack of compassion and support that she did, and retrained as a professional bereavement counsellor so as to be able to provide to others the care that was denied her **[T/18.9.24/67]**.

607. Father OPR told the Inquiry:

'*Had we received some support, we might have been in a better position to try to act on what our instincts were telling us, which is that something had gone badly wrong. As it was, our lives had been devastated, but got no support and we had to fend for ourselves. Moreover, … we did not know how to navigate our way around the system. We did not understand how the coronial system worked, for example. We had no idea where to start when it came to getting hold of information*

and answers. We were in no fit state mentally to take on a hospital which had no interest in trying to help us or be honest with us.' **[Transcript 24.09.24].**

608. As the evidence gathered by the inquiry shows, appropriate bereavement support is a cornerstone not just of compassionate care, but also of safe care. Whether or not an organisation is capable of clear and compassionate communication at the point of a death (particularly when sudden and unexpected) is a bellwether for the culture of candour within it. As SANDs put it in their evidence to the Inquiry,

"Recent reviews and investigations of maternity and neonatal services have identified the lack of a culture of safety within organisations as a key recurring problem. Staff working within services must feel more able to escalate concerns about care whenever necessary, without fear of repercussions. We fear that too often reputation management is prioritised over a culture of learning and improvement. We must focus on systems change, including the support NHS Trusts need to embed and sustain improvements to move away from a culture of denial and blame, and instead to incentivise candour, support improvements, and systematically revisit recommendations to ensure sustained change. Without a just culture of openness and without blame, mistakes and system errors will continue to be down-played or even covered up by Trusts that are incentivised to demonstrate infallibility. This needs to be tackled at every level, from clinical training to management ethos, to resource allocation. We need a system that applauds honesty and transparency, highlighting what needs to change."

Before concluding,

"Listening to the voices and experiences of bereaved parents will help to drive a change in culture and must be at the heart of all policies developed to save babies lives and improve future care."

609. On behalf of the Families we submit that bereavement support – particularly for those who suffer neonatal bereavement – ought to be afforded its due priority as an item of safe care. We endorse the national bereavement care pathway on Neonatal death **[INQ0108675]** and invite the Chair to consider recommending that NHS England and individual trusts give priority to its implementation.

CCTV

610. The role of CCTV within a neonatal unit is a complicated and, evident from the evidence heard before this Inquiry, controversial topic. The Families maintain, as many of them have said, that the provision of CCTV within the unit would provide greater security to the vulnerable patients who are cared for there. In cases where deliberate harm is suspected its presence would either confirm the occurrence of crimes or exonerate the individual accused of them. It would act as a deterrent to an individual intent on causing harm to vulnerable patients, whether that individual was a

healthcare worker or another individual present on the unit. At the very least, it would make the act of causing harm to babies considerably more difficult.

611. The counterpoint to this argument is that the events occurring within an NNU are peculiarly private and personal for Families visiting babies who are receiving various levels of intensive support. CCTV would intrude into personal and private moments such as feeding or skin to skin contact that could make families uncomfortable in the unit. It would act as a reminder that there is a perceived need to provide constant monitoring because of a risk of deliberate harm. This could lead to a sense that the NNU is not a safe place, which might increase anxiety around it. That anxiety would seem well-placed to those who were affected by Letby's crimes but would be a vanishingly rare prospect for most families attending the NNU.

612. The use of CCTV within hospitals shouldn't be underestimated, though. Most public spaces within the hospital are subject to CCTV coverage. Patients entering through A&E, for example, will be seen on CCTV sat in the waiting room. Patients and families moving through corridors and arriving at the door of the ward or NNU will be captured on CCTV. As a society we are used to passing through multiple zones of CCTV coverage without giving a second thought. Would monitoring with discrete cameras within the NNU really be seen as significantly different, especially where the presence of multiple patients within each nursery would mean that privacy is often not a realistic aspiration.

613. The Families would say that CCTV covering each cot/incubator but not the wider spaces within the NNU would limit the risk of intrusion into private or intimate moments. It would have a valuable deterrent effect.

614. The storage areas for insulin and controlled drugs should be monitored to ensure that those who access them can more easily be traced.

Controls Regarding Insulin

615. The Inquiry has heard that Insulin is commonly used as a means of causing harm to patients by those who are intent on doing so. It has been implicated in various cases, including this one and the case of Beverley Allitt, and Colin Norris. Insulin appears to be used as a means of attacking and harming patients because it is readily accessible to healthcare workers and induces a condition that might be seen as mimicking a natural illness. Its use is undetectable unless blood samples are taken, processed and understood.

616. The Families do not suggest that Insulin should be designated as a controlled drug but would recommend that it is stored and dispensed in a way that makes its use more traceable.

617. The Families would recommend that blood tests that appear to show exogenous insulin should more readily trigger a response in those reporting the sample and those receiving the report of the

sample. Requests for Insulin tests should include a record of whether the patient has hypoglycaemia and whether they are being treated with exogenous insulin. If exogenous insulin is found in a patient with hypoglycaemia who is not receiving exogenous insulin there should be reporting standards that require the immediate escalation of that report. It should be treated as a 'never event'.

The communication of private patient information through personal devices

618. The Inquiry has heard evidence regarding the use of personal messaging as between Letby and other individuals working on and around the NNU as a means of passing on private patient information. In the way that it was done in this case it is clearly undesirable and should be more closely regulated.

619. The Families understand that in some circumstances it is important for people working together to communicate information by any means possible. This should not however be confused with communications that are personal and have no connection with providing support to patients during shifts. The Families strongly consider that the methods of communication revealed through this Inquiry and the information passed between Letby and others, often including personal and private information about families and babies, is entirely unacceptable. The Families note that the Inquiry is awaiting further information from the NMC as to its response on this issue. A similar response is required from the GMC.

Final Observations – the Families

620. The Families whose children were named on the indictment have rightly been granted a place at the heart of this Inquiry. They expressed a common desire, set out within their opening to this Inquiry that their legacy should be one of real improvement and change. They are not the first group of bereaved or injured families to attend an Inquiry with that desire and will sadly not be the last. They would however like to be last group of families who should need to raise these issues regarding their experiences within the NHS. It is simply not good enough for the same problems to recur time and time again without any obvious momentum towards change.

621. Whilst all of the Families have a common goal, their experiences have been different, in preparing this written submission we asked them whether they had anything that they would like to communicate to those reading this submission. Some wanted to comment, others were content to leave things as they were set out within their witness statements.

622. Mother C said:

"The last ten years have been filled with grief, pain, trauma and confusion. We have been horrified to learn how the woman who murdered our son was protected by a pack mentality and afforded

so much support without scrutiny, whilst ourselves and other families were left in the dark and, at times, actively lied to. There is absolutely no doubt that the actions of senior management delayed justice and their accounts and weak words of condolence demonstrate their lack of true reflection on the mistakes they made. The executives attempt to halt the inquiry shows their own self-serving intentions and ongoing lack of respect or care for the families. The media PR campaign aimed to garner public sympathy for Letby demonstrates a complete lack of understanding for Letby's crimes and the complexity of the case. The misinformed and inaccurate media circus surrounding this case, our son and the other babies is potentiating the distress of all of the families involved.

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

623. Mother D asked to say the following:

"It is one hurtful realisation to come face to face with Evil. The one that took my child's life.
Another, to be in the dark waiting for a consideration,
an investigation,
a trial,
a jury to decide,
a judge to sentence ...
and then an Inquiry to get answers to years of questions.
All topped by the noise from ill and misinformed people out there.
Not one day of peace ... ever again.
There was life before ...
And then hell broke loose.
And life was never going to feel okay.

To process the fact that one human has decided to attack, torture and kill our babies. How can we ever feel safe or trust again.

To later find out this murderer had the support, sympathy and full protection from an army of people that allowed for more victims.
The people who failed us are responsible for the deaths of our children too.

These people had a chance to speak up, explain to us what happened and still after everything we now know, they didn't manage to sincerely apologise for their failure.
They don't half recognise their mistakes.

At the end of this Inquiry, having heard far too many failings, we are left let down, disgusted and even more sad than before.

Finding out so many missed opportunities, listening to lies and facing the arrogance of the team of managers and chief executives will forever haunt me and weigh me down.

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

I sincerely hope this Inquiry will help in avoiding anything of this nature ever to happen again. I want people to remember that being brave, responsible and selfless by speaking up and facing adversity is always the right thing to do.

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

Thank you to the inquiry team for looking after us and caring.
To Lady Thirlwall for listening and all her work in making a difference.
To every one who is part of our legal team and the other families legal team for everything they have done, wrote and said. It has been an enormous task at hand and I am thankful for their work, support and beyond."

624. Mother and Father J wanted to pass on their thanks to the Chair and the Inquiry team for the way that the process has been conducted and for their professionalism and dedication. They wanted to express their disappointment and frustration at the efforts made to halt the Inquiry and their desire that it should continue:

"During the Inquiry, we believe that a number of failings have become clear that need to be addressed for the benefit of the families and future families in the NHS. These failings occurred, and would have remained failings, regardless of the trial outcome. This Inquiry should be allowed to bring benefits to the wider public to reinstate confidence in patient safety in the NHS. These lessons need to be learned. Those trying to prevent lessons being learned, by stopping the Inquiry for ulterior motives, will be doing the public a disservice."

625. Mother and Father K would want me to remind the Inquiry of Mother K's words in evidence **[T/23.09.24/140-141]** about the impact of these events upon them and their wider family and the need for accountability:

"There's no accountability for anybody in a senior position to make – if they don't make the decisions based on the information that they're given, they need to be personally accountable for it. Theres many organisations out there that have that in place. They're not dealing with lives but they are held personally accountable, they will be fined, they can be put into prison, because they haven't followed procedures that are put in place to safeguard against these issues. That's exactly the same as what happened in the Countess, but they're dealing with people's lives and the impact of that is forever. It doesn't stop. It doesn't stop. For myself and my husband, the ripples are unbelievable and I never appreciated that and, you know, you're around and you hear it but you don't appreciate it until you're in it and its scarred your life. It's changed you. You look back and you don't only just grieve your daughter, you're grieving who you were. I grieve for who we were as a husband and a wife. It just completely destroys what's around you and you have to pick yourself up and find out who you are again in this new world and it just doesn't. It doesn't go away and we live with it every single day and for nobody to take accountability for that or ownership for that is not right. It can't continue to be like that because this will happen again because what's the reason to stop them? There is no reason. They just protect themselves."

626. The Family of Child G wanted to communicate that:

"The crime perpetrated by Letby has robbed Family G of the lives that they would have had. Child G has been deprived of the future that she would have had. Whilst Mother and Father G are immensely grateful that their daughter survived Letby's attacks and remain dedicated and devoted to their treasured and deeply-loved daughter, their main roles are now and will remain that of her carers. The trajectory of all of their lives have be permanently derailed, They will never have the future that they had planned and envisaged for their family in the days prior to Letby's attacks.

Like the other families involved in this Inquiry, Family G's resilience has been repeatedly tested to the limit. They had to cope with the distress and worry when Child G was attacked by Letby prior to her final discharge from CoCH. They had to learn, without any warning or preparation, that Letby was to be arrested for crimes committed against their babies on the NNU including their own child. They had to learn, for the first time during the criminal trial, the seriousness and full circumstances of Child G's 'collapse' on 7th September 2015 and that there were further attacks on 21st September 2015. Whilst they are grateful for the work that the Inquiry has done, the process of giving evidence and hearing the evidence of other witnesses, many of whom continue to deny any wrongdoing or personal responsibility for not stopping Letby's crimes earlier, has again brought up heightened emotions. The recent news conference conducted by Letby's 'new legal team' has once again plunged the family into the depths of distress and upset. Whilst Family G do not deny people's right to follow the relevant legal processes as they see fit, the way in which Letby's new legal team have conducted this as a campaign through a media circus, has exacerbated the harm and hurt that the Family have been living through since the first days of their child's attacks and finding out that they were all caused by the malevolent acts of Letby. Family G is utterly convinced of the guilt of Letby

but now have to avoid watching the television, listening to the radio, reading newspapers and online articles and accessing social media to protect themselves from the mostly inaccurate and often biased and toxic messages that are being reported and published. It was suggested in the recent press conference chaired by David Davis that they 'hope to give comfort and assurance to the families knowing the truth about what really happened'. This cannot be further from reality. Family G know the truth about what really happened. Letby murdered and attempted to murder babies. The conference and messages that Letby's team are broadcasting far from bringing comfort and assurance cause distress. The message is conveyed in a way that shows no respect towards how families might be affected by it.

Family G feel very deeply that they were left uninformed about what happened to their child. As parents, they entrusted the care of their vulnerable daughter to others. Regardless of what suspicions could or ought to have been raised, or whether Letby ought to have been caught sooner, as Child G's parents they should have been told what was happening. About the nature, seriousness and circumstances of their child's collapses and deteriorations. It is utterly unacceptable not to have been informed of the full facts until the criminal trial especially when Child G remained under the care of the paediatric team at the CoCH. Had they been given more information at the time, they would have asked questions about why their child had unexpectedly collapsed. They would have asked for further investigations to find out what injuries she had suffered. They would not be left still asking those questions now without a way to know for sure. Had they been unsatisfied by the hospital's answers they would have sough further advice and potentially gone to the police themselves. They were deprived of this by the failure of the CoCH to inform them in a timely, open and honest way of the concerns surrounding their daughter's care."

627. Mother and Father OPR asked us to include the following:

"This Inquiry has been another very difficult and emotional process for us as a family. We have had to relive the trauma of 2016 whilst listening to and processing new evidence (including from the hospital executives and others), As a family it is very important to us that this process brings real and significant change within the NHS to ensure events like these never happen again. Nobody should have to ensure the pain we feel on a daily basis."

628. The written opening on behalf of the Families, closed with these words from Mother J, which eloquently sum up the experiences of many if not all of the Families. It is appropriate to conclude this submission with the same words:

"It is difficult to move forward when you are still looking back at the past and revisiting the sadness, anxiety and stress of the memories and images from that time. So, the biggest impact this experience has had on our future, is not being able to grow our family and regrettably we are now too old and fearful to try. I so much want to be part of doing good and assisting the Inquiry but the

shadow of this remains. I hope that the recommendations of this Inquiry are far reaching and substantial enough to make real change in the NHS and protect patients going forward."

RICHARD BAKER KC
SIMON DRIVER
SARA SUTHERLAND
ALEX JAMIESON
ROCHELLE RONG
March 2025

ANNEX

The Executive's Application

629. In the closing phases of the Inquiry, those representing the Former Executives of the Trust applied for the Inquiry to be adjourned pending the outcome of an application to the CCRC by Letby's new "Legal Team"[2]. The Families note also the recent correspondence from Sir David Davis MP, a supporter of Letby, urging the Chair to do the same.

630. The Families submissions are provided within an annex to their written closing in order to reflect that these submissions have been prepared without the input of Mr Simon Driver. Mr Driver was junior prosecuting counsel at Letby's trials and during both appeals to the Court of Appeal. If the case is referred back to the Court of Appeal he will be junior counsel for the Crown at that appeal. I considered that it was important that the Families' submissions in this regard should not be taken to represent a preview of any arguments that might be advanced by the Crown in response to any substantive application. To avoid any implication that there might be a cross-over in roles, or that these submissions were in the form of a statement by the prosecution, I recommended that the submissions be enclosed separately and should not bear his name. For the avoidance of doubt, however, I do not consider that his role in representing Families at the Inquiry was in any way compromised by his role in other proceedings.

631. As things stand at the time of writing, Lucy Letby is a convicted multiple child murderer, the most prolific child murderer in Britain. She has twice brought appeals before the Court of Appeal and on both occasions was unsuccessful. When Sir David Davis urges the Chair, as he does in his letter dated 28 February 2025 to pause the Inquiry: "Until Ms Letby's avenues of appeal have been fully exhausted" he ignores the fact that those avenues of appeal have already been exhausted. Her right to appeal in the future could only arise within closely defined circumstances, which have so far not been established. Upon the assumption that Letby has abandoned the prospect of making a further direct appeal to the Court of Appeal (see below), her only potential route to re-referral to the Court of Appeal is through the Criminal Cases Review Commission (CCRC) as established by the Criminal Appeals Act 1995.

632. According to press releases, the CCRC received a 'preliminary application' on the day before a press conference held in February 2025 by Letby's supporters, and chaired by Sir David Davis MP alongside her counsel. The Families are concerned that this is not a substantive application and that it was made in order to prevent the media attending the press conference from questioning why no formal appeal/application had been lodged given Mr McDonald's assurances at a press conference in December 2024 that a direct application to the Court of Appeal, along with an

[2] The full identity of this team is not entirely clear to the Families. Mark McDonald, (barrister) has presented two press conferences revealing evidence in the case but the nature of his instructions and status has not been revealed. It is not known whether he is instructed by Solicitors and, if so, who those Solicitors are.

application to the CCRC were imminent. The Families are concerned by the reference to a 'preliminary application' and would ask why no substantive application has been made. The reference to a 'preliminary application' to the CCRC appears entirely at odds with Mr McDonald's announcement at the December 2024 press conference that he would be making an immediate and direct application to the Court of Appeal, that the papers had been prepared and would be sent imminently. Despite this, no such application was made and in February 2025 he appeared to concede that the only route available to Letby was through the CCRC. The Families are concerned that such a bold statement could be made to the press in December 2024 only to have been abandoned by February 2025. It suggests to them that Letby's team are more concerned with publicity stunts than putting forward a properly reasoned or legally sound appeal. How can the Families, or the Inquiry, feel reassured that the basis for the application to the CCRC has been any more carefully reasoned or considered? This is important within the context of the Former Executives' application as it will offer the Chair no reassurance that a properly formulated and reasoned application to the CCRC is in existence, let alone that it will be considered imminently.

633. Irrespective of the progress that Letby may have made with formulating her application it is axiomatic that an application to the CCRC is not an appeal. Whilst the CCRC will, within its framework, consider any application and determine whether there are reasonable grounds to refer a case back to the Court of Appeal. According to data published on its website, the CCRC reviewed 31,590 cases between April 1997 and December 2024, referring 855 cases to the appeal courts resulting in 592 successful appeals. Of the cases accepted by the Court of Appeal, 227 convictions were upheld. It follows that applications to the CCRC are common but rarely lead to a successful appeal.

634. There is no obvious time-frame attached to the CCRC process, or the process that might follow it, if that application is successful. It is unlikely that the process will be dealt with rapidly. Sir David Davis' suggestion that the appeal is paused until "Ms Letby's avenues of appeal have been fully exhausted and the new evidence has been allowed to be properly tested before a court" is woefully open ended. If the Inquiry is paused, when would it resume? At the point, if it is ever reached, that Letby concedes that her convictions are safe?

635. The Inquiry, in contrast, is almost complete. It has heard evidence over several months and the participants have provided closing submissions - a report is intended before the end of the year. There is no obvious purpose in deferring those findings, which have the potential to result in recommendations that encourage a greater focus on patient safety within the NHS. Recommendations have the real potential to save lives. They will not realistically be affected by any challenge to Letby's convictions, which have never been considered during the course of the Inquiry. The Families would say that the more probable outcome would be that the forward momentum achieved during the Inquiry would be lost whilst Letby continues to pursue successive unsuccessful attempts to challenge her convictions. There is nothing in the present application, or the evidence in support of it, that provides an obvious or realistic challenge to the status quo.

636. The Inquiry is not in a position to review the merits of Letby's grounds for appeal and should not do so. The Families do however have some observations with regard to the evidence that has been adduced in support of the application:

(a) The Families are concerned by the fact that evidence has been presented on two occasions in press conferences, an approach that is entirely unprecedented within the context of an appeal from a criminal conviction. It raises the obvious suspicion that the priority for Letby and her supporters is to generate maximum publicity for her cause rather than approaching the issues that form the basis of any appeal in a reasoned way. A key example of this was the approach adopted at the December 2024 press conference in which Mr McDonald permitted a Dr Richard Taylor (Neonatologist) to present expert evidence that had been obtained by Letby's legal team presenting as an alternative cause of death for Child O that a paediatrician involved in the resuscitation of Child O had instead caused his death by injecting a needle in the wrong side of the body "lacerating the liver by mistake". Dr Taylor stated "The needle perforated the liver. The baby was still being ventilated with a needle in the liver. The liver was now being lacerated by the needle, this led to bleeding free blood flow into the abdomen. The baby went into shock". He added "I think the doctor knows who they are I have to say from a personal point of view that if this happened to me, I wouldn't be able to sleep at night knowing that what I had done had led to the death of the baby, and now there was a nurse in jail, convicted of murder." (Daily Telegraph 16th December 2024). Child O is referred to within the "International Expert Panel" summary report as "Baby 15"[3]. The account of Child O's case within the summary report states: "The blind abdominal insertion of a needle during resuscitation *may* have penetrated the right lobe of the liver, causing further injury" (emphasis added). The cause of death, according to the panel, was liver injury resulting from 'extremely rapid delivery' at birth. It is concerning in the extreme that a statement could be made in a press conference that accused an identifiable doctor of causing Baby O's death and implying that the doctor then withheld that information, allowing Letby to be incarcerated to hide their own actions. It is even more concerning that the evidential basis for that allegation was not revealed, but rather reported second hand by a different expert, and thereafter contradicted by another expert less than three months later. Mr McDonald and Dr Taylor made hyperbolic, very serious, publicity grabbing statements in a press conference without taking the time to ensure that the position would be supported by the reports of the other witnesses who would be presented to the press. These allegations, presented to achieve maximum dramatic effect caused significant distress to the Family of Child O and no doubt to the doctor against whom the allegation was made. It causes the Families to feel, with some justification, that evidence is presented by Letby's team in order to create drama and headlines and that the proper basis for it is not being analysed or tested. The same concerns should also apply in respect of how the information provided to the second press conference in February 2025 is being managed and used by Letby's supporters.

[3] This can be determined from the fact that he is referred to as "a second triplet". Child O was the second triplet.

(b) The panel of experts who form the International Expert Panel are paediatricians and neonatologists who were tasked to carry out case note reviews of individual cases and determine whether those records disclose alternative causes of death to those presented by the prosecution. Each case was reviewed by two experts, that is to say that the cases were reviewed in silos rather than collectively (see "Methods" page 3 of the Summary). It is unclear what information was provided to the experts save that they saw "medical records and witness statements." From the summary it appears that "witness statements" means "expert witness statements", although again, this is not entirely clear as only a summary report has been produced. In any event it is not suggested that the Panel saw transcripts of the evidence given at trial, that they necessarily saw all of the expert reports provided at trial, or that they saw other evidence, such as the witness statements provided by other witnesses or read transcripts of their evidence given at trial. The Families will say that this creates an obvious limitation in the panel's approach. Firstly, in looking at cases in isolation the experts are vulnerable to the suggestion that they miss the bigger picture, or that evidence that could be drawn from one case might influence their interpretation of another. The fact that Child O, for example, had a brother who died in suspicious circumstances 24 hours after him. Similarly, that Child A and Child F, also referred to by the panel, had siblings who collapsed or died within a short time before or after them. Or that it might appear increasingly less plausible that the NNU, and Letby in particular, would be plagued by a succession of events that would, if they occurred individually, appear inherently unlikely. The Families would think it obvious that when trying to consider evidence as a jury might have done, it is important to look at that evidence as a whole, not in silos. As there is nothing in the panel's report to suggest that Children A, F and O had conditions that would also have harmed their siblings, why did their siblings collapse or die in quick succession following interactions with Letby? Another collection of unfortunate coincidences?

(c) Secondly, case note reviews, as Dr Hawdon agreed, are by their nature, superficial in approach. The medical records contain specific information, namely the observations or findings that were seen as important by the doctor or nurse who created the record but are not comprehensive of every piece of information provided to the jury during the criminal trials. When considering the case of Child E, for example, the medical records provide a misleading account of events because Letby altered them. Without hearing the evidence of Mother EF, corroborated by her telephone records, the experts wouldn't be able to appreciate that a different sequence of events actually unfolded on the night of Child E's death. They would not have been able to ask themselves, as the jury did, whether Letby deceived Mother EF and whether she then falsified the notes. They would not have been able to ask whether there was an innocent reason for her to falsify the notes. An approach purely from the perspective of the medical records is almost bound to miss other evidence. It will dogmatically assume that the notes are accurate, and/or that they give a full account. As Dr Hawdon agreed, a case-note review is not a forensic review. It covers some things but not others.

(d) Thirdly, the accounts given within the summary appear to miss key details or truncate timelines:

i. In their analysis of Baby 7 (Child G) the panel fail to mention that there was a very large projectile vomit crossing several feet away from Child G's cot, evidenced in the medical records but explained more fully within the evidence given at trial. The volume of that vomit, combined with the volume of gas and fluid that was removed from Child G's stomach by the treating doctors far exceeded the small amount of expressed breast milk that she had received. This formed part of the prosecution's case against Letby but is not analysed by the Panel. Events that unfolded hours or days after this precipitating event are truncated so that they all appear to be occurring simultaneously. Rather than being critically unwell at the time of her vomit, Child G was doing well. She deteriorated and became severely unwell after she was attacked.

ii. In their analysis of Baby 9 (Child I) the Panel postulate that colonisation of an endotracheal tube (ETT) with Stenotrophamonas maltophilia caused thick secretions to block the ETT and interfere with ventilation causing: "…recurrent episodes of apnoea, desaturation, bradycardia, respiratory failure, and collapse. S. maltophilia colonisation would have further compromised her ventilatory capacity." The summary report omits to explain that Child I was never treated for S. maltophilia because testing never revealed evidence that Child I developed an infection due to S. maltophilia. The Panel also fail to recognise that whilst Child I was ventilated using an ETT during the early part of their life, they were not ventilated and did not have an ETT in place at the point when Letby caused their death, and had not been so for some time.

(e) The Families are concerned by the range of experts who form the Panel. Although 14 experts are put forward, they are all neonatologists or paediatricians, with one specialist in infectious diseases. None of the experts appear to possess any forensic experience. The evidence presented by the prosecution at trial was, as one would expect, multidisciplinary. Taking Child O, for example, the Chair can see from the Court of Appeal's analysis of the expert evidence (*R v. Letby* [2024] EWCA Crim 748 at paragraphs 89 – 97) that the prosecution adduced evidence from multiple expert witnesses of different disciplines: Dr Marnerides (Paediatric Pathologist) who gave evidence to the effect that Child O's liver injury was the sort that one would only see in serious accidents (such as a road traffic accident), that it was inconsistent with CPR. Professor Arthurs (Radiologist) who reviewed post-mortem x-rays and noted that there was air in the heart and the great blood vessels. This was, in his view unusual, which would sometimes be seen in cases of necrotising enterocolitis (not present) or after severe trauma. It was consistent with air embolus. Dr Dewi Evans (paediatrician) who felt that Child O's collapse was consistent with air embolus and severe trauma to his liver. He noted that transient skin discolouration was consistent with air embolus. Dr Sandi Bohin (neonatologist) who concluded that the collapse had been caused by air embolus based upon a constellation of factors, including the transient skin discolouration and the finding of air in the great vessels. She did not accept that it was plausible that the liver damage was caused during resuscitation (CPR). This multi-disciplinary approach is missing from the Panel's analysis. There is no reference to Professor Arthur's findings of gas in blood vessels on x-ray, indeed the Panel do not contain any experts qualified to comment on the analysis of post-mortem x-rays. The statement

that: "Blunt direct force trauma to the right abdomen or chest is implausible because it is very difficult to generate the kind of forces required to produce the observed injuries in a liver protected by the lower chest wall" disregards the fact that a paediatric pathologist experienced in examining traumatic injuries gave evidence to the contrary. The statement also stands curiously at odds with the suggestion that the same injury could have been caused when Child O was delivered by caesarean section. Child O's medical records describe an entirely normal delivery without any reference to any untoward events. It is notable that the Panel does not include an obstetrician, who one would expect to be better placed to comment on the types of injuries that might plausibly be sustained during a caesarean section. The Families would therefore say that whilst the number of experts fielded is impressive, their experience and expertise is not sufficiently diverse to cover the issues that are being explored.

(f) The Families are concerned that amongst the panel was Professor Neena Modi who was president of the RCPCH at the time that it conducted its own review of the CoCH in 2016. The Inquiry has heard evidence regarding this review and will note that the RCPCH apologised through its representatives and witnesses for its own failings in that review. The Families consider that Professor Modi's role as President of the RCPCH creates a conflict of interest. They would observe that it is highly unlikely that she would be accepted as an expert on issues relating to Letby in civil or criminal proceedings due to this conflict. She is, curiously, the only UK based expert on the panel. This point is not made out of a lack of respect for experts working outside of the UK, however it is at least plausible that experts primarily working in North America and Asia would have a different perspective on clinical notes created by doctors and nurses working within the NHS than those who primarily worked in the UK.

(g) The evidence relating to Child F is particularly problematic. Child F is referred to as Baby 6. The prosecution alleged, and the jury accepted, that Child F suffered profound hypoglycaemia having been administered with manufactured insulin through his feeding bags. The key evidence in support of that allegation was a blood test result showing a high level of insulin alongside a low c-peptide. The report of the Panel concludes that "Exogenous insulin is unlikely to be the cause of hypoglycaemia because the C-peptide was not low for preterm infants…the Insulin/C-Peptide (I/C) ratio was within the expected range for preterm infants, insulin autoimmune antibodies (IAA) which are common in preterm infants bind to insulin and increase measured insulin levels, and the immunoassay test is unreliable because interference factors like sepsis and antibiotics can give false positive insulin readings." The Panel summary is not transparent as to the source of this evidence but the introduction to the report states: "The panel also relied on the reports of external experts in engineering, Professor Geoff Chase and Helen Shannon, for information about insulin and c-peptide testing (Annex). These experts were instructed by those representing Lucy Letby." The Annex confirms that the opinions expressed about the reliability of the insulin/c-peptide results were not derived from the Panel's independent analysis but were taken from a report prepared by experts instructed by Letby's legal team. The experts relied upon by the defence team are a New Zealand based Professor of Mechanical Engineering and a Chemical Engineer. The evidence

presented by the prosecution at trial was from Professor Peter Hindmarsh, a Professor of Paediatric Endocrinology at University College London and Great Ormond Street Hospital, London and a specialist in childhood diabetes (Court of Appeal paragraph 29). The Inquiry will note that all of the professionals giving evidence before the Inquiry were unanimous in saying that the blood test results for Child F were indicative of exogenous insulin. It is also notable that Letby's defence team do not appear to have disputed that Child F had been deliberately given exogenous insulin.

(h) The approach of the Panel also appears to adopt some lines of argument that were excluded during the original trial, or which have been excluded by evidence given before this Inquiry. In relation to Child A, for example, the Panel identify a blood clotting disorder suffered by Mother A and rely upon that as evidence in support of the suggestion that Child A was prone to develop blood clots. This ignores the evidence given at trial by Professor Sally Kinsey (Haematologist at Great Ormond Street Hospital) that she had reviewed blood samples taken from Child A during his life and confirmed that he had not inherited his mother's clotting disorder. This error arises from the absence of experts in Haematology from the Panel and from an apparent failure to review or consider the evidence given at trial. That Child A had not inherited his mother's clotting disorder was accepted by the defence at trial. The Panel also ignored the evidence from Dr Marnerides and Professor Arthurs in relation to Child A (as it did with Child O) that: "The evidence showed that in life, Baby A had air bubbles in his brain and lungs; and immediately after his death, a lot of air was found in his great vessels (Court of Appeal at paragraph 190).

(i) The Panel include within their general findings that: "Poor plumbing and drainage, resulting in need for intensive cleaning: this was a potential factor in Stenotrophomonas maltophilia colonization and infection". The Inquiry has heard evidence about potential concerns at the CoCH regarding infection passing from the plumbing and that this was considered at the time and excluded as a potential source of harm to the babies. The defence called evidence from a hospital plumber at trial, who referred to certain plumbing problems that had occurred in the unit but crucially none that occurred at or about the time of any of the incidents referred to within the indictment (Court of Appeal paragraph 5). This statement therefore appears to be ignorant of the issues raised at trial, presumably due to the fact that the experts on the Panel were unaware of the evidence given at trial.

637. The Families are concerned that the Panel appear to be describing issues that have already been ventilated at trial or which were considered as part of the first Appeal. At their highest, the panel put forward alternative explanations for why some, but not all, of the babies collapsed and/or died based upon a review of the medical records and some, but by no means all, the evidence called at trial. It is difficult to see how a panel of experts of a single discipline provided with limited evidence could reach a better conclusion than experts of multiple disciplines considering the evidence in the round. It is unclear to the Families why Mr McDonald (or his Instructing Solicitors if he has them) would instruct multiple experts of a single discipline to undertake a limited review of the evidence and present their findings as superior to the evidence adduced at trial.

638. The elephant in the room, which Letby's legal team appear to be studiously ignoring is that Letby had experts available to her at trial, who had access to all of the same material available to the prosecution experts and who provided multiple reports. As the Court of Appeal observed at paragraph 5 of their judgement in the first appeal:

"The defence mounted a robust approach to the evidence that was called. Serious allegations were put to the numerous professional witnesses (including expert witnesses) who were called on behalf of the prosecution. Two points may be noted at the outset. First, though the defence instructed a number of expert witnesses of their own, and many reports were served from them before and during the trial, no evidence was called on the applicant's behalf. The entirety of the evidence called for the defence consisted of the applicant's own testimony, and that of an estate plumber, who had worked at the hospital since 1986. He gave evidence about certain plumbing problems that had occurred at various points in the unit: and of two particular incidents in the unit, but not on a date or around the time of any incident in the indictment. Secondly, to make a somewhat basic point, what was put to the prosecution witnesses in cross-examination, was not evidence, save to the extent it was accepted by the witness. More specifically, in the context of this appeal, suggestions made in cross-examination which were not accepted by prosecution witnesses and were not supported by evidence called on behalf of the applicant, are, as the respondent has submitted, irrelevant."

639. The Families would also observe that it is easy to make points at a press conference and somewhat more difficult to do so at a trial, where the evidence being given is scrutinised and tested. One might suppose that the expert witnesses relied upon by Letby at trial would have managed to give a cogent and convincing account of their opinions at a press conference, in the unlikely event that they had been asked to attend one. Why then didn't Letby call them to give evidence at trial? The Families will say that she is refusing to disclose this for one obvious reason, she understood that as clear as her experts were in their written reports, when faced with the full evidence, and when questioned by the prosecution, they would have effectively convicted her. The key deception in Letby's approach in holding press conferences is that she can present evidence without the risk that it will be analysed, challenged or questioned. It permits her to control the narrative without having to explain why she chose not to call that evidence at trial. It is not new evidence but rather a re-hash of evidence that was available to her at trial and which could have been called in her defence, had she been willing to subject that evidence to scrutiny.

640. Even the evidence of Professor Shoo Lee cannot be regarded as new evidence, as the Court of Appeal observed in their judgment on the first appeal. Professor Lee gave evidence before the Court of Appeal. They commented (paragraph 187):

"But even if the applicant could persuade us that there was a reasonable explanation for the failure to adduce Dr Lee's evidence at trial, she faces a further – and in our view, insuperable – obstacle.

Even accepting for present purposes that Dr Lee is correct in his opinion that only one form of discolouration is sufficient in itself to diagnose air embolus in a neonate, the proposed fresh evidence cannot assist the applicant because it is aimed at a mistaken target. The core of the proposed evidence is that, save for that one very specific form of discolouration, it would be wrong to diagnose air embolus on the basis of skin discolouration alone. But as we have said when considering ground 2, there was no prosecution evidence diagnosing air embolus solely on the basis of skin discolouration. Dr Evans and Dr Bohin relied on the differing forms of skin discolouration observed in individual babies as consistent with air embolus. Their evidence in that regard was in our view entirely consistent with the observational study in Lee and Tanswell paper, and with Dr Lee's review of 64 cases since that paper was written. Indeed, Mr Myers realistically accepts that skin discolouration – other than the one type which Dr Lee states is pathognomonic of air embolus – is indicative of circulatory collapse which may be associated with air embolus and that air embolus may be associated with a variety of skin discolouration. In short, the prosecution witnesses did not fall into error which the proposed fresh evidence seeks to assert they made. The proposed evidence is therefore irrelevant and inadmissible."

641. It is difficult to see how the Court of Appeal could reach a different position with regard to the new evidence adduced by the International Panel. Altering the text of his original study, as Professor Lee did prior to the press conference in February 2025, to provide greater clarity as to what that study meant, does not amount to fresh evidence any more than the clarity that he sought to offer when giving evidence to the Court of Appeal in 2024. In any event, as the Court of Appeal observed above, the clarification of that evidence does not overcome the insurmountable hurdle described by the Court of Appeal in the extract above and therefore does not progress the issue further.

642. The Families would also observe that in providing evidence based upon medical records that were available to Letby's defence experts at trial the Panel also do not provide fresh evidence. A defendant is not entitled to refuse to call evidence at trial that would harm her defence, only to thereafter produce evidence from different experts addressing the same issues and claim a right to retrial in the hope that they might do better next time around. Insofar as the evidence from the International Panel seeks to raise new arguments, it is firstly not clear that these are in fact new arguments – with many or most of the same issues having been examined at trial. Secondly there are obvious deficiencies in the disclosure of material to the experts, methodology and breadth of expertise that would inevitably undermine the evidence if it were presented at trial. The jury were entitled to consider whether there were alternative explanations for the deaths and collapses, indeed various alternatives were postulated at trial. Having heard all of the evidence they concluded that Letby was guilty of murder and attempted murder beyond all reasonable doubt. It is fanciful to suggest that this evidence would have caused them to reach a different conclusion.

643. The Families will say that there is no obvious benefit to stopping the Inquiry now, indeed there are clear and overwhelming disadvantages. The purpose of the Inquiry has never sought to address

whether Letby murdered or harmed babies on the NNU between June 2015 and June 2016 but rather to examine the response of the CoCH to that event. The Inquiries findings with regard to that response have broad application to numerous patient safety issues across the breadth of the NHS. The importance of this Inquiry goes beyond preventing the next healthcare serial killer. It will provide benefits to patients in numerous scenarios. It should, the Families hope, lead to a more open, honest and transparent culture within the NHS. It should, they hope, lead to a safer NHS. That goal should not be lost in the face of noise.

644. The approach by the executives to halt this Inquiry, and indeed by Letby's supporters to do the same thing is, insofar as the Families are concerned, a naked attempt to prevent the Inquiry from reaching conclusions that criticise the actions of the executives. From Letby's perspective she is keen to control the narrative and prevent the events that occurred between June 2015 and June 2016 being set out in a way that she cannot control. It is, as the Inquiry heard occurred following June 2016, an attempt by Letby to use her own victimhood as a way of deflecting attention away from her actions. None of these motivations are reasonable or credible reasons for stopping now.

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