THE THIRLWALL PUBLIC INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF

IAN HARVEY

(former Medical Director of the Countess of Chester Hospital 'COCH')

ALISON KELLY

(former Director of Nursing and Quality of the COCH)

ANTONY CHAMBERS

(former Chief Executive of the COCH)

SUSAN HODKINSON

(former Director of People and Organisational Development of the COCH)

Introduction

1. These written Closing Submissions are made on behalf of Ian Harvey (former Medical Director of the COCH), Alison Kelly (former Director of Nursing and Quality of the COCH), Antony Chambers (former Chief Executive of the COCH) and Susan Hodkinson (former Director of People and Organisational Development of the COCH) in accordance with the approach set out by the Inquiry Legal Team ('ILT') in its 'Note on Closing Submissions', dated 6 January 2025. They also contain submissions on their request to pause the proceedings of the Inquiry pending the outcome of Lucy Letby's application to the Criminal Cases Review Commission ('CCRC') in respect of her criminal convictions connected to the deaths and collapses of the babies in the Neonatal Unit ('NNU') between 2015 and 2016 at the COCH.

2. Once again, the Senior Managers wish to express their deepest condolences to the families of all the babies who died or suffered a collapse at the COCH in 2015 and 2016. It was only ever their desire to help run a hospital in which all patients were safe. In all their actions and decisions this was their primary and sole motivation.

3. Ordinarily, hindsight imposes a clarity where, at the time, there was simply none for those trying to understand the factors at play. However, at the time of drafting these submissions, ten years after events began to emerge, there remains an ever-growing concern about what was, in fact, happening on the NNU, demonstrating that the picture has not resolved, rather it has become less defined.

4. As is evident from their written and oral evidence to the Inquiry, each of the Senior Managers has reflected in detail on the roles they played individually and collectively during the events at the COCH in 2015 and 2016. They have assisted the Inquiry fully and candidly. They did so with the aim of providing the families with the answers they deserve and to assist the Chair of Inquiry to identify recommendations to make improvements in the future.

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

Concessions and Apologies

Communication with the Families

6. Communication with the families could and should have been better. The Senior Managers have explained how they struggled to identify what ought to be shared with families during a period of immense uncertainty about the cause of deaths and collapses. It was never the case that the Senior Managers had any desire to hide information from the families or keep them in the dark[1]. In part, the Senior Managers feared compounding the grief of the families at a time when they could not provide them with solid answers. They recognise, in hindsight, that this approach was misguided and for this, they offer their sincere apologies to the families.

7. The Senior Managers remain unclear about what could legally and appropriately have been shared with families regarding concerns about an individual and their potential culpability. The tenor of the evidence provided by Sir Robert Francis KC to the Inquiry

[1] {Tony Chambers, Week 11, Day 3, pg. 209, line 19-pg. 210, line 4; pg. 211, lines 7-11; and pg. 123 lines 2-17} and {Day 4, pg. 18 lines 9-22} and {Ian Harvey, Week 11, Day 5, pg. 110, lines 5-25; and pg. 111, lines 3-16}

was that it is difficult to avoid the tension between being open with families and potentially prejudicing any future criminal investigation[2]. It was this tension with which the Senior Managers wrestled throughout 2016 and 2017.

Reporting to the Police

8. The Senior Managers will address later in these submissions the actions and decisions that were taken following the escalation of concerns in late June 2016. However, the Senior Managers would like to make clear from the outset that they accept the police should have been involved at an earlier stage. Even in the absence of evidence to formally document and clearly explain the concerns, they could have approached the police for advice on the best approach. However, there was no guidance available on what Senior Managers should do when faced with allegations of this nature in circumstances where the concerns are rooted in a 'gut feeling'.[3] The Inquiry will be considering this issue and how the provision of advice in this area can be improved. The Senior Managers welcome any recommendations around the creation of guidelines for managers finding themselves in a similar position.

9. It has been suggested that Mr Chambers actively sought to stall and obstruct the police being called. This is not accepted by Mr Chambers, nor is it supported by the evidence of the other Senior Managers[4]. There was never any intention by the Senior Managers to not go to the police. Their concern was that they went to the police at the right time when the precise nature of the concern was clear and could be fully articulated. They wanted to be in a position to assure the police that other factors had been thoroughly investigated and eliminated as potential explanations[5]. Furthermore, they had been given clear advice from Stephen Cross that calling in the police would have significant consequences for the hospital and, therefore, the families that it served. The legitimacy of these concerns was reflected in the evidence of Simon Medland KC:

> *"One of the matters which seemed to concern the hospital considerably was the prospect of starting a criminal investigation which would have impacted on families who had already undertaken the grieving process and what if the bringing in of the police was to give an indication of criminal action and criminal*

[2] {Sir Robert Francis KC, Week 4, Day 1, pg. 199 lines 7-21}
[3] {INQ0005273, pg. 10 - Draft for client review' of the Service Review of the Countess of Chester, completed by the Royal College of Paediatrics and Child Health, dated October 2016}
[4] {Ian Harvey, Week 11, Day 5, pg. 167, lines 16-25}
[5] {Alison Kelly, Week 11, Day 1, pg. 144, lines 4-8 and pg.145, lines 15-23}, {Sue Hodkinson, Week 11, Day 2, pg. 72, line 24 – pg. 73, line 3 and pg. 89, lines 17-23}, {Tony Chambers, Week 11, Day 3, pg. 44, lines 6-22, pg. 50 lines 10-24 and Day 4, pg. 31, lines 12-20 and pg. 23, lines 5-14}, {Ian Harvey, Week 11, Day 4, pg. 172, lines 1-18 and Day 5, pg. 132, lines 5-12}

investigation when actually it had been sadly a course of nature or something less than crime, for example bad practice or negligence or something of that nature.”[6]

Breakdown in the relationship with the Consultants

10. It is accepted by the Senior Managers that there was a breakdown in the relationship between them and the Paediatric Consultants towards the end of 2016 and early 2017. As expressed by Mr Harvey in his oral evidence[7]:

> “*…one of the greatest regrets of my career is the breakdown in the communication between the paediatricians and the Executives and with me in particular. I recognise how intense and difficult a situation that was. I recognise the strength of feeling they had and the suffering they had associated with the grievance process, and I can fully understand their anger in terms of the perception of the Royal College report because it didn’t reflect what they felt and recalled that they had reported to the College*.”

11. The Senior Managers were clear in their evidence that it was not their intention to create or perpetuate a culture of fear. There was a good relationship in place between the Senior Managers and Paediatric Consultants prior to the end of June 2016 but this became strained in late 2016 and early 2017. It is acknowledged that the Consultants should have received more pastoral care[8] and that more could have been done to support the Paediatric Consultants who were feeling under immense pressure at the time.

12. The Senior Managers were clear in their evidence that there was no intention on their part to report the Consultants to the GMC for raising concerns. Indeed, their evidence was that they sought to protect the Consultants from a potential referral by Letby or her family[9]. Indeed, real efforts were made to address the breakdown in the relationship as it was always appreciated that patient safety could well be affected by a lack of cohesion between teams, as acknowledged by Dr Gilby:

> “*Mr Chambers was very concerned about the breakdown in the relationship, and he emphasised the need to address that, to fix it, and he had already made*

[6] {Simon Medland KC, Week 10, Day 4, pg. 186, lines 3-14}
[7] {Ian Harvey, Week 11, Day 5, pg. 46 lines 9-25}
[8] {Ian Harvey, Week 11, Day 5, pg. 47 line 1 – 21 - pg. 48 line 23} and {Alison Kelly, Week 11, Day 1, pg. 69 line 1 – pg. 71 line 14}
[9] {Ian Harvey, Week 11, Day 5, pg. 49, lines 13 – pg. 50 line 17 and pg. 89 line 18 – pg. 91 line 6}, {Sue Hodkinson, Week 11, Day 2, pg. 176 lines 19-24}, {Alison Kelly, Week 11, Day 1, pg. 65 lines 5-8} and {Tony Chambers Week 11, Day 3, pg. 104 lines 12-23}.

some effort to identify a team of people who were professional mediators who might be able to help...I agreed with him that if there has been a complete breakdown of relations, then that is a patient safety issue as well as a staff experience and safety issue".[10]

13. How the Inquiry seeks to determine this issue has become problematic. Throughout the course of the evidence, Counsel to the Inquiry ('CTI') asked questions of the Senior Managers on the basis of written evidence received from the Consultants, in particular, Dr Brearey and Dr Jayaram. It was suggested to the Senior Managers that they were bullies. The Senior Managers had also provided written evidence to the Inquiry in which they described their own recollections of the tension between the two groups and what had caused this to escalate[11]. It was notable that these Consultants were not asked by CTI about the Senior Managers' alternative views. It appeared to the Senior Managers that the Inquiry had a narrative which it was determined to follow, rather than seeking the truth from these witnesses. The Consultants were repeatedly described and presented as *'experts'*, the Senior Managers as having deliberately ignored the advice that the Consultants were giving.[12] At one point in her questioning of Mr Harvey, Rachel Langdale KC went so far as to accuse him of *"harbouring a murderer*" which carries with it the clear connotation that he, and his senior management colleagues, were protecting Letby in the knowledge that she was killing babies:

    "The grave irony, of course, about that comment, upon the focus, of which was being used here against the Consultants, is that it was true: she was in the hospital and you were harbouring a murderer."[13]

    "criticising the attitudes of Consultants towards the nurses and being asked about comments...they have turned out to be true: she was killing babies and the hospital was harbouring a murderer?".[14]

14. This line of questioning had no basis in fact or law but is an example of the apparent determination of the ILT to support the Consultants against the Senior Managers. Of course, if it transpires that Letby did not murder any babies but that they died from a

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[10] {Susan Gilby, Week 16, Day 1, pg. 71, lines 11-25 and pg. 72, lines 1-8}

[11] {Rule 9 Statement of Alison Kelly, INQ0107704, pg. 28, para 8} and {Rule 9 Statement of Tony Chambers, INQ0107708, pg. 26, para 96 and pg. 183, para 667}

[12] {Alison Kelly, Week 11, Day 1, pg. 15 line 19 – pg.18 line 25; and pg. 35 line 2 - pg. 36 line 24}, {Tony Chambers, Week 11, Day 3, pg. 16 line 8 – pg. 19 line 21} and {Ian Harvey, Week 11, Day 4, pg. 97 line 12 – pg. 98 line 9}

[13] {Ian Harvey, Week 11, Day 5, pg. 64 lines 10-23}

[14] {Ian Harvey, Week 11, Day 5, pg. 65 lines 7-15}

combination of poor care and natural causes, then this line of attack upon the Senior Managers would be exposed as being entirely based on fallacy. Moreover, the stark reality would be that those very Consultants who were most vociferous in their desire to blame Letby and have her removed from the ward were themselves involved in providing sub-standard care to some of the babies who died.

Grievance procedure

15. The Senior Managers accept that the grievance procedure concerning Letby ought to have been paused whilst investigations concerning the increase in neonatal mortality were ongoing[15]. It is acknowledged that the continuation of this procedure contributed to tension and feelings of mistrust between the Paediatric Consultants and the Senior Managers and unduly impacted the ability and willingness of staff to raise concerns. There was a balance to be struck between the Senior Managers' duty of care to a member of staff and the protection of others under the 'Speak Out Safely' Policy.[16] The Senior Managers welcome recommendations from the Chair to assist with providing greater clarity on getting this balance right. The Senior Managers accept that they could and should have better reflected on how the grievance procedure might have had an impact on those raising concerns about Letby and the difficult position the Consultants found themselves in. Also, whilst the Consultants' concerns were taken seriously and were acted upon, the Senior Managers acknowledge that the whistleblowing procedures were in their infancy and had not been fully embedded at the COCH.

16. The Senior Managers were dealing with a complex and unprecedented set of circumstances which required a careful weighing up of options during the decision-making process. Indeed, there was a balance to be struck between adhering to Trust policy whilst attempting to comply with the recommendations of the grievance and, at the same time, managing those who were raising concerns. The Senior Managers concede that they did not always get this balance right.

17. Mr Harvey is recorded as stating in his grievance interview that this was "*by far the most difficult situation I have ever had to deal with*".[17] This accurately reflects the feeling of the Senior Managers then and now. They were balancing a situation whereby

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[15] {Ian Harvey, Week 11, Day 5, pg. 95, lines 7-17 and pg. 96, lines 11-13} and {Sue Hodkinson, Week 11 Day 2, pg. 75, lines 8-13}

[16] {INQ0002746, pg. 2– Email correspondence between Alison Kelly, Tony Millea and Karen Rees, dated 02/09/2016}

[17] {INQ0002879, pg.10 - Grievance file and appendices of Lucy Letby, dated November 2016}

the Consultants did not want Letby working on the NNU, but there was no evidence to support the allegations made against her. This made for a complicated picture in which Senior Managers had to consider the employment implications for Letby and how she might be managed away from the NNU.

18. Letby was informed of the decision to redeploy her to the Risk and Patient Safety Team on 18 July 2016 on her return from annual leave. She never returned to the NNU or to any other patient facing role.

19. Letby filed a written grievance focusing on the behaviour and comments she felt she had been subject to on the NNU and the way in which her removal from the NNU, and her subsequent treatment by the Trust, had been managed. The grievance sat in isolation to the concerns raised by the Consultants regarding the increase in neonatal mortality. The grievance process was in no way a clinical process and did not impact patient outcomes in the sense that Letby remained on redeployment and any perceived risk to patient safety on her part had been removed. However, the Senior Managers now recognise that the grievance procedure could have been paused whilst investigations concerning the increase in neonatal mortality were ongoing[18].

20. Letby's grievance was ultimately upheld by an independent Chair, and it was recommended that the Paediatric Consultants provide Letby with a letter of apology and engage in mediation. It should be noted that this is not an unusual outcome in the context of a grievance. Mediation is also common within NHS organisations where there has been a breakdown in relationships between staff members.[19]

Safeguarding procedures

21. The Senior Managers acknowledge that safeguarding procedures were not followed as they should have been in circumstances where concerns were raised about a staff member potentially harming babies. A common theme throughout the oral evidence was that concerns about deliberate harm by a staff member were not recognised by anyone as a safeguarding issue per se and, in light of this, witnesses did not consider initiating safeguarding procedures (including Dr Isaac, the Consultant Community Paediatrician, with specific safeguarding responsibilities and Dr Mittal, the Designated

[18] {Ian Harvey, Week 11, Day 5, pg. 95, lines 7-17 and pg. 96, lines 11-13} and {Sue Hodkinson, Week 11, Day 2, pg. 75, lines 8-13}

[19] {Professor John Bowers KC, Week 12, Day 4, pg. 79 line 11 – pg. 80 line 3}

Doctor for Safeguarding).[20] In addition, many clinicians did not appreciate that the 'Sudden Unexpected Death in Infants' system applied to deaths in healthcare settings[21].

22. The Senior Managers endorse a recommendation to clarify and raise awareness of the application of safeguarding procedures in cases where an unspecified allegation of deliberate harm has been made in circumstances where there is no evidence of wrongdoing.

Appreciating the whole picture

23. The Inquiry has obtained many thousands of documents, received hundreds of statements, and called live evidence from a significant number of witnesses in order to answer the Terms of Reference as set by the Secretary of State. In approaching that evidence, we respectfully remind the Chair of her duty to act fairly. In order to do so, we say, she must have regard to the following important factors.

24. First, the context in which the witnesses were operating. The Inquiry must guard against ignoring the full, real-world context in which witnesses were working. It would be all too easy to ignore the fact that the Senior Managers were responsible for the operation and running of a busy, 600 bed hospital, treating thousands of patients on a daily basis with a staff body of some 4,400. As with many working within a hospital setting, their responsibilities were carried out during lengthy office hours, often during evenings and weekends.[22] Dr Brearey provided the following contextual evidence:

> "*Its quite difficult to pause in the job that we are doing actually and it – it's an exceptionally busy job anyway at the best of times and – when you are getting these through, there is a rate you are talking about then obviously that adds another workload as well and obviously a clinical workload that shared with all my colleagues...But I – I think with the – with the resources that I had and the resource of time that I had the time, it would have been very difficult to – to spend enough time reviewing these cases adequately in the way that you suggest*".[23]

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[20] {Dr Isaac, Week 10, Day 1, pg. 211, line 25 and pg. 212 lines 1-8} and {Dr Mittal, Week, 10, Day 3, pg. 135, lines 5-8}

[21] {Dr Brearey, Week 10, Day 2, pg. 5, lines 10-15}, { Julie Fogarty, Week 6, Day 2, pg. 87, line 17 – pg. 90, line 12}, {Dr Newby, Week 4, Day 4, pg. 14, line 14 – pg. 16, line 16} and {Dr Gibbs, Week 4, Day 2, pg. 29, line 1 - pg. 40 line 14}

[22] {Alison Kelly, Week 11, Day 1, pg. 276, line 22 to pg. 277 line 16}

[23] {Dr Brearey, Week 10, Day 2, pg. 57, lines 8-23 and pg. 58, lines 7 to 25}.

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

26. The Senior Managers' responsibilities involved the balancing of differing duties and obligations – including a duty of care to the patients, a duty of care to staff, and duties of care and candour to the parents of infants who had died and who had already gone through a grieving process. Simon Medland KC, brought in as an independent legal advisor to the Trust, expressed it as follows:

> "*Throughout my involvement in this, and certainly subsequently, as the court cases became public news and then the Inquiry was underway, I have reflected many times that the – there was a series of not always aligned duties of care, which he [Stephen Cross] and others found themselves rather caught in, was my impression. For example, he [Stephen Cross] had a duty of care to the hospital but also to the patients and the staff. The staff had duties of care to each other and the hospital but also the patients. And this internal problem, where the whole thing seemed internalised to me, was one of the features which I felt did not help and certainly he expressed those views to me that he felt rather pulled, as it were, from pillar to post".*[24]

27. There is also the wider context which must be taken into consideration. As Jeremy Hunt described in his oral evidence to the Inquiry,[25] death (and indeed collapse) is not unusual in a hospital. He noted that:

> "*There is a problem in health systems all over the world that, unlike any other industry, there is a high number of deaths, it's completely normal for people to die in the NHS and the typical district hospital will probably have a dozen deaths a month and so in that context the risk is that deaths become normalised*".

28. He went on to say that:

> "*its very difficult if you are a doctor or a nurse responsible for a patient and that patient dies, it's very traumatic for you personally and sometimes its very difficult for you and your colleagues to accept that you may have made a mistake and in fact all the psychological pressure on yourself is to try and*

[24] {Simon Medland KC, Week 10, Day 4, pg. 161, lines 14-25}
[25] {Rt Hon Jeremy Hunt MP, Week 14, Day 3, pg. 178, lines 1-7}

persuade yourself that it was inevitable, nothing could have been done differently".[26]

29. In January 2025, towards the end of the public hearings, Counsel to the Inquiry produced a document titled, "Countess of Chester Evidence about the number of deaths on the neonatal unit pre-2015'". This demonstrates that Dr Brearey, Eirian Powell and Ruth Millward each performed the task of calculating the number of deaths on the NNU between 2010 and 2014 and their number didn't always tally.[27] In his evidence to the Inquiry, Professor David Spiegelhalter described the neonatal mortality rates at the COCH in 2015/2016 as being high but not indicative of being an outlier. He observed that:

> *"But, actually, Countess of Chester's crude neonatal mortality rate in 2015 was 2.96 per 1,000, there were about 3,000 deaths – 3,000 births, so that means there is about, there was nine deaths they had counted in their definition in its tier and it was the highest in its tier of centres with 2,000 to 4,000 deaths a year. I have to say only just. Blackpool had eight deaths compared with the Countess of Chester's nine. So, again, it was high, it was in the tails, one would not call that an outlier"* [28]

30. Second, hindsight bias and exceptionality. Throughout the Inquiry, there have been repeated references made to the Beverley Allitt case. The suggestion being that, as a fact, there is always a possibility that a health professional might be causing deliberate harm or even murdering patients and, therefore, this is something that ought to be in the minds of nurses, clinicians, managers, Senior Managers and Board members if there is an unexpected or unexplained patient outcome. When asked about the Beverley Allitt case, Dr Brearey put it succinctly:

> "*I think we all would have been aware of it historically but there's one thing to be aware of it historically; and another thinking to be considering that it's – it might be happening on your unit*".[29]

31. The reality is that cases such as Beverley Allitt are extremely rare. In virtually all incidents where there is an unexpected or initially unexplained patient outcome the

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[26] {Rt Hon Jeremy Hunt MP, Week 14, Day 3, pg. 178, line 21 – pg. 179 line 3}
[27] {Countess of Chester Evidence about the number of deaths on the neonatal unit Pre-2015, Inquiry Legal Team, January 2025}
[28] {Professor David Spiegelhalter, Week 15, Day 3, pg. 38, lines 5-14}.
[29] {Dr Brearey, Week 10, Day 2, pg. 65, lines 19-25 and pg. 66, lines 1-9}.

root cause will lie in the state of care and treatment. The inherent improbability of deliberate harm no doubt explains why there is no published guidance for Senior Managers or healthcare professionals in what to do in a Beverely Allitt situation. The authors of any such guidance would, of course, have to have regard to what happened at the Stepping Hill Hospital, Stockport[30], in 2011-2012, referred to by a number of witnesses in the course of their oral evidence. Police commenced a criminal investigation into two adult patient deaths and the poisoning of 19 others. In the course of the investigation, a nurse, Rebecca Leighton, was wrongfully accused of the crimes and arrested. She spent six weeks in prison and was later released.

32. Professor Mary Dixon Woods observed in her evidence that:

> "*I think our procedures for dealing with these kinds of very transgressive, unusual incidents have remained underdeveloped in the NHS and we know from other areas, like fraud or sexual abuse, unless you've got the procedures in place it's very difficult for organisations to deal with them. I think there is an absence of clarity about what you do in – confronted with an unexpected series of highly transgressive events, particularly in those caring for children".*[31]

33. Finally, what might appear more obvious over nine years after the final death, after a three and a half year police investigation, a 10-month criminal trial and a re-trial and the Inquiry's own 18-month investigation, was simply not obvious at the time nor could it have been. Hindsight bias may well have unfairly founded much of the criticism of those who were operating in the real-world context of the COCH at the time.

Raising suspicions and acting on them

Contemporaneous evidence of growing concerns

34. On the timing of disclosure to them of concerns in relation to Letby's actions, the Senior Managers have been consistent throughout their evidence to the Inquiry. The first-time concerns of deliberate harm being caused to the babies on the NNU were articulated followed the death of Child P at the end of June 2016. Prior to that point, it had never been articulated to any member of the Senior Management team that there was a suspicion or concern that a member of staff was deliberately harming babies. If, having heard the evidence, the Inquiry finds that a Clinician or Clinicians harboured real

[30] {Ian Harvey Week 11, Day 4, pg. 92, line 24 – pg. 93, line 4}

[31] {Professor Mary Dixon Woods, Week 3, Day 4, pg. 7, lines 23-25, pg. 8, lines 1-7, and also at lines 12-25}.

concerns that Letby was deliberately harming babies prior to death of Child P on 24 June 2016, fundamental questions for it to resolve will be why it was these individuals did not clearly and unambiguously report these concerns either to the police or anyone else? Why did they not act on their concerns, given their professional duties and code of conduct? Whilst relations between Senior Managers and some clinicians became strained in the latter part of 2016 and 2017 there had previously been no history of difficulty. Indeed in 2016, the Care Quality Commission ('CQC') produced a favourable inspection report rating the Trust as "good"[32] and had commended the leadership and management of the COCH finding that:

> "*The hospital was led and managed by an accessible and visible Executive team. The team were well known to staff, visited most wards and departments regularly, responded to issues that staff raised"* and, that: *"There was clear leadership and communication in services at a local level, Senior Managers were visible, approachable, and staff were supported in the workplace. Staff achievements were recognised both informally and through staff recognition awards*".[33]

35. It is not a sustainable proposition to suggest that at any time prior to the end of June 2016, at which point there was an articulation of concerns in relation to deliberate harm by Letby, that any clinician was fearful for their position or livelihood.

36. It remains unclear from the evidence when such concerns became crystallised. When Dr Brearey was asked about this during his evidence, he was simply not able to identify a point at which he was of the mind that Letby was harming babies: *"Well obviously I was aware of her association from the first three and it was more of a growing nagging concern than any one seminal moment"*[34]. Dr Brearey's conduct suggests that, in reality, for him it was after the death of Child P on 24 June 2016. As regards Dr Jayaram, the picture is far less clear. On his own evidence (which had strengthened considerably by the time he stepped into the witness box at Manchester Crown Court for the Child K retrial) he concluded, as he saw Letby standing over Child K's cot on 17 February 2016, that Letby had deliberately dislodged the baby's feeding tube and disabled the alarm. Despite describing a scene during which he caught Letby in the

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[32] {INQ0002649, pg. 2 - Report by Care Quality Commission titled The Countess of Chester Hospital Quality Report, dated February 2016}
[33] {INQ0002649, pg. 1 - Report by Care Quality Commission titled The Countess of Chester Hospital Quality Report, dated February 2016}
[34] {Stephen Brearey, Week 10, Day 2, page 59, lines 13 to 22}

act of murder, he neither acted on this astonishing event at the time nor mentioned it to anyone, nor reported it to anyone, but rather waited over 12 months, until March 2017, before communicating anything to Senior Managers about what he claimed to have witnessed.[35] The Inquiry will have to resolve the issue of why it was that Dr Jayaram did not act on what he says that he saw.

37. The evidence received by the Inquiry is that prior to the death of Child P, the deaths and collapses were being treated by all – clinicians, nurses, staff and those Senior Managers who were made aware of the increase in mortality on the NNU – as matters which were explicable by a combination of issues around care, treatment, and the sickness of babies. That is evident both from contemporaneous records including emails, minutes of meetings and reviews and by what was done by the individuals involved and of course what was not done by them. The Inquiry ought to be guided, so far as possible, by such contemporaneous material rather than the scattered recollections contained in the witness statements of those whose Rule 9 responses were received by the Inquiry up to ten years after the relevant period. There is an overwhelming likelihood that, to a greater or lesser extent, these recollections have been tainted by the convictions of Letby. The wisdom of undertaking such a careful consideration of historical recollections is underlined by the number of witnesses whose evidence has included the qualifying statement, "*If I had known then what I know now*" on the topic Letby's convictions. Equally, the Inquiry ought to guard against ignoring the apparent reluctance of certain witnesses to give evidence which may be viewed as supporting Letby in an Inquiry whose starting point was her guilt and in relation to which, on more than one occasion, the Chair made it clear that her role did not allow her or, indeed, anyone to question the convictions. In addition to which, and despite being pressed by certain parties to postpone the start of the public hearings, the Chair dismissed any concerns about the safety of Letby's convictions as *'noise'* and others, including Counsel for the families, insisted that anyone raising such concerns ought to be ashamed of themselves. If this Inquiry is a search for the truth, then it is unthinkable that, in the face of powerful evidence that the juries in the Crown Court proceedings have been presented with misleading and incomplete evidence, it should continue to produce a report based on the bedrock of such convictions. Whilst the awaited decision of the CCRC cannot be predicted, the increasing concern expressed by world class experts that the prosecution case was based on medical

[35] {Dr Jayaram, Week 9, Day 3, pg. 199 line 23 – pg. 206 line 12}

misunderstandings and poor expert evidence are in real danger of dissolving this bedrock into a beach of shifting sands.

Chronology of baby deaths and action taken

38. Between 8 June and 22 June 2015, there were a cluster of deaths on the NNU[36]. Child A on 8 June, Child C on 14 June and Child D on 22 June with Child B suffering a collapse on 10 June. In July 2015, a Serious Incident Panel was convened to discuss the deaths of Child A, Child C and Child D. Nothing is recorded in respect of this meeting relating to any concerns about the deaths being unnatural.[37] Those who are recorded as being in attendance are Ms Kelly, Dr Brearey, Julie Fogarty, Sian Williams, Debbie Peacock and Ruth Millward. No concerns were raised or expressed about the possibility of deliberate harm by any member of staff. Only one attendee, Dr Brearey, has subsequently recalled that there was a reference to Letby and of her being present in relation to the deaths of Child A, C and D. On this, in his Rule 9 statement, he states that he was not "*overly concerned about it at the time*"[38]. In his oral evidence to the Inquiry Dr Brearey stated that:

> "*I was aware that sometimes you do get clusters in, in medicine, in neonatology, where your deaths for a year won't be spread out evenly. You know there will be times when you have more than others and, and I thought that wasn't within the realms of, you know, it didn't strike me as – you know obviously it's something to concern and consider the factors we concerned. But once you have, you have done the things that we were doing, there -there was nothing too concerning at that stage for me*".[39]

39. At the conclusion of the Serious Incident Panel, it was agreed by all that no further investigation was required nor any additional action needed to be taken. Following the meeting on 2 July 2015, Ms Kelly sent Dr Brearey an email inviting Dr Brearey to contact her with anything further that he wanted to discuss.[40] Dr Brearey confirmed in evidence that he did not contact her.[41]

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[36] {Dr Brearey, Week 10, Day 2, pg. 51 lines 19-25, pg. 52 lines 1-4 *"- there was nothing too concerning at that stage for me"*}
[37] {INQ0003530, pg.1 – note of Serious Incident Panel meeting, dated 02/07/2015}
[38] {INQ0103104, page 17, para 116 - Witness Statement of Dr Brearey, dated 12/07/2024}
[39] {Dr Brearey, Week 10, Day 2, pg. 51 lines 19-25, pg. 52 lines 1-4}.
[40] {INQ0003625, pg. 1 - Email from Alison Kelly to Dr Stephen Brearey, regarding contribution at neonatal/maternity mortality review meeting, dated 02/07/2015} and {Dr Brearey, Week 10, Day 2, pg. 53, lines 6-25 and pg. 54, lines 1-4}.
[41] {Dr Brearey, Week 10, Day 2, pg. 202, lines 14-22}

40. Approximately one month later, Child E[42] died on 4 August and Child F collapsed on 5 August. There was a further collapse: Child H on 26 September. No concerns about deliberate harm being the cause of the death of Child E or the other collapses were reported by any clinician to the Senior Managers. Indeed, there were other deaths in September which did not appear on the indictment in relation to Letby, about which Dr Brearey was aware but about which he had no concerns, notwithstanding the numbers and the relative increase in mortality.[43] On 23 October Child I died. Again, as with the other babies, no concerns in respect of deliberate harm were articulated at the time. Indeed, Dr Brearey produced a Mortality Review for Child I on 31 October 2015, cognisant of the deaths of Child A, Child C, Child D and Child E, which summarises the cause of Child I's death as follows: [44]

> "*Child I was a 27-week preterm baby who is likely to have died from abdominal pathology, probably NEC or its complications. However, I believe post mortem examination has been requested and might give further information. She was transferred a number of times between hospitals and had a number of different specialists involved with her care. It is hard to judge whether the number of transfers affected the sad outcome. However, I don't think transferring a preterm baby 5 times between 3 hospitals and planning further transfers if she had survived is sensible or in the baby's best interests. There was also an apparent delay in decisions to transfer which seem due to the three way communication process between referring centre, surgical centre and tertiary neonatal centre(s). I will bring both these points to the mortality review with the Cheshire and Merseyside neonatal network. Also to be discussed at PMM".*

41. There is nothing contained within the review either in its body or summary conclusion to suggest or even hint at a possibility of a malicious act by a member of staff. As CTI suggested in her questioning of Dr Brearey, the review goes beyond a differential diagnosis. It asserts a likely cause.[45] It does not indicate any doubt, nor does it identify any need for further reflection or review as to the cause of the death[46]. If the Inquiry

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[42] {INQ0003296 - Dr Brearey's review of Child E, dated October 2015}
[43] {Dr Brearey, Week 10, Day 2, pg. 60, lines 4-16}
[44] {INQ0003286, pg. 3 - Report from Stephen Brearey titled Mortality Review, regarding Child I, dated 31/10/2015} referred to in evidence: {Dr Brearey, Week 10, Day 2, pg. 73, line 15 - pg. 76, line 2}
[45] {Dr Brearey, Week 10, Day 2, pg. 75, lines 17-23}
[46] On 26th November 2015, Dr Brearey wrote to Dr Subhedar and Caroline Travers in relation to Child I stating that a review of Child I had been undertaken and provided the review documents and presentation. He asks whether *"the different teams could review their own contribution to her care before we discuss it at the next network mortality review? I think there is also a surgical mortality review in Liverpool which might also be appropriate?"* {INQ0103121, pg. 1 - Emails between Stephen Brearey and Caroline Travers regarding death of Child I, dated between 26/11/2015 and 27/11/2015}

finds that at the time of writing this review Dr Brearey had real concerns that the cause of Child I's death may have been as a result of deliberate harm by Letby (which he appeared to suggest in his oral evidence)[47] then the Inquiry must resolve the question of why he failed to refer to this in his review? Why, as the neonatal lead, he failed to clearly articulate such concerns and, moreover, escalate them?

42. Between the death of Child I and the Thematic Review meeting held on 8 February 2016 there were no further deaths. However, there was a collapse of Child J, although not a child in respect of whom Letby was found guilty of attempting to harm. Dr Brearey made clear in his evidence that he had no concerns about Child J stating that:

> "*Child J was a baby with known abdominal surgery and stomas, and I think the deterioration overnight with Dr Gibbs had been put down to a seizure. He was the epilepsy Consultant expert at the Trust at the time. You can have electrolyte disturbances with babies who have stomas and at the time I didn't see it as overly concerning in terms of again the categorisation of what represents normal care and expected deteriorations or unexpected deteriorations, if you like.*"[48]

43. The fact that the Thematic Review was convened, involving Dr Brearey, Dr V, Dr Subhedar, Eirian Powell, Anne Murphy, Laura Eagles and Debbie Peacock is entirely inconsistent with the suggestion that any clinician involved at this stage held the belief that a member of staff was deliberately harming babies. Rather, it suggests that the cause of the rise in mortality was believed to be clinical in nature. Whilst the recollections of those who attended the meeting differ, they are entirely consistent about the fact that at no stage was it suggested or discussed that these deaths could be the result of deliberate acts perpetrated by a member of staff.

44. Dr Subhedar's role as an external, independent, participant and specialist is instructive. Having been brought in as an experienced Consultant in neonatology from a different hospital to review the cases, he did not identify anything untoward about the cases reviewed. He described the meeting as constructive. He could not recall staffing or a concern about a particular member of staff being discussed.[49] If that was a belief held by any participant at the meeting, there can be no justification for not clearly and

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[47] {Dr Brearey, Week 10, Day 2, pg. 80, lines 1 and 2}
[48] {Dr Brearey, Week 10, Day 2, pg. 79, lines 2-11}.
[49] {Dr Subhedar, Week 10, Day 3, pg. 39, lines 17-18}

unambiguously communicating this to Dr Subhedar either formally in the meeting or informally outside of the meeting. If such a concern had been raised, he would have recalled this. In response to questioning by CTI, Dr Subhedar stated that if Dr Brearey had been concerned that a member of staff was harming babies, he would have expected him to raise a safeguarding issue at local level.[50] Indeed, at the conclusion of the meeting further steps were agreed which were directed at a clinical or care management cause, namely, to do another review of the 12-hour period prior to death/collapse. There was no suggestion or action in relation to exploring the events being reviewed and the action of any staff member.

45. Whilst it has been asserted by Dr Brearey that he sought an urgent meeting with Mr Harvey on 15 February 2016 following the Thematic Review meeting, there is no documentary evidence to support this. Nor does Mr Harvey recall this.[51] Nor would this be in any way consistent with the tenor of subsequent emails from Dr Brearey[52] of which the Inquiry is in possession. Nor did Dr Brearey make any attempts to speak to Mr Harvey in person or indeed any other member of the Senior Management team following the meeting.

46. On 17 March 2016, Eirian Powell emailed Ms Kelly[53] in relation to the Thematic Review. Ms Powell copied the email to Dr Brearey, Dr Jayaram, Yvonne Farmer, Yvonne Griffiths and Mary Crocombe. She states the following in her email:

> "*Hi Alison, I was hoping that we could arrange a meeting with you to discuss how to move forward with regards to our findings. 1. High mortality – 8 as opposed to our normal 2 to 3 per year 2. A commonality was that a particular nurse was on duty either leading up to or during (this particular nurse commenced working on the unit in January 2012 without incident). 3. A doctor was also identified as a common theme however not as many as the nurse)*".

47. Ms Powell concludes her short email as follows:

> "*Despite reviewing these cases there was nothing obvious that we were able to identify – therefore your input would be valued*".

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[50] {Dr Subhedar, Week 10, Day 3, pg. 28, lines 13-17}
[51] {Ian Harvey, Week 11, Day 4, pg. 210, lines 8-9}
[52] {INQ0038966 - Email correspondence between Ian Harvey and Stephen Brearey, entitled 'Neonatal mortality', dated 15/02/2016}
[53] {INQ0003089, pg. 2 - Emails between Alison Kelly, Eirian Powell and others, regarding mortality rates, dated between 17/03/2016 - 22/08/2019}

48. The evidence of Mr Harvey and Ms Kelly was that nothing within this emailed conveyed to them a sense of urgency.[54] There is nothing within this email that expresses a concern that a member of staff is deliberately harming babies on the NNU. Absent that concern being expressed, as would have reasonably been expected – and absent the lens of hindsight bias – this email can and indeed was reasonably read as suggesting there was likely to be, an as yet, unidentified, clinical care issue[55]. All those copied into the email had an opportunity to either write an additional email or clarify the concern. If that was a concern or belief held by any of the individuals copied into the email there is no reasonable explanation for failing to communicate further by email, by telephone or by personal approach. This is particularly striking – in light of the evidence given by Dr Jayaram of having witnessed Letby attack Child K on 17 February 2016, nine days after the review meeting. The absence of this urgency is something that evidently influenced and informed the decision making of Ms Kelly and Mr Harvey.[56]

49. The Thematic Review was sent by Ms Powell to Ms Kelly on 21 March 2016. Some three weeks passed between the receipt of the report and a follow up email from Ms Powell on 14 April 2016[57] asking for Ms Kelly's thoughts. It is notable that there were no emails sent by Dr Brearey or Dr Jayaram, i.e. those who have suggested that, by this time, they entertained concerns about Letby deliberately harming babies. Nor did anyone go to Ms Kelly's office or any other Senior Manager's office or contact them in any way. This behaviour is not consistent with a belief that there was a murderer on the ward. This is important contextual information which Ms Kelly and Mr Harvey took into consideration when making their decisions.

50. Nowhere in the Thematic Review is there a suggestion of a possibility of deliberate harm as an explanation for the increase in mortality rates.[58] Absent such an assertion, the only reasonable interpretation of its contents is that the cause/s or factors being considered are care related, not criminal. The review which had had the input of the Neonatal Lead, Dr Brearey, Dr V, Dr Subhedar, Eirian Powell, Anne Murphy, Laura Eagles, and Debbie Peacock, indicated a natural cause of death in respect of all of the babies, save for Child A (with one baby "*awaiting a postmortem – probable prematurity*

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[54] {Alison Kelly, Week 11, Day 1, pg. 99 line 24 –pg. 100, line 2} and {Ian Harvey, Week 11, Day 4, pg. 129, lines 5-8}
[55]{Alison Kelly, Week 11, Day 1, pg. 102, lines 8-11}.
[56] {Alison Kelly, Week 11, Day 1, pg.103, lines 22-25}.
[57] {INQ0003089, pg. 1 - Emails between Alison Kelly, Eirian Powell and others, regarding mortality rates, dated between 17/03/2016 - 22/08/2019}
[58] {INQ0003251 - Minutes of meeting between various Consultant Paediatricians, E Powell, N Subhedar, A Murphy, L Eagles and D Peacock , Chaired by S Brearey, regarding the Thematic Review of Neonatal Mortality 2015, dated 08/02/2016}

and sepsis" and another baby awaiting a postmortem) and in that context concludes as follows:

> "*There was no common theme identified in all the cases. One baby had severe HIE and the Trust's rate of HIE in 2015 was low and similar to previous years. One baby had severe multiple congenital abnormalities with a very poor prognosis. One baby had a significant congenital heart disease and probable sepsis. 2 babies (possibly 3 pending PM result) died of sepsis despite timely antibiotic treatment. 2 babies (possibly 3 depending on PM result) the cause of death is uncertain despite having PMs".*

51. It goes on to identify themes (*not* causes) which connected some of the deaths, namely: 1. Sudden deterioration in relation to some of the babies; 2. Timing of arrests 6 of the 9 arrested between 0000-0400; 3. Delayed cord clamping in respect of 3 babies and one case of mild hypothermia; 4. Use of Ranitidine in relation to two babies; and 5. 3 babies had care issues around UVCs ("*One was used when too low, one was used when too high and one was displaced and came out.*"). However, the absence of a clearly articulated concern that a member of staff is harming babies in combination with the actions identified along with the areas to improve practice[59] had the inevitable effect of focusing minds on issues of care – which in almost all cases would be the explanation. There was also nothing contained within the report to mitigate the risk Dr Brearey suggests he had apprehended at this time, such as, for example, additional training or supervision of Letby or even removing her from a patient-facing role within the hospital.

52. It is also noteworthy that the first draft of the minutes of the Thematic Review prepared by Dr Brearey[60] made no mention of the first theme "*1. Sudden deterioration. Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM.*" The version circulated by Dr Brearey to Eirian Powell, Debbie Peacock, Doctor V, Dr Subhedar, Anne Murphy and copied into Dr Jayaram, Gillian Mort and Emma Punter-Jayne by email on 8 February 2016 did not

[59] {INQ0003251, pg. 7 - Minutes of meeting relating to Thematic Review of Neonatal Mortality 2015 – Jan 2016, dated 08/02/2016} and {INQ0008841, pg. 3-5 – Thematic Review of Neonatal Mortality 2015 – Jan 2016}
[60] {INQ0003217, pg. 7 - Report titled Thematic Review of Neonatal Mortality 2015 - Jan 2016, dated 08/02/2016}

contain any reference to babies suddenly and unexpectedly collapsing[61]. This additional theme was suggested by Dr Subhedar in his email of 10 February 2016[62]

> "*One additional comment that you might consider adding somewhere that relates to the 'theme' of some of the cases involving babies that suddenly and unexpectedly deteriorated and in whom there was no clear cause for deterioration/death identified at PM*".

53. The original version of the Thematic Review without this theme is understood to have been sent to Mr Harvey by Dr Brearey on 15 February 2016 who then forwarded it to Ms Kelly[63]. The very fact that Dr Subhedar had to prompt this change to the Thematic Review minutes, suggests that Dr Brearey did not at that point in time believe that this was of great significance and certainly indicates that his mind was not focussed on deliberate harm as a potential explanation for the deaths and collapses.

54. On 4 May 2016, Dr Brearey sent an email in response to the rescheduling of a meeting with Ms Kelly, Mr Harvey and Eirian Powell to discuss the Thematic Review.[64] Again, nothing in Dr Brearey's email suggests a belief on his part that Letby was murdering or deliberately harming babies. This would be completely inconsistent with the statement: *"Eirian has sensibly put her on day shifts*" without any suggestion of requiring supervision or some other mitigation or indeed, being removed from the ward. Accordingly, it was reasonable for Ms Kelly to form an impression that this email related to support for Letby and concerns around her welfare.[65] Indeed, Dr Brearey's email suggests that he anticipated Letby's return to the night shift at some point: *"It would be very helpful to meet before she is due to go back on night shifts. There is some pressure regarding staffing numbers with this at the moment".*[66] There is nothing to suggest that at this point in time Dr Brearey had in his mind that Letby was murdering and deliberately harming babies.

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[61] {INQ0102684, pg. 215 - Email correspondence between Dr Subhedar, Stephen Brearey and others, dated between 08/02/2016 and 10/02/2016}
[62] {INQ0102684, pg. 215 - Email correspondence between Dr Subhedar, Stephen Brearey and others, dated between 08/02/2016 and 10/02/2016}
[63] {INQ0003140 - Emails between Alison Kelly, Ian Harvey and Stephen Brearey, regarding feedback form external review, dated 15/02/2016}
[64] {INQ0003138, pg.2 - Emails between Stephen Brearey, Alison Kelly and others, regarding staff trends, dated 03/05/2016 - 05/05/2016}.
[65] {Alison Kelly, Week 11, Day 1, pg. 281, lines 11-14}
[66] {INQ0003087, pg. 1 - Email chain between Alison Kelly, Stephen Brearey and Ian Harvey, regarding the presence of a nurse for multiple deaths on the neonatal unit, dated between 03/05/2016 - 04/05/2016}

55. A meeting to discuss the Thematic Review was held on 11 May 2016. In attendance were Ms Kelly[67], Mr Harvey, Stephen Brearey, Anne Murphy and Eirian Powell. At no stage during the course of the meeting did Dr Brearey (or anyone else) state that he was concerned that Letby was deliberately harming babies, as evidenced by the contemporaneous note of the meeting.[68] There were a number of possible factors discussed to explain the increase in mortality. If Dr Brearey held a suspicion that Letby was murdering babies on the NNU at this point in time, why didn't he articulate this in the very clearest of terms? Eirian Powell and Anne Murphy speaking with emotion[69] could not, on any view, justify Dr Brearey's failure to clearly express his concerns about deliberate harm, particularly so given his position as clinical lead for the NNU[70]. Both Ms Kelly and Mr Harvey have been clear that there was no suggestion of deliberate harm during this meeting and that the issues being highlighted were related to care and possible competency issues in respect of a nurse and a doctor – albeit there was reassurance given by Eirian Powell that there were no performance issues regarding Letby. Additionally, reassurance was provided by the fact that the Thematic Review had involved careful consideration and scrutiny of each case, a natural cause of death provided in respect of all but one baby and the clinical actions and areas of improvement identified within the report.

56. In an email from Dr Brearey on 16 May 2016, to other NNU Consultants and doctors (including Dr Jayaram, Dr Gibbs, Dr Murthy, Dr Holt) the meeting was characterised by him as having been "*helpful*". He noted that Mr Harvey and Ms Kelly were "*grateful for the work we have done in the various reviews and involving an external clinician*".[71] The Inquiry has not disclosed any emails from any of the recipients of this email, including from Dr Jayaram, taking issue with its contents or querying the absence of action being taken in respect of Letby. To suggest that there was a fear of corresponding amongst themselves at this stage is wholly without merit and not supported by later email correspondence between clinicians.[72]

57. It was reasonable for the Senior Managers to expect that the lead Consultant for the NNU would clearly articulate if he had concerns about a member of staff deliberately

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[67] {Alison Kelly, Week 11, Day 1, pg. 5 to pg. 13}
[68] {INQ0003181 - Handwritten minutes of the NNU Thematic Review meeting, regarding the trends visible across the NNU deaths subject to the thematic review, written by Alison Kelly, dated 11/05/2016}
[69] {Rule 9 Statement of Dr Brearey, INQ0103104, pg. 40, para 230}
[70] {Dr Brearey, Week 10, Day 2, pg. 127, lines 11-17}
[71] {INQ0005721 - Email from Stephen Brearey to Ravi Jayaram and colleagues, regarding reporting of any baby who suddenly or unexpectedly collapsed, dated 16/05/2016}
[72] {Dr Gibbs, Week 4, Day 2, pg. 118 line 16 – pg. 199 line 6}

harming babies, or, indeed, to have called the police himself. On the last day of the evidential hearings, Dr Susan Gilby gave evidence about conversations she had had with Dr Brearey after she had joined the Trust. She articulated a crucial question for this Inquiry to resolve:

> "*I did have in my mind questions about why were they [the Consultants] not able just to go to the police themselves? Our A&E Consultants, for example, would call the police all the time, and they don't ask the Executive team if that's okay. But later, I went – I learned that the interactions had been so threatening that they were fearful*".[73]

58. Between the meeting on 11 May 2016 and the death of Child P at the end of June 2016 there was no further contact from Dr Brearey (or any other clinicians) with any member of the Senior Management team. There is no evidence that Dr Brearey acted in any away to suggest that he had active concerns about Letby posing a risk to the babies on the NNU during this period. His conduct is simply not consistent with this interpretation. In his email to Ms Kelly on 28 June 2016, following the death of Child P he states that:

> "*There's been a watchful waiting approach since our last meeting with Ian and Alison in March*[74]*. However, <u>since</u> 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".*[75]

59. This can only be read as confirming that the concerns about Letby crystallised following the deaths of Child O and P, that is the end of June 2016. That notwithstanding, within the same email Dr Brearey identified other actions which ought to be undertaken to make the NNU safe thereby suggesting that there may be other potential issues at play within the NNU:

> "*Other measures I think would be helpful would include a deep clean and reducing the number of allocated cots on the NNU at least temporarily. 2 ICU cots and 3 HDU cots (rather than 3 and 4) would improve nurse staffing ratios*

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[73] {Susan Gilby, Week 16, Day 1, pg. 81, lines 1-7}

[74] {INQ0003116, pg. 2 - Emails between Stephen Brearey, Ravi Jayaram, Karen Townsend and colleagues, regarding concerns held about the NNU and Lucy Letby staying on this unit, dated 28/06/2016} We suggest that should read May – this would be entirely consistent with the evidence there being no meeting in March.

[75] {INQ0003116, pg. 2 - Emails between Stephen Brearey, Ravi Jayaram, Karen Townsend and colleagues, regarding concerns held about the NNU and Lucy Letby staying on this unit, dated 28/06/2016}

and reduce the risk of nosocomial infection by making the space around the cots closer to BAPM standards"

60. Whilst there was an apparent link between Letby's shift pattern and a number of the deaths, that was balanced by the fact that she worked more shifts than others and due to her skills and training she was more likely to be looking after the sickest infants on the NNU.[76] Added into the balance was the fact that nothing was ever identified to actually connect her with the deaths. The clinicians had not witnessed Letby doing anything untoward in relation to a baby (or at least not escalated to any Senior Manager that they had witnessed such an incident). Nothing was identified or raised in respect of any concerning insulin test results or rashes/skin discolouration. These undefined concerns about Letby were not shared by nursing staff, in particular, the NNU Manager, Eirian Powell, who was firmly of the view that Letby was a good and competent nurse. In addition, natural causes of death were ascribed to almost all of the babies, save for Child A, whose cause of death was unascertained, with a further two babies awaiting postmortems. On the other hand, there appeared to be real care issues as identified in the Thematic Review.

61. The collective view of the Senior Managers was that a better understanding of what was going on was required. Given how extremely rare acts of deliberate harm by healthcare professionals are, it was entirely reasonable to approach the undefined concerns raised by the clinicians with an open mind and have regard to all possible explanations, likely and unlikely. The Senior Managers had a responsibility to understand what was going on so that they could be in a position to clearly articulate this to the police, should there be a need to make a referral. Because of the many factors set out above and the absence of any clear, causal connection between the deaths and Letby it was felt by the Senior Managers that further investigation had to be undertaken. As Ms Kelly put it:

"*I think at the time we felt that we needed to get much more information internally so that we knew how we would articulate these concerns to the police. You know, on reflection maybe we could have gone to the police then but it actually didn't feel -- it didn't feel the right thing to do at that time because we felt we needed more information so that we could articulate clearly to the police*

[76] {INQ0001888 - Draft Paper from the Countess of Chester Hospital titled Position Paper – Neonatal Unit Mortality 2013-2016}

what the problem was and at that time we weren't clear, it was complex"..."*we needed to pull things together to see what the fuller picture was at the time*".[77]

The views of others

62. The Senior Managers' understanding of the evidence provided by the following clinicians to the Inquiry is that they were not aware of suspicions of deliberate harm until the end of June 2016 - Dr Saladi, Dr Barrett, Dr Neame, Dr V, Dr ZA, Dr Mayberry, Dr Ventress and Dr McCormack

63. Furthermore, the Inquiry sent out a series of questionnaires to nurses who worked on the NNU over the relevant period. Some of these nurses also provided witness statements to the Inquiry having received Rule 9 requests to do so. This evidence was summarised by CTI and read into the Inquiry record on 15 October 2024.[78] This summary included the following statements:

> *"most of the nurses commented positively about the quality of management, supervision and/or support that they received…from…Eirian Powell and…Yvonne Griffiths".*
>
> *"Most nurses described being aware of or worried about the increase in the numbers of deaths on the NNU."*

64. What this summary failed to explain was that a significant number of the nurses considered the increase in mortality to be due to natural causes. Furthermore, CTI chose not to include the fact that a significant number of nurses had told the Inquiry that they had no concerns regarding Letby: Lisa Walker, Nurse Z, Amy Davies, Jennifer Jones, Bernadett Butterworth, Caroline Oakley, Chris Booth, Mary Griffiths, Joanne Williams, Nurse Y, Belinda Williamson.

Reputation

65. It has been suggested that the Senior Managers were more concerned with protecting their own reputations than ensuring the safety of babies. The Inquiry has received no evidence which supports this assertion.

66. The suggestion that the Senior Managers were reluctant to act on concerns about Letby appears to have been prompted by an entry made on the Risk Register by Karen

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[77] {Alison Kelly, Week 11, Day 1, pg.145, lines 15-23 and pg.18, lines 23-25}.

[78] {Summary of Evidence of Nurses and Midwives, read by Ms Lyons (CTI), Week 6, Day 2, pg. 193 line 8 – pg. 228 line 20}

Townsend on 11 July 2016 which read "*potential damage to reputation of neonatal service and wider Trust due to apparent increased mortality within the neonatal unit*"[79]. Both Mr Chambers and Mr Harvey gave evidence that they could not specifically recall the entry on the Risk Register but insofar as reputation was concerned, their only concern was maintaining public confidence that the NNU was safe at that time[80]. The Senior Managers have emphatically refuted the proposition that either their own reputation or that to the Trust was prioritised over safety[81].

Internal and External Reviews

67. After meeting with the Paediatric Consultants to better understand the concerns about the rise in neonatal deaths and collapses at the end of June 2016, a decision was taken to downgrade the NNU to a level 1 unit and undertake some internal investigations.

68. The motivation of the Senior Managers has always been the safety of the babies on the NNU. If the Senior Managers had not kept an open mind and had instead accepted, without question, the allegations made by the Consultants that Letby was deliberately harming babies then there would have been no downgrading of the NNU, no internal or external investigations and this would have increased the risk of more babies collapsing and/or dying and hampered the search for the truth about what had happened.

69. Even when the downgrading took effect, there needed to be a micro-management of the NNU by the leadership team to ensure adequate care of patients and that the right decisions around treatment were being made. It became clear that there had been a culture of coping which had developed on the NNU with care being given to some babies who ought to have been transferred to other hospitals for more specialised care.[82] The Inquiry will want to consider whether the desire for the NNU to remain as a level 2 unit, with the status that this generated, overawed the ability of the clinical leads to identify shortcomings in the care being provided. It is notable that, for the past nine years, the NNU has remained classified as a level 1 unit, this being despite the efforts of the clinical leads to have it reassessed and reinstated as a level 2. It is

[79] {INQ0049845, pg.2 - Executive Risk Register, dated July 2016}
[80] {Tony Chambers, Week 11, Day 3, pg. 58 line 7 – pg. 62 line 5} and {Ian Harvey Week 11, Day 4, pg. 84 line 2 – pg. 87 line 19}.
[81] {Tony Chambers, Week 11, Day 3, pg. 58 line 7 – pg. 62 line 5} and {Ian Harvey Week 11, Day 4, pg. 84 line 2 – pg. 87 line 19}
[82] {Dr Neame, Week 4, Day 3, pg. 57, line 24 – pg. 59, line 2}

understandable if the clinicians viewed the downgrade as an implicit criticism of their skills and that this may have had a bearing on their reluctance to report collapses and send a clear message up the chain that the unit was struggling[83].

70. Furthermore, the Inquiry will want to consider if there should be stronger networks of oversight from clinicians in other local hospitals to ensure the objectivity of reviews and reduce the prospect of such myopia occurring in the future. The tendency for clinicians to 'mark their own homework' ought to be avoided wherever possible.

71. Following the downgrading, tasks were assigned to various individuals within the Trust and information was compiled as part of an operation known as Silver Command. The work was multi-factorial but included the preparation of a communications plan, a review of the NNU in terms of its activity levels and the number / nature of the admissions, a clinical review of the babies who had collapsed and been transferred out of the COCH, the collation of data from staff rotas and a staffing review was also carried out. Whilst there were no formal Terms of Reference for this work, it was considered a reasonable step by the Senior Managers to collate information about the deaths and collapses with the support of Dr Gibbs, Anne Martyn, Ruth Millward, Sian Williams and others.

72. As a result of the internal review work, a 'Position Paper' was prepared by Ruth Millward. Ms Kelly and Mr Harvey were the co-authors.[84] This identified a number of issues in terms of how risk was being managed by the NNU including the fact that sudden deteriorations were not being reported via Datix.[85] The Inquiry has heard evidence in relation to the "*limited*" incident reporting practices on the NNU and the concern amongst Risk and Patient Safety staff around the scope of incident reporting and the lack of responsiveness of some Paediatric Consultants to improving these practices.[86]

73. The Position Paper also identified 11 incidents which were reported between June 2015 and March 2016 regarding staffing levels and acuity concerns. The Paper noted

[83] {Tony Chambers, Week 11, Day 3, pg. 141, lines 7-15}

[84] {INQ0001888 - Draft Paper from the Countess of Chester Hospital titled Position Paper - Neonatal Unit Mortality 2013-2016, undated}

[85] {INQ0107704, pg.131, paragraph 429 - Witness Statement of Alison Kelly, dated 13/08/2024} and {INQ0107653, pg. 68, paragraph 274 - Witness Statement of Ian Harvey, dated 11/08/2024}

[86] {Ruth Millward, Week 8, Day 1, pg. 199 line 5 – pg. 200 line; pg. 160 line 7 - pg. 163 line 7; pg. 168 line 5 - pg. 173 line 23; and pg. 203 line 22 - pg. 205 line 25}

an increase in acuity and activity on the NNU during the period in question. Mr Harvey dealt with the conclusion of the Position Paper in his statement:[87]

> "*Overall, the conclusions of the report indicated that there had been an increase in workload intensity and acuity on the NNU and that those factors may partly have explained the increase in mortality. It was not a satisfactory explanation for the increase in the sense that it was clear those factors were not the whole answer, but were potential contributing factors*".

74. As the Inquiry is aware, the RCPCH was commissioned by Mr Harvey to conduct a service review in light of the increase in unexpected incidents on the Neonatal Unit. The Terms of Reference requested that the RCPCH consider whether there were "*any identifiable common factors or failings that might in part, or in whole, explain the apparent increase in mortality*"[88]. The Senior Managers respectfully maintain that the commissioning of an independent review was a sensible course of action at that stage. In the absence of any evidence, it could not be assumed that Letby and not any other factor, or combination of factors, was the cause of the increase in mortality. To have accepted the Consultants' concerns without exploring all potential issues on the NNU would have been irresponsible and would have risked patient safety.

75. Mr Harvey's expectation at the time of instruction was that this review would incorporate a case note review; he could not foresee how they could fulfil their brief without doing one. With the benefit of hindsight, Mr Harvey accepts that the letter of instruction should have been explicit as to the requirement for a case note review.[89]

76. It is accepted by Ms Eardley that she was aware from her initial discussions with Mr Harvey about the Consultants' concerns regarding the commonality of one nurse. Her interpretation from her initial conversations with Mr Harvey was that the Consultants had raised the possibility of potential harm based on a "*correlation*" [90]. The RCPCH were provided with unfettered access to staff on the Neonatal Unit, including the Consultants, to explore all the circumstances in relation to the increase in mortality. Having spoken with the Consultants, some members of the RCPCH review panel formed the view that Letby's presence on the unit at the times of death was nothing more than a commonality which was "*uncorroborated*" against all the other information

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[87] {INQ0107653, pg. 69, paragraph 280 - Witness Statement of Ian Harvey, dated 11/08/2024}
[88] {INQ0010256 - RCPCH Draft Terms of Reference, undated}
[89] {Ian Harvey, Week 11, Day 4, pg. 198, line 15 – pg. 200, line 25}
[90] {Sue Eardley, Week 8, Day 4, pg. 137, line 16 – pg. 138, line 20}

they were provided with. They emphasised that the Consultants had provided a "*mixed picture*" about Letby and that when looking at the context as a whole there were "*no red flags*"[91].

77. The RCPCH highlighted a number of issues on the NNU which were consistent with the Trust's own internal investigation findings including problems with the neonatal environment, staffing levels and serious incident reporting. Having had the opportunity to meet with Neonatal staff, including Letby herself, the RCPCH raised no concerns about her or any other individual.

78. There appears to have been a misunderstanding between the RCPCH and Mr Harvey as to the identity of those with whom the RCPCH's report could be shared. Mr Harvey's understanding from previous correspondence with the RCPCH was that the version of their report which referenced confidential HR issues relating to Letby was for very limited circulation and that only the formal version, which excluded those issues, was for dissemination to those who had contributed. Mr Harvey was reliant on the expertise of the RCPCH and followed what he understood to be their advice. Notwithstanding that advice, it is accepted now that the report should have been shared with the Paediatric Consultants at an earlier stage than transpired.[92]

79. As to why the RCPCH report was not shared with the families sooner, Mr Harvey explained in evidence that until a full case review had been completed, he did not consider that the requirements of the report had been fulfilled. He explained that he felt uncomfortable with sharing the report until he was able to provide a much fuller picture and pass on all relevant information in respect of their babies, so that the Senior Managers "*weren't leaving any details hanging or unanswered*"[93]. Notably, the evidence from some of the parents was that that they felt that RCPCH report did not answer their questions about the deaths or go into specifics. This was precisely the feeling Mr Harvey had wanted to avoid.

80. It is a matter of deep regret to the Senior Managers that some parents became aware of the report when it was leaked by others to the press and in some cases were not aware of it until it was raised in other legal processes. The Senior Managers are profoundly sorry that this was how some families came to learn of the report. This

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[91] {Alexandra Mancini, Week 9, Day 1, pg. 176, lines 15-21 and pg. 177 line 24 – pg. 178, line 2} and {Claire McLaughlan, Week 9, Day 1, pg. 31, lines 1-7 and pg.32, lines 17-25}
[92] {Ian Harvey, Week 11, Day 5, pg. 72 lines 13-17, pg.196, lines 15-18 and pg. 74, lines 7-9}
[93] {Ian Harvey, Week 11, Day 5, pg. 13, lines 12-20}

should not have been the case. At the time the report was leaked, the Senior Managers and others had been in the process of formulating a detailed communication plan[94] to ensure that all parents and other stakeholders were notified of its completion.

81. Mr Harvey instructed Dr Hawdon to conduct a detailed case note review. There is a difference in the recollection of Dr Hawdon and Mr Harvey as to what was communicated to her about the nature of the Paediatric Consultants' concerns at the time of her instruction. It does not appear to be disputed that Dr Hawdon had been placed on notice of a review into staff with access to the unit in the four hours before each incident. When asked in evidence whether she was surprised to see this, she said it would not necessarily indicate criminal intent and could be looking into, for example, clinical competencies[95]. That was precisely the view that the Senior Managers had formed. Dr Hawdon suggested in evidence that had she been aware of a concern that a member of staff had harmed babies deliberately, this would have triggered a much more detailed conversation about whether she could have accepted the instructions[96]. It will be a matter for the Chair to determine how reliable this evidence is in circumstances where concerns about Letby were based solely on her presence on the unit at the time of the incidents, which was within the detail of the documents provided to Dr Hawdon. It is notable that she appeared to express no surprise in her email exchanges with Mr Harvey in 2017 when addressing suspicions about Letby[97]. This is evident from Dr Hawdon's response to Mr Harvey's email dated 14 February 2017[98] in which he refers to the Paediatricians' allegations against one member of staff: *"I perceive a combination of understandable professional pride regarding standards of care on the unit along with concern over unexpected and unexplained events, both of which are entirely reasonable reactions, but both of these should not prevent accepting and learning what could have been improved*".

82. Dr Hawdon provided her initial report to Mr Harvey in October 2016. Her evidence was that her review revealed a varied clinical picture raising concerns in clinical management, including the use of antibiotics, delays in escalation and whether babies had been born in the right unit for the level of care they required[99]. This compounded

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[94] {Ian Harvey, Week 11, Day 5, pg. 12, line 19 - pg. 13, line 2}
[95] {Dr Hawdon, Week 9, Day 2, pg. 22 lines 8-20}
[96] {Dr Hawdon, Week 9, Day 2, pg. 14, lines 9-16}
[97] {INQ0014376 - Emails between Ian Harvey and Dr Hawdon dated 14/02/2017} and {Dr Hawdon, Week 9, Day 2, pg. 77, lines 19-25}
[98] {INQ0014376, pg. 2 - Emails between Ian Harvey and Dr Hawdon dated 14/02/2017}
[99] {Dr Hawdon, Week 9, Day 2, pg. 20 line 24 – pg. 21 line 8}

the views of Senior Managers that the cause of unexplained deaths and collapses was likely to be multifactorial in nature[100].

83. Whilst Dr Hawdon went on to say that she agreed with the view later expressed by the Paediatric Consultants that her report did not explain the deaths, she did not convey that to Mr Harvey at that time. Dr Hawdon was asked whether, had she received her own report, she would have recognised the significance of the grouping of babies she had identified requiring further forensic review. She suggested that the recipient should have identified that there was "*a problem here*" which necessitated triggering the safeguarding process[101]. The Senior Managers submit that the only problem raised by Dr Hawdon's report, on any reading of it, was that there were issues with clinical management on the unit which may have caused or contributed to the incidents.

84. During further questions from Mr Skelton KC, Dr Hawdon suggested that by grouping "*unexplained"* deaths she was in fact saying that something other than medical cause was in play. She said there were a number of possibilities that she was not in a position to comment on, which were for the Trust to look into[102]. If these were her views at the time, they were not communicated to Mr Harvey either explicitly or implicitly by the tone of her report or correspondence thereafter.

85. Mr Harvey was keen to ensure that there was further consideration of the "*unexplained*" deaths and therefore he contacted Dr McPartland, a Consultant Pathologist at Alder Hey Hospital, on 21 December 2016 to request a review of the deaths of Child I, Child O, Child P and Child A[103]. Dr McPartland and her colleagues undertook a review of these cases from a specialist paediatric pathologist viewpoint.

86. Dr McPartland was asked in evidence about the initial post-mortem investigations of babies and the information provided by the Paediatric Consultants when those deaths were reported by them. She explained that a pathologist is very reliant on the information provided and that it would be very difficult to pick up that a death was potentially suspicious without something "*very concerning*" being highlighted[104]. She noted that it was open to the Paediatric Consultants to raise any concerns they had

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[100] {Tony Chambers, Week 11, Day 4, pg. 2, lines 2-25} and {Ian Harvey, Week 11, Day 4, pg. 172, lines 1 –18}
[101] {Dr Hawdon, Week 9, Day 2, pg. 24, line 8-20}
[102] {Dr Hawdon, Week 9, Day 2, pg. 74, lines 4-12}
[103] {INQ0102002, pg. 2 - Email correspondence between Ian Harvey and Dr McPartland, dated 21/12/2016}
[104] {Dr McPartland, Week 9, Day 2, pg. 109, lines 4-10 and pg. 122, lines 3-11}

about the conclusions reached at post-mortem[105]. The Consultants at the COCH had raised no such concerns. Dr McPartland was asked whether the cluster of deaths ought to have raised any concerns. Her evidence was that without knowing that any of those deaths were unexpected or unexplained or concerning in any way, a cluster alone would not necessarily raise a suspicion of an inflicted mode of death[106].

87. With regard to the review of four cases undertaken at the instruction of Mr Harvey, Dr McPartland explained that the pathologists involved in the review did not know why three of the babies had collapsed, but that no concerns about the nature of the deaths were raised from the pathology reviews alone[107]. The Senior Managers suggest that it is implicit from that evidence that the simple fact that a neonate had collapsed and died without explanation was not considered by the pathologists to indicate something unusual or concerning.

88. Mr Harvey has candidly accepted that the way in which Dr Hawdon's report was shared with the families was unthinking and insensitive. He has expressed that he was keen to share the information as soon as possible, particularly in view of the delays, but accepts that this does not excuse the way in which this was done. He wishes to reiterate his apology to the families for this[108].

89. The Inquiry has sought to examine whether the commissioning of various external reviews was appropriate. Mr Harvey accepts that none of the external reviews were specifically designed to identify deliberate harm. As set out earlier in these submissions it is a matter of regret to Mr Harvey and the other Senior Managers that the police were not contacted sooner. However, it is worthy of note that when the police were contacted, and eventually persuaded to investigate, their chief investigator and, more latterly, expert witness, retired Paediatric Consultant Dr Dewi Evans, was able to identify evidence of murder based on his interpretation and analysis of the very same notes and records which had been considered by the RCPCH investigators, the neonatal pathologists at Alder Hey hospital (whose post mortem examinations were considered by Coroner Nicholas Rheinberg to be as thorough as those conducted by forensic pathologists),[109] Dr Hawdon and Dr McPartland. None of these neonatal experts had noticed anything of the sort.

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[105] {Dr McPartland, Week 9, Day 2, pg. 156, lines 9-13}
[106] {Dr McPartland, Week 9, Day 2, pg. 144, lines 13-20}
[107] {Dr McPartland, Week 9, Day 2, pg. 131, lines 8-11}
[108] {Ian Harvey, Week 11, Day 5, pg. 113, line 19 – pg. 114 line 14}
[109] {Nicholas Rheinberg, Week 12, Day 5, pg. 101, lines 7-20}

90. It was not unreasonable for the Senior Managers to have regard to the professional conclusions of those highly experienced in neonatal matters. Whilst none of these reviews specifically excluded the possibility of criminal activity, none of them identified behaviour which positively supported the possibility of a malicious act. It had been anticipated by the Senior Managers that, in the event there had been a malicious or negligent act, evidence of it would have been flagged up by the reviews[110].

91. Instead, the reviews undertaken internally and by the RCPCH, Dr Hawdon and Dr McPartland pointed towards significant clinical concerns and suboptimal care. The view shared by the Senior Managers of the various reviews when taken together was that they pointed away from deliberate harm and towards a natural or clinical cause.[111]

Information provided to the Coroner

92. By January 2017 the internal and external investigations were complete. The genuine belief of the Senior Managers at this time was that the effect of those reviews was to point away from deliberate harm and towards natural causes[112].

93. On 10 February 2017 Mr Chambers received a letter from the Consultant paediatricians stating that they did not consider that the reviews had adequately explained the deaths[113]. They invited the Senior Managers to ask the Senior Coroner for Cheshire to undertake an investigation.

94. It is worth noting that the initial notification of a death requiring a coronial investigation should occur immediately after the death. The responsibility for making a report to the Coroner lies primarily with the treating clinician, who is best placed to form a provisional view about whether the death is unexplained or unnatural and may need further investigation. The Senior Managers' understanding was that a number of babies had post-mortems identifying a natural cause of death and it had been considered by the treating clinician, or the Coroner, that no further investigation was necessary[114]. In relation to the seven babies Letby was ultimately convicted of murdering:

    a. The death of Child A was reported to the Coroner by Dr Saladi. An initial post-mortem found that the death was unascertained.[115] A full inquest took place in

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[110] {Ian Harvey, Week 11, Day 4, pg. 202, line 16 – pg. 204, line 10 and pg. 2017, line 22}
[111] {Ian Harvey, Week 11, Day 5, pg. 19, lines 4-21}
[112] {Tony Chambers Week 11, Day 3, pg. 159, line 24 - pg. 160, line 3}
[113] {INQ0003117 - Letter from Paediatric Consultant group to Tony Chambers, regarding the Board's findings and the RCPCH report, dated 10/02/2017}
[114] {Ian Harvey, Week 11, Day 4, pg. 172, lines 10-18}
[115] {CTI Opening, Week 1, Day 1, pg.145 lines 13-14}

October 2016 during which the Senior Coroner concluded that the death remained "*unascertained*".[116]

b. The death of Child C was reported to the Coroner by Dr Gibbs. This was done by way of a Coroner's Authorisation Form 1 which identified the cause of death as "*respiratory distress syndrome*".[117] A post-mortem was undertaken, recording the cause of death as "*widespread hypoxic/ischaemia damage to heart/myocardium due to immaturity of lung due to severe maternal vascular under-perfusion/MVUP*".[118] "*Severe intrauterine growth restriction*" was listed as a contributory cause.[119] The coronial investigation was discontinued after the post-mortem suggested a natural cause of death.

c. The death of Child D was reported to the Coroner by Dr Newby. This was done by way of a Coroner's Authorisation Form 1 which noted that this was the third neonatal death in 12 days (a reference to Child A and Child B), and that there had been a further episode of apnoeic event and CPR for a previous twin death, with the surviving twin receiving successful CPR.[120] A post-mortem was undertaken, recording the cause of death as "*1a) pneumonia with acute lung injury*".[121] The coronial investigation was discontinued but later recommenced at the request of Child D's family.

d. Dr ZA completed a Coroner's Authorisation Form 1 in which she recorded the cause of death as "*1a) Necrotising enterocolitis and 1b) Prematurity*".[122] No postmortem was requested, and no Inquest was opened[123].

e. The death of Child I was reported to the Coroner by Dr Gibbs. This was done by was of a Coroner's Authorisation Form 1: "*Born 27 weeks early and has been in hospital since birth has underlying chronic lung disease of prematurity and intermittent bowel obstruction….Dr is not clear as to why arrest has happened and cannot issue a certificate".*[124] A post-mortem was undertaken, recording the cause of death as *"1a) Hypoxic ischaemic damage of brain and*

116 {CTI Opening, Week 1, Day 2, pg. 164 line 22 - pg. 165 line 2}

117 {Dr Gibbs, Week 4, Day 2, pg. 44 lines 4-5}

118 {CTI Opening, Week 1, Day 2, pg. 172, lines 18-22}

119 {Dr McCormack, Week 5, Day 2, pg. 29, lines 2-5}

120 {INQ0002045, pg. 4-8 - Bundle of coronial materials in relation to Child D, produced by the Senior Coroner for Cheshire, undated. [File metadata indicates date of 28/11/2023]}

121 {CTI Opening, Week 1, Day 1, pg. 61, lines 17-19}

122 {Dr ZA, Week 5, Day 1, pg. 66, lines 23-25}

123 {Nicholas Rheinberg, Week 12, Day 5, pg. 30, line 20 – pg. 31 line 6}

124 {{Nicholas Rheinberg, Week 12, Day 5, pg. 32, lines 4-8}

chronic lung disease of prematurity due to 1b) Extreme Prematurity".[125] The Coroner determined that it was not necessary to hold an inquest into the death of Child I.[126]

f. The deaths of twins Child O and Child P were reported to the Coroner by Dr V. Post-mortems were undertaken which identified the cause of death for Child O as "*1a) haemorrhage to peritoneal space due to 1b) rupture of subcapsular haematoma due to 1c) prematurity'*.[127] The death of Child P was attributed to *"prematurity*".[128] Both deaths were due to proceed to an inquest hearing but, in the event, these did not take place.

g. The Senior Managers understood that the Coroner had been notified that there had been an increase in the number of neonatal deaths and had been provided with a copy of the Thematic Review.[129]

95. The Senior Managers were not involved in the preparation for the inquest into the death of Child A which fell to Stephen Cross, who instructed external lawyers to assist with that process. It is notable that Dr Jayaram gave evidence before the Coroner and raised no concerns about deliberate harm. In his evidence to the Inquiry, he explained his position as follows:

> *"...I was aware that the deaths had been - I think bar one of them had been reported to the Coroner. And I was also cognisant of the fact we had been told: do not speculate. And again, hindsight: I didn't specifically say I or we as a group are concerned that an individual member of staff is causing harm. I was trying to make it clear to the Coroner that I did not understand what was going on here and I couldn't think of a clinical explanation and there had been other things like this as well. But I didn't explicitly say that.*
>
> *Q. Stephen Cross's email which was forwarded to you made it clear he was in direct communication with Mr Rheinberg?*
>
> *A. Well, it gave me the impression that, that the concern we had, the specific concern regarding Letby, was on the Coroner's radar. Now I in retrospect don't know whether that is the case or not because I have not been party to – to discussions. But certainly my understanding is that the Coroner was aware that*

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[125] {Nicholas Rheinberg, Week 12, Day 5, pg. 32, lines 10-13}

[126] {Nicholas Rheinberg, Week 12, Day 5, pg. 32, lines 4-20}

[127] {CTI Opening, Week 1, Day 2, pg. 174, line 24 - pg. 175, line 2}

[128] {CTI Opening, Week 1, Day 2, pg. 175, lines 15-17}

[129] {Ian Harvey, Week 11, Day 4, pg. 127, lines 19-23}

a very detailed Casenote Review was going on because nothing else clinically could be found". [130]

96. The evidence of the Senior Managers was that if Dr Jayaram was concerned that Child A had been deliberately harmed, that information should have been explicitly shared with the Coroner, rather than "*trying to sort of throw as many breadcrumbs as possible for the Coroner to pick up without explicitly saying what the suspicion was*", a failing accepted by Dr Jayaram in his evidence.[131]

97. On 15 February 2017, Mr Harvey and Stephen Cross met with the Senior Coroner, Mr Rheinberg, and the Assistant Coroner, Mr Moore to discuss the Consultants' request for an investigation. During the meeting, the Senior and Assistant Coroners were provided with a bundle of documents including Dr Hawdon's report, the letter from the paediatricians dated 10 February 2017 and a document headed "*Observations additional to the RCPCH Review of Neonatal Services*".[132] The final document included the green text from the RCPCH report setting out the Consultants' allegation that Letby had been involved in the deaths in some way.[133]

98. It is acknowledged that there is a difference in the recollections of those in attendance at this meeting as to what was discussed. Mr Harvey's clear recollection is that the topic of conversation was the events surrounding the Consultants writing their letter seeking a referral to the Senior Coroner.[134] As Mr Harvey explained in evidence, he had to explain and provide documentation to support why the Consultants had written that letter and were requesting a meeting with the Coroner.[135] There is no evidence to support any suggestion that the Coroner was, at any stage, deliberately misled by any of the Senior Managers. Any such suggestion is refuted in the strongest terms. Moreover, this allegation bears no weight in circumstances where it is accepted that the Senior Coroner was provided with a document which made explicit reference to the Consultants' concerns.[136]

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130 {Dr Jayaram, Week 9, Day 3, pg. 68, lines 17-25 and pg. 69, lines 1-14}
131 {Tony Chambers, Week 11, Day 3, pg. 228, lines 11-20}, {Ian Harvey, Week 11, Day 5, pg. 217, line 9 - pg. 218 line 8} and {Dr Jayaram, Week 9, Day 3, pg. 245, lines 8-20 and pg.246, lines 11-14}
132 {Ian Harvey, Week 11, Day 5, pg. 218, lines 15-21}
133 {Ian Harvey, Week 11, Day 5, pg. 218, line 13–25}
134 {Ian Harvey, Week 11, Day 5, pg. 219 lines 5-10}
135 {Ian Harvey, Week 11, Day 5, pg. 219 lines 11-14}
136 {Ian Harvey, Week 11, Day 5, pg. 117, lines 17-24}

Reporting to the Police

99. It was agreed during an Executive Team meeting on 27 March 2017 that the Trust would report the Consultants' concerns to the police[137].

100. Prior to contacting the police, Stephen Cross instructed Mr Medland KC to provide advice. It is accepted that seeking advice from Mr Medland KC ultimately caused further delay. However, the Senior Managers emphasise that this was done on the advice of Stephen Cross and with their understanding was that the central purpose of his instruction was to provide advice as to how to approach the police.

101. The Senior Managers ultimately approached Cheshire Police via a Child Death Overview Panel ('CDOP') police representative in April 2017. This led to Mr Chambers making a formal request in writing to the police to open an investigation into the deaths at the COCH[138] and there were a number of follow up meetings between members of the Senior Executive team and Cheshire Police. It is Mr Chambers' recollection that the police were initially reluctant to commence a full criminal investigation[139], this is consistent with the evidence of Stephanie Davies[140]. The minutes of the meeting on 5 May 2017 between Mr Harvey, Stephen Cross and Chief Superintendent Nigel Wenham[141] record in the summary section "*If Cheshire Constabulary are involved, then it would be deemed an 'investigation'. ...There are no significant concerns to suggest any unlawful acts, it appears a series of anomalies that needs to be investigated further*". At a further meeting on 12 May 2017 with Cheshire Constabulary, Assistant Chief Constable Martland noted that there was nothing in the reviews to suggest significant negligence or a criminal act. He also noted that he felt "*uncomfortable*" about speaking to the families of the babies without a specific allegation at that point to suggest a criminal act.[142]

Information provided to external bodies

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[137] {INQ0003150 - Minutes of a Paediatrics meeting, regarding unexplained deaths on the neonatal unit, dated 27/03/2017}
[138] {INQ0102319 - Letter from Tony Chambers to Chief Constable Simon Byrne, regarding a request to open a police investigation, dated 02/05/2017}
[139] {INQ0107708, pg. 172, paragraph 627 - Witness Statement of Tony Chambers, dated 13/08/2024}
[140] {Rule 9 Statement of Stephanie Davies, INQ0011616, pg. 17, paras 88-91}
[141] {INQ0003077, pg. 2 - Minutes of a meeting involving Cheshire Constabulary regarding the events on the neonatal ward and reviews undertaken, dated 05/05/2017}
[142] {INQ0003076, pg. 2 - Minutes of a meeting between Cheshire Constabulary and Countess of Chester Hospital regarding Operation Hummingbird, dated 12/05/2017}.

102. Sir Francis KC gave evidence about the bureaucratic burden of collecting data and passing it on to regulators which he described as "*immense*".[143] This data is designed to ensure there is openness and transparency about key metrics and to alert external bodies to any concerning trends. The COCH, like other healthcare providers, had a system in place to manage this data driven exercise which included mortality statistics.

103. When there was an escalation of concerns about the rise in neonatal mortality following the death of Child P in June 2016, there were various discussions with external regulatory bodies to make them aware of the situation. The Senior Managers were mindful of the lack of any evidence that Letby had intentionally harmed any babies, but they felt that it was important to raise an awareness of the actions they were taking to seek to establish the likely cause or causes of these deaths. Evidence has been given about the discussions held with NHS England, NHS Improvement, the CQC, the NMC and the Department of Health and Social Care. Each of these bodies was made aware of the concerning rise in deaths on the NNU and the actions being taken to seek to investigate the issue and also to make sure the unit was safe. It is noteworthy that none of these bodies advised that a safeguarding referral be made.[144] The NMC were also told about the Consultants' concerns that a member of staff presented a "*serious risk to public safety*"[145] because they were the body responsible for regulating Letby and they could have imposed restrictions on her practice. This did not happen.

Closing Remarks

104. We understand from what has been publicly stated by the CCRC that:

i) An application has recently been made to the CCRC by Letby's legal representatives, received on 3rd February 2025.

ii) This application relates to all of her convictions arising from the period of June 2015 and June 2016 whilst at the COCH.

iii) The CCRC has begun work assessing the application and it anticipates further submissions being made.

iv) The CCRC is not able to determine how long it will take to review the application.

[143] {Sir Robert Francis, Week 4, Day 1, pg. 8, lines 8-9}
[144] {Helen Herniman, Week 14, Day 2, pg. 128, lines 5-13}
[145] {INQ0003607, pg. 2 – Email chain between Alison Kelly and Tony Newman regarding concerns about Lucy Letby, between 04/07/2016 to 12/07/2016

105. In light of this information, the Senior Managers have written to the Secretary of State for Health and the Chair of the Inquiry requesting that the Inquiry be suspended or paused pending the outcome of the CCRC's consideration of an application made by Lucy Letby in respect of her criminal convictions. Both are empowered under the Inquiries Act 2005 to affect a pause in proceedings under the following sections: Under section 13 of the Inquiries Act 2005 the Secretary of State has the power to, at any time, by notice to the Chair, suspend an inquiry for such period as appears to him to be necessary to allow for (a) the completion of any other investigation relating to any of the matters to which the inquiry relates, or (b) the determination of any civil or criminal proceedings (including proceedings before a disciplinary tribunal) arising out of any of those matters (13(2)). This power may be exercised whether or not the investigation or proceedings have begun. Before exercising this power, the Minister must consult the Chair (13(3)).

106. We submit that CCRC's consideration of Letby's application amounts to "*any other investigation relating to any of the matters to which the inquiry relates*", given that the Terms of Reference of the Inquiry are conditional on Ms Letby's criminality and that being the cause of the deaths and unexplained collapses of babies present on the NNU in the COCH between June 2015 and June 2016.

107. In addition, under section 17(3) of the Inquiries Act 2005, the Chair must, in making any decision as to procedure or conduct of an inquiry, act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or to others).

108. It is understood that the application to the CCRC is supported by the opinion evidence of an international panel of independent experts who have considered the medical evidence presented at Ms Letby's trial. These experts are distinguished and recognised leaders in their field. They include Neena Modi, a distinguished Professor of Neonatal Medicine at Imperial College, a past president of the Royal College of Paediatrics and Child Health, the British Medical Association and the current president of the UK Medical Women's Federation who was served with two Rule 9 requests by the ILT and has provided two witness statements to the Inquiry.

109. This new evidence merits and is therefore being given serious consideration by the CCRC. Where there is a real possibility, as appears to be the case here, that Ms Letby's convictions may be referred by the CCRC to the Court of Appeal and there

quashed, we submit that the Inquiry proceedings must be paused. To ignore the appellate proceedings which have now commenced would be wrong on three grounds:

i) The Terms of Reference are conditional on Ms Letby's criminality and there is now an active investigation into the evidence upon which her convictions are based;
ii) The duty of the Chair to act fairly under section 17(3) of the Inquiries Act 2005;
iii) The duty of the Chair to have regard to the need to avoid any unnecessary cost under section 17(3).

110. There now appears to be a real likelihood that there are alternative explanations for these deaths and unexplained collapses, namely poor clinical management and care and natural causes. These alternative explanations were not put to the jury in either of Letby's Crown Court trials. There was no presentation of the RCPCH report which the Inquiry has now delved into in some depth. But, despite now being alive to the many problems that were present on the NNU over the relevant period of time and their being alternative causes of death (now being proposed with force and corroboration by Dr Lee's panel of international experts and other UK neonatal leads), given the Terms of Reference, these were not explored by the Inquiry as alternatives to murder. This was despite a letter to the Chair from Sir David Davis MP on 29 August 2024 expressing his reservation about the Terms of Reference and requesting that they be broadened so as to not depend on the presumption that Letby's convictions were safe.

111. To continue to make findings on the evidence heard, given the filter through which that was drawn, is to breach the duty to act fairly to those individuals and witnesses, as required under section 17(3) of the Inquiries Act 2005. It also defeats the very purpose of any public inquiry which must be to fully and fearlessly understand the circumstances in which these babies came to die or suffer unexplained collapses. If there is evidence to indicate that there are alternative explanations, then it would be wrong for the Inquiry to ignore it because it is inconvenient. Nor would it be appropriate, without more, to make a determination about its evidential value at this stage. That is now a matter for the CCRC. Until there is clarity as to Letby's involvement, as determined by a proper and legitimate appellate process, the proceedings must be paused.

112. If the Inquiry is determined to continue to its conclusion, considering closing submissions, engaging in the warning letter process and drafting its report, it will do so in the absence of considering the alternative hypotheses that are now in the public arena. In doing so, it will be disregarding potentially serious and, in some cases, fatal

issues that have been identified in the provision of care at the COCH. The Inquiry has a duty to investigate "*The effectiveness of NHS management and governance structures and processes…in keeping babies in hospital safe and well looked after*" and identify what changes are needed to prevent similar tragedies from being repeated in the future.[146]

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7 March 2025

146 {Thirlwall Inquiry Terms of Reference, Part C}