Thirlwall Inquiry

Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018

Summary report

September 2026

HC 601

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Summary report

Chair: The Rt Hon. Lady Justice Thirlwall DBE

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1. Introduction

The Report

1.1 This Summary report is an introduction to the main themes and findings of the Inquiry. It will be understood by reading the Report in full, which contains references to supporting material.

1.2 The Report is not a recitation of all the evidence. I have made findings about what happened at the Countess of Chester Hospital (the Countess) from 2015 to 2018 on the balance of probabilities, having considered the evidence and the submissions made on behalf of all Core Participants.

1.3 My focus has been on the questions asked in the Terms of Reference, not on the guilt of Lucy Letby or on her convictions. My starting point was the experiences of the parents. I have divided this Report into three parts: Part One (in Volumes I and II) deals with Parts A and B of the Terms of Reference since those two parts combine to give an account of events at the Countess. Part Two (in Volume III) responds to Part C of the Terms of Reference. Part Three (in Volume III) contains the recommendations and appendices.

Hindsight

1.4 No one expects people who are giving evidence about events that happened 10 or 11 years ago to give a perfect account of what precisely they knew and when precisely they knew it. During the hearings, I was reminded by Counsel for the senior managers not to use hindsight and to avoid hindsight bias when approaching the facts. There are two points to make about that. The first is that, inevitably, anyone looking back at events between 2015 and 2018 does so knowing what happened in 2023, and what came before and after 2023. That cannot be avoided. It is the case whenever a witness gives evidence in any proceedings. I have approached the evidence of the witnesses with that in mind and acknowledging that, in the main, witnesses were doing their best to help the Inquiry. Whenever there is a difference of recollection between witnesses, or where the position is not clear from the oral evidence, I have looked at what the other evidence shows they knew or should have known at the time of the events or decisions about which they were giving evidence. Where there is documentary evidence that assists, I have referred to it. Some witnesses remembered nothing at all about an issue or topic unless it was set out in a document, and even then a document did not always prompt recollection. Second, when assessing the evidence, particularly about decisions made many years ago, I have reminded myself to consider the position of the witness acting at that time, knowing what they knew at that time, not what I or they have learnt since, in order to make a finding about the quality of a decision.

1.5 Some of the witnesses (Mr Stephen Cross, Ms Sue Hodkinson and Ms Alison Kelly) made contemporaneous and often detailed notes of meetings of which no formal minutes were taken (the majority of the meetings with which I am concerned). Sometimes there are several notes by different witnesses of the same meetings. The notes have been a useful aid to assessing the evidence of witnesses at the Inquiry.

1.6 In setting out what was known to have happened to the babies at the Countess, I have, where necessary, relied on contemporaneous medical or nursing records in addition to the oral evidence, and, on occasion, on later reviews. I have kept references to the babies' medical records, and other similar documentation, to a minimum to protect the families' privacy, whilst acknowledging that many records have already been placed in the public domain without warning or even reference to the parents.

1.7 The Report sets out a dispiriting and at times shocking account of multiple and repeated mistakes and failings by organisations and individuals. In the time that has passed since these events, some of the people involved have reflected long and hard on their actions and, in particular, what they could and should have done differently. Many have apologised unconditionally to the parents of the babies for the mistakes they made.

Context

The Countess

1.8 In 2015, the Countess of Chester Hospital was a 600-bed district general hospital with about 4,000 staff. Part of an NHS Foundation Trust, the Countess had a good reputation with NHS England and with the regulator, the Care Quality Commission (CQC).

1.9 Mr Tony Chambers, a former nurse, was the Chief Executive from 2012 to 2018. Mr Ian Harvey, an orthopaedic surgeon, was appointed Medical Director in 2012. He retired in 2018. Ms Alison Kelly, a nurse, was the Director of Nursing and Quality from March 2013. All three of these executive roles were demanding and well paid. In addition to her full-time role as Director of Nursing, Ms Kelly worked occasional shifts as a nurse.

1.10 Ms Sue Hodkinson was appointed the Director of People and Organisational Development (Human Resources (HR)) in 2013. Ms Lorraine Burnett, a former nurse, became Director of Operations in 2016. Mr Stephen Cross, a former police officer and qualified solicitor, became Director of Corporate and Legal Services in 2012. Mr Cross died in 2025. There were also two Chief Finance Officers at this time.

1.11 Sir Duncan Nichol CBE, former Chief Executive of the NHS, was Chair of the Foundation Trust Board. There were five other Non-Executive Directors, of whom two were chartered accountants, one had a background in retail and business, another came from a local authority, and one was a former nurse and midwife who joined the Board in 2016.

1.12 Until 2009, paediatrics and maternity services formed the Women and Children's Division. That division was abolished in 2009, along with the role of Clinical Director for the division. Maternity services and obstetrics were separated from paediatrics.

Paediatrics (including neonatology) was moved into the Urgent Care Division with the very much larger Accident and Emergency Department. Maternity services and obstetrics became part of the Planned Care Division.

1.13 As a result of the reorganisation, the profile of paediatrics (including neonatology) was diminished. Its voice was not heard on the Board. Instead of a Clinical Director, there was a Lead Clinician for children's services (Dr Ravi Jayaram, a consultant paediatrician), who had no regular meetings with the Medical Director.

The neonatal unit

1.14 Until July 2016, the neonatal unit was a Level 2 local neonatal unit, caring for babies born at or after 27 weeks' gestation and weighing 800 grams or more. It was equipped to provide intensive care for up to 48 hours, with babies requiring longer-term or complex care transferred to the Level 3 units at Alder Hey Children's Hospital (Alder Hey) or Liverpool Women's University Hospital (Liverpool Women's). Level 1 units provide special care for babies born after 32 weeks' gestation.

1.15 The unit was one of the larger Level 2 units in the Cheshire and Merseyside Neonatal Network (the Neonatal Network), with 16 cots spread across four nurseries.

1.16 At the time of these events, the neonatal unit was cramped and outdated, had repeated problems with the plumbing and lacked facilities for mothers to stay with their babies. It was very inconveniently located on a different floor from the post-natal ward. The description of the neonatal unit in 2015 and 2016 is echoed in the findings of the NHS Maternity and Neonatal Infrastructure Review, published in September 2025, and referred to in Baroness Amos's final report of the National Maternity and Neonatal Investigation in June 2026. It is plain that many of the same issues persist across the country. In the absence of funding for better facilities, a fundraising appeal, BabyGrow, was launched to raise £4 million for a new, more modern unit. Photographs of Letby were used in the fundraising campaign. By the end of June 2016, the fundraising had stalled at £2 million and it was costing more to run than the funds raised were generating. The appeal was closed in 2017. Funding was made available for improvements: first, the neonatal unit was replaced in 2021; and then, in 2025, a large modern women and children's unit opened, providing integrated family care for babies and their families. This welcome change represents a huge improvement in neonatal care at the Countess.

1.17 At the time of these events, the neonatal unit was separate from the main children's ward. Dr Stephen Brearey, a consultant paediatrician, was the Lead Clinician for the neonatal unit. Ms Eirian Powell, a senior nurse (band 7), was the Manager of the neonatal unit.

1.18 The doctors (junior doctors and six consultants in 2015) were based on the main children's ward. The nurses were based on the neonatal unit and worked exclusively there.

1.19 Having heard evidence from nurses, junior doctors and consultants, along with nurse managers, I am satisfied that relationships on the neonatal unit within each staff group and across the groups ranged from good to excellent.

1.20 A consultant was allocated the role of paediatrician of the week. The paediatrician of the week would lead a ward round on the neonatal unit on two days of the week. On the other five days, a registrar would lead the ward round and would discuss their findings and decisions with that consultant at a later morning handover.

1.21 During 2015 and 2016, the neonatal unit was very busy. Nurses spoke in evidence about peaks and troughs but the workload was considered manageable. Nursing staff shortages were covered by people taking on extra shifts when asked to do so. Shortages of junior doctors were covered by consultants acting down – and there was a shortage of consultants too. An application to the Board for funding for two further consultants for the Paediatric Department had been refused in 2014. At the end of 2015, the consultant paediatrician Dr ZA approached Mr Chambers directly about the need for more consultants. In early 2016, Dr Susie Holt was appointed, taking the number of consultant paediatricians to seven.

1.22 The unit received very few visits from senior managers. Other nurses considered neonatal nursing very niche and tended not to come to the unit. However, the atmosphere on the unit was positive and mutually supportive. The nurses were a cohesive group and were respected by the doctors (consultants and juniors) who, in turn, were respected by the nurses. The junior doctors were well supported by consultants. There was strong team working. Relationships frayed in 2016 when suspicions were expressed about Letby.

Deaths on the neonatal unit

1.23 In the years preceding 2015, the number of deaths on the neonatal unit at the Countess was consistently low. The number of deaths against the number of admissions each year was:

- 2010: 1 death; 422 admissions
- 2011: 3 deaths; 514 admissions
- 2012: 3 deaths; 556 admissions
- 2013: 2 deaths; 460 admissions
- 2014: 3 deaths; 557 admissions

1.24 In 2015, eight babies out of 468 admissions died on the neonatal unit. In addition, two other babies born at the Countess were transferred to other hospitals, where they died. Three of the eight babies who died at the Countess were babies in respect of whom no charges were brought against Letby. Two of them died from severe congenital abnormalities. The third died from prematurity with sepsis. Letby was charged with and convicted of murdering the other five babies: Baby A, Baby C, Baby D, Baby E and Baby I.

1.25 There were 496 admissions to the neonatal unit in 2016. In the first six months, five babies died. Three babies who died in January, February and March all died from congenital abnormalities. No charges were brought against Letby in respect of these deaths. Letby was charged with and convicted of murdering the other two babies – Baby O and Baby P, two of three triplets – in late June 2016. Following their deaths, and as a result of serious concerns persistently expressed by consultant paediatricians,

Letby was moved off the unit into a non-clinical role in the Risk and Patient Safety Department in July 2016. At about the same time, the neonatal unit was downgraded to Level 1, with a higher limit of gestation for admission of 32 weeks. The babies named on the indictment (the list of charges in the Crown Court) who had died in 2015 and 2016 ranged in gestation from 23 weeks and 6 days to 37 weeks and 1 day.

1.26 If the babies whom Letby was convicted of murdering were removed from the annual number of deaths in the neonatal unit, the mortality figures for the Countess would be three deaths in 2015 and three deaths in 2016, broadly consistent with previous years.

1.27 Since July 2016, there has been one death on the neonatal unit, in September 2019.

2. The babies

Baby A

2.1 Baby A was born, with twin Baby B, at the Countess. Baby A and Baby B were delivered at 31 weeks and 2 days' gestation by caesarean section. They were taken to the neonatal unit shortly after their birth. Baby A weighed slightly over 1.66 kilograms and was described to Mother A and B by the hospital staff as "*in one of the best conditions that they'd ever seen*" for a pre-term baby.

2.2 Baby A remained stable, after a period of respiratory support. During the day, an umbilical venous catheter was put in place but was not correctly positioned. It was replaced but still did not sit correctly, so a long line was then inserted at about 7pm to administer fluids. Letby was Baby A's designated nurse for the nightshift. Shortly after 8pm, Baby A began to deteriorate. The deterioration happened suddenly, over the course of a very few minutes. Baby A's heart stopped beating and Baby A required resuscitation. Within half an hour of this sudden collapse, Baby A died.

2.3 During this period, Father A and B overheard staff discussing whether to come and get Baby A's parents as there was something wrong. Mother A and B explained that the hospital staff "*came to get me when* [Baby A had] *already crashed and there was nothing more that could be done*". As a result, the first time Mother A and B held Baby A was after Baby A had died. Mother A and B described feeling "*traumatised*" and that there was "*a gaping hole where Child A should be*".

2.4 Baby A's sudden collapse and death were unexpected and unexplained. Nurses and doctors were shocked. The speed and severity of the collapse were exceptional in their experience. The nurse in charge of the shift remarked in evidence that, "*in what's now 25 years of neonatal nursing experience, I have never witnessed a deterioration in that manner that fast*".

Skin changes

2.5 Before Baby A died, a number of people noticed an unusual rash across Baby A's body. It was a "*blotchy pattern of well perfused pink skin … coupled with patches of white and blue skin*". The rash disappeared and reappeared. It was not static. The rash was not properly recorded by Dr Jayaram, and Baby A's parents were not told about it.

2.6 All the records were provided to the coroner's office. A post-mortem was carried out by a consultant paediatric pathologist. He expressly found that Mother A and B's blood disorder had not contributed to Baby A's death. He identified a structural anomaly in

the aorta, but did not consider it to have had any role in Baby A's death. He considered the placement of the long line and the umbilical venous catheter and, after research, concluded that neither had contributed to Baby A's death. He concluded that the cause of death of Baby A was 'unascertained'. An inquest into Baby A's death was opened in December 2015. Following an inquest hearing in October 2016, the Senior Coroner for Cheshire, Mr Nicholas Rheinberg, found that the cause of death was 'unascertained'. I return to this later in the Summary report.

2.7 Letby was convicted of the murder of Baby A.

Baby B

2.8 Baby B was a similar weight at birth to Baby A, at a little over 1.66 kilograms. After the collapse and death of Baby A, Parents A and B were "*riddled with fear for our baby*". On the night shift that followed the death of Baby A, Baby B also collapsed and required resuscitation. Baby B survived.

2.9 Observations of Baby B by the designated nurse at 20:00 noted Baby B as active. Just prior to midnight, an alert sounded as Baby B's oxygen saturation had dropped. Baby B had knocked out the continuous positive airway pressure (CPAP) prongs. They were put back into position and Baby B was checked by paediatric registrar Dr Rachel Lambie. Baby B seemed to recover. Shortly afterwards, there was a further alert. The prongs had come out of Baby B's nose again. Baby B's nurse was drawing up antibiotics, and so Letby attended to Baby B. Letby called her colleague over saying that Baby B looked just like Baby A. Baby B had the same rash and had collapsed in the same manner.

2.10 Dr Lambie attended to Baby B, who was ventilated. She recorded in the medical notes that Baby B had "*acute apnoea with no warning. Widespread purple discolouration of skin with white patches.*" Dr Lambie described the collapse as "*so acute and so unusual*". The rash covered Baby B and was moving. A nurse commented at the time that this was the same thing that had happened to Baby A the day before. Dr V, the consultant who was on call and attended Baby B, recorded a florid, widespread and blotchy rash. The cause of the rash was unclear. At the time, Dr V's differential diagnosis was that the rash was caused either by Mother A and B's blood disorder, or by an infection. It was later found to be neither.

2.11 The unexplained presentation of both Baby A and Baby B and the very sudden deterioration of both babies were the subject of discussion amongst staff. They were concerned by the unexplained rash on both babies; no one had seen it before.

2.12 Mother A and B saw the blotchy rash when Baby B collapsed. She recalled that a consultant told her that the rash was extremely unusual. She did not know at that time (nor did the consultant) that Baby A had the same rash when Baby A died. If she had known about the rash on Baby A, she "*would have demanded that something was done*".

2.13 Letby sent a series of text messages to colleagues discussing the collapses of Baby A and Baby B. She expressed a desire to get back into Nursery 1, where the most unwell neonates were cared for. She sent detailed accounts of what had happened to other colleagues. She fabricated parts of those accounts. This included making up that Father A and B was on the floor crying when Baby A was taken to the mortuary.

This was not true. In Mother A and B's view, these messages were "*attention seeking*" and a "*red flag*".

2.14 Letby was convicted of the attempted murder of Baby B.

Baby C

2.15 Baby C weighed 800 grams when he was born by caesarean section at 30 weeks and 1 day's gestation. His growth in the womb had been slow, hence his relatively low weight. However, Baby C was in good condition. No resuscitation was required; on the neonatal unit he was ventilated for a short period and then began breathing by himself.

2.16 Mother C, who was on the post-natal ward, was told by a midwife that she had to be able to stand up unaided to go and see her baby on the neonatal unit. Mother C had had an epidural and a caesarean section. She was desperate to see her baby. She should have been taken to see her son. After six or seven hours, she forced herself to stand "*because I needed to go and see him*".

2.17 Dr John Gibbs, a consultant paediatrician, was very involved in the care of Baby C. He told Parents C that, although there were risks for a baby born at that gestation and weight, Baby C was making good progress and was doing well. Dr Gibbs said that the "*prognosis was good and that he was not expected to die*".

2.18 That evening, Letby made it clear to Nurse W, a neonatal nurse (band 6) and the shift leader, that she would rather be in Nursery 1 than in Nursery 3, where she was assigned. When an alarm sounded for Baby C in Nursery 1, and his allocated nurse entered, Letby was already by his cot. Baby C had entered a prolonged period of bradycardia and desaturation. Resuscitation was started. Letby was heard to say: "*He's going.*"

2.19 Dr Katherine Davis, a paediatric registrar who attended Baby C in response to a crash call, could see no obvious explanation for Baby C's collapse. She described it as unusual. It was her experience that most neonates in need of resuscitation usually had a slow heart rate but Baby C's heartbeat was completely absent and did not respond to the administration of drugs or other resuscitation techniques. She had not seen that before and has not seen it since. Dr Gibbs attended ten minutes into the resuscitation efforts.

2.20 At approximately 11pm, Mother C was woken by a midwife and informed that she should come to Nursery 1 immediately. She did so and arrived as CPR was being administered to her son but he was not responding. Dr Gibbs was involved in Baby C's care. A nurse (Mother C believes it was Letby) asked Mother C whether she would like a priest to attend. Mother C asked whether she thought her baby was going to die. The nurse said: "*Yes, I think so.*" During the prolonged wait for the arrival of the priest, limited resuscitation was continued. After Baby C was baptised, he and his parents were transferred to the family room and at his mother's insistence pain relief was given to him. He settled peacefully for his final hours in the arms of his family.

2.21 During this time, Ms Melanie Taylor, the neonatal nurse (band 6) to whom Baby C was allocated, and Letby were coming in and out of the family room making preparations for a memory box, taking handprints and footprints and some of Baby C's hair. This was not Letby's responsibility, and she had not been asked to be involved. Nurse W had

told her repeatedly that she should be looking after the child for whom she was the allocated nurse. Nurse W explained that Letby kept trying to be in the room with Baby C, and to help Ms Taylor, despite this being unnecessary. Nurse W reported this to Ms Powell, who told her to complete a Datix form (Datix is a web-based risk management system). Ms Powell did nothing else about Letby's conduct.

2.22 Before Baby C's death, Letby brought in a ventilated Moses basket, known as a cold cot, and plugged it in. Father C was curt with Letby, who left the room. In the parents' joint statement, he said: "*Reflecting on it now, I believe she wanted to savour my son's dying moments for herself, which fills me with both emotion and anger. Had I not challenged her, she would have further intruded on our private goodbye to Child C.*"

2.23 Dr Gibbs' evidence was that the collapse and death of Baby C were unexpected and unexplained. In his 21 years' experience, such deaths were very occasional. Baby C had been breathing well. In the time leading up to his collapse, he did not seem unwell. In that context, the lack of response to resuscitation was very surprising. It may have been expected from a baby who had been ill for a while and had no reserves left, but that was not Baby C, Dr Gibbs said.

2.24 A post-mortem was conducted, which concluded that Baby C had no signs of infection but that there were signs of heart damage – which was given as the primary cause of death. Dr Gibbs thought this view "*didn't quite fit together*". He wondered whether the heart damage had occurred after the collapse rather than before. The second cause of death was 'prematurity of the lung', which Dr Jane Hawdon, a consultant neonatologist from a London hospital who reviewed the death in late 2016, would later say in evidence was unlikely given that Baby C was born at 30 weeks.

2.25 Letby was convicted of the murder of Baby C.

2.26 Mother C told the Inquiry that the "*events of that night and everything that has happened since have left an indelible mark*".

Baby D

2.27 Mother D attended the maternity unit at the Countess at 11:30 on 18 June 2015 after her waters broke. At 37 weeks and 1 day's gestation, her pregnancy was close to full term. She was advised to go home until her contractions started. She returned the next day because she was concerned that there was a risk of infection since it was now 30 hours since her waters had broken. She was admitted and the following day was started on intravenous induction. Labour did not progress. She was anxious about her baby and repeatedly asked for a caesarean section. She felt her concerns were dismissed and she was not listened to. Her daughter, Baby D, was delivered by emergency caesarean section just after 4pm. Baby D was born in good condition, with Apgar scores of 8 after one minute and 9 after five minutes, and weighed 3.13 kilograms. However, her mother noticed she was beginning to grunt and seemed floppy. After a prolonged period of observation, she was transferred to Nursery 1 in the neonatal unit, where she was given antibiotics and light therapy for a period.

2.28 Dr Andrew Brunton, a paediatric registrar, reviewed Baby D at the start of the night shift. He had no concerns. He told Mother D: "[E]*verything's fine, she's much better.*

She's come off the light therapy. She's picking up. She seems to be more lively." Mother D could see her daughter looked better and so went back to bed. Letby was on shift in the neonatal unit.

Skin changes

2.29 At 01:30, Baby D collapsed. Dr Brunton attended quickly. He noted that there were areas of "*light brown/dark brown and black lesions tracking across the trunk*" and that she needed extra support with her breathing. Dr Brunton contacted Dr Elizabeth Newby, the consultant paediatrician on call. An attending nurse noted that the rash was similar to the others seen on the unit at that time. Dr Emily Thomas, then a junior doctor and now a consultant paediatrician, said in evidence that she had never seen anything like the rash and has not seen such a rash since. Mother D recalled that "*they told me clearly they don't understand, they've never seen this, they don't know what's going on*".

2.30 Baby D stabilised by 02:35. At 03:15 she deteriorated again, but subsequently stabilised. However, at 03:45, Baby D collapsed for a third time and stopped breathing. Letby was present for the resuscitation. Dr Thomas assisted, as did Dr Brunton and Dr Newby. Dr Brunton was concerned by the unusual pattern of collapses followed by periods of stability. He said: "*It was completely unclear to me as to why Child D had suffered dramatic deteriorations in her clinical condition punctuated by periods of being completely stable.*"

2.31 Mother D was woken up by the nurses. She was told her daughter was very ill, and she needed to attend the neonatal unit. When she arrived, she saw Dr Brunton holding Baby D, trying to save her. At 04:25, Baby D died. Her death shocked staff. Her designated nurse called her death "*unexpected*". She remembered "*feeling happy with* [Baby D] *at the start of the shift*" and "*thinking she looked well*".

2.32 Dr Newby could not explain why Baby D had died. In evidence she referred to the lesions on Baby D's abdomen and said she could not fully explain Baby D's death. She still had a clear and independent recollection of the death of Baby D because, as she explained in evidence, "[I]*t's very unusual to get a death on a neonatal unit, particularly a child that's not known, for example, to have significant congenital abnormalities*." She described Baby D's death as "*very difficult and traumatic*" for staff.

2.33 Mother D felt that Letby was observing her and her husband when they were with their daughter after she had died. Letby was out of place. Her presence made Mother D feel uncomfortable. She subsequently found out that Letby had "*looked us up, both my husband and I … she should have had no reason to go and look us up*". She was also shocked to learn of Letby's text conversations with colleagues about Baby D, and attributing her death to "*fate*".

2.34 Dr Newby reported Baby D's death to the coroner. She described the death as sudden and unexplained. She reported the rash that had been seen on Baby D and the fact that this was the third death in a short period on the neonatal unit. A post-mortem was conducted. The cause of death was recorded as 'pneumonia' and 'acute lung injury'. This contradicted the theory of Dr Newby that Baby D had acute sepsis, which was not borne out by blood cultures.

2.35 Letby was convicted of the murder of Baby D.

Baby E

2.36 Baby E, and his identical twin Baby F, were born by caesarean section at 29 weeks and 5 days' gestation. Baby E was born in good condition, at 1.327 kilograms. Mother E and F said that she and her husband considered having twins to be "*a miracle*". They were told repeatedly how well the twins were doing. They were doing better than could be expected for babies born at their gestation. Baby E was breathing for himself.

2.37 On 3 August 2015, Parents E and F spent all day with their newborn sons. They both had skin-to-skin contact with Baby E. Mother E and F described him as "*thriving*".

2.38 That evening, Mother E and F took expressed milk for Baby E to the neonatal unit. As she approached, she heard screaming and crying of a type she had never heard before. She realised it was Baby E. She went to him and found him with blood around his mouth. Letby was in the room with Baby E. Mother E and F asked her why there was blood around his mouth. Letby was dismissive, abrasive and avoided eye contact. She said the blood would have been caused by the feeding tube rubbing on his throat. She told Mother E and F to go back to the ward and that she would be called for if there were any problems. Mother E and F followed Letby's instructions. She told the midwife what she had seen, and phoned her husband as she "*knew there was something not right*".

2.39 It is Mother E and F's belief that, when she went down to the nursery with the expressed milk, she witnessed "[a]*n interrupted attack*". In her view, she "*caught her off guard. Something had happened to him for him to be bleeding. Stable babies don't bleed.*"

2.40 Dr David Harkness, the paediatric registrar, was on the night shift in the main children's ward. He was bleeped by Letby and went across to the neonatal unit. Letby asked him to review Baby E as he had vomited with flecks of blood, thought to be from irritation from the feeding tube. Dr Harkness prescribed medication and Baby E was relatively settled. Approximately half an hour later, Baby E developed sudden, substantial bleeding. Dr Harkness thought that this was unusual. There was then a subsequent episode of bleeding, which Dr Harkness described as "*'out of nowhere' and something I had not seen before or since*". Baby E suffered a further sudden collapse. Strange patches appeared and disappeared across his abdomen. The only other time Dr Harkness, who is now a consultant, had seen such patches before was in the case of Baby A.

2.41 Dr ZA, Dr Harkness and the nurses began resuscitation. The midwife Mother E and F had spoken to earlier asked her to contact her husband and tell him to come to the hospital. Mother E and F then went down to the neonatal unit and could see the team working on Baby E. Without the intervention of the midwife, Mother E and F does not think she would have been with Baby E. She overheard the midwife explaining to staff that Mother E and F should be there. Mother E and F sat in the corridor for a while and was then invited to go in. She explained: "*I was just talking to him, telling him everything was going to be okay and all the fun that we were going to have when we got home.*" Baby E was christened. He died at 01:40 on 4 August 2015.

2.42 Baby E's death was very sudden. Dr Christopher Wood, a GP trainee on the unit, said: "'[I]*t really seemed to come out of the blue' – Child E had seemed well leading up to this and wasn't 'on the radar' as a child of particular concern.*" Mother E and F described how earlier she had "*two thriving little boys*", but that "*in the space of a couple of hours, it had all been taken*".

2.43 Letby omitted from the nursing notes any reference to the episode described by Mother E and F. Mother E and F stated that those records had been "*changed to suit a different narrative of when Child E's bleed started*". However, at the time, Parents E and F considered Letby was doing all she could. After he had died, Letby bathed him and chose the clothes that he was buried in. Letby made a memory box, without Mother E and F's prior knowledge or consent. It is "*painful*" for Mother E and F to know that the contents in that box were created or touched by Letby.

2.44 At the time of Baby E's death, Dr ZA believed he had died of necrotising enterocolitis (NEC). There was, however, no sign of the condition on Baby E's abdominal X-ray, a factor she missed.

2.45 Parents E and F decided against a post-mortem, in conversation with Dr ZA. Baby E's mother explained that making an informed decision at the time when your child had just died was "*an impossible decision to have to make and I couldn't -- I couldn't make an informed decision at that time*". She asked: "[I]*f there was nothing on Child E's X-ray to say there was any signs of NEC, why was the postmortem not, you know, mandatory? Why was it left for me to make that decision?*"

2.46 After Baby E's death, Parents E and F went to see Baby F. Baby E was still in his incubator. Mother E and F was shocked and said to Letby: "*He's still here.*" Letby replied, "*You haven't told us to take him.*" As Mother E and F said, she did not know what she was supposed to do. Letby's remark was cold and unfeeling, at best.

2.47 Letby was convicted of Baby E's murder.

Baby F

2.48 Baby F was 1.434 kilograms at birth, slightly heavier than his brother. When he was admitted to the neonatal unit, he had a low blood glucose of 1.9 millimoles per litre. This rose dramatically the following day to a very high level of 15.1 millimoles per litre. At 03:40 on 31 July 2015, manufactured insulin was administered. Baby F responded well to this, and his blood glucose level dropped to 8.7 millimoles per litre. No more manufactured insulin was prescribed or administered to him.

2.49 During the night of 4/5 August, Dr Harkness was called to attend Baby F. At this point, Dr Harkness was concerned about Baby F's increased heart rate and low blood sugars. He discussed this over the phone with Dr Gibbs, the on-call consultant. Dr Gibbs examined Baby F at around 8.30am the following morning and noted he continued to have low blood sugar. Dr Gibbs also suspected that Baby F had an infection. The low blood sugar levels had persisted, despite the fact that Baby F had been given extra sugar. Dr Gibbs described this as "*unusual*". Blood samples were taken at 17:56 on 5 August, while Baby F had low blood sugar levels, and were sent to Liverpool Clinical

Laboratories at Royal Liverpool University Hospital for analysis. He was taken off the intravenous feeds, and the total parenteral nutrition (TPN) bag – a feeding bag – was taken down. His blood sugar levels began to increase.

2.50 Parents E and F were asked to come into Nursery 2. They were told that Baby F was experiencing a "*really rapid, fast heart rate*". They were understandably scared. Mother E and F reports thinking: "[N]*ot again. This simply cannot be happening to us again.*" Dr Gibbs explained to Parents E and F that Baby F had an infection in the long line of his leg. The long line was moved, and he was given a course of antibiotics. Baby F's parents were told this should rectify things. They were not told that he had been tested for insulin.

2.51 Baby F recovered and his parents were waiting for a move to a hospital nearer their home. The blood test result came back from Liverpool Clinical Laboratories on 12 August. It showed there was low C-peptide to insulin. Baby F had an insulin level of 4,657 picomoles per litre and insulin C-peptide levels of 169 picomoles per litre. This does not happen when insulin is being produced naturally in the body. The result showed that the blood sample contained insulin from an external source – that is, exogenous insulin. Baby F had been given insulin, which had not been prescribed to him.

2.52 Dr ZA realised that the results made it look as though Baby F had been given exogenous insulin as a medicine, which he had not. She checked to see if another baby in the unit had been prescribed insulin. They had not. This significantly reduced the likelihood of insulin having been accidentally administered. However, Dr ZA did not interrogate this further. She found "*the idea that someone could be doing it deliberately … so fantastical and unlikely that that couldn't possibly be what had happened*". Dr ZA did nothing to check that her conclusion was correct. She did not speak to the laboratory, nor did she speak to colleagues. With hindsight, Dr ZA considered that she had "*made the wrong decision*" and reflected: "*I deeply regret that that is how I interpreted things both for Child E and F's parents and for all the babies that happened subsequently.*" Long before the Inquiry, she had apologised to Parents E and F for her mistakes in respect of both babies.

2.53 Mother E and F said that what happened to her sons has changed the course of her family's life completely. She said: "[W]*e've had to try and grieve in so many different ways. We tried to grieve for Child E … We had to grieve for the life that we thought we were going to have with Child F, with his learning difficulties.*"

2.54 Letby was found guilty of the attempted murder of Baby F.

Baby G

2.55 Baby G was born in Arrowe Park Hospital at 23 weeks and 6 days' gestation. She weighed 535 grams. After 11 weeks, she was transferred to the Countess in a stable condition. Throughout this time, at both hospitals, Baby G continued to improve. She was, in her mother's words, "*our little miracle, a gift from God*". As she neared 100 days of life, the nurses at the Countess prepared balloons and a banner. Parents G were told that they would soon be able to take her home. She was reviewed by Dr Brearey on 6 September 2015. He confirmed that she was stable and improving. Preparations for her discharge continued.

2.56 In the early hours of 7 September, Baby G suffered repeated collapses. Letby was on the night shift and allocated to a baby in Nursery 1. Baby G, in Nursery 2, vomited at around 2.15am. This was substantial, and projected across the room away from her cot. During subsequent attempts to resuscitate Baby G, 100 millilitres of milk was aspirated from her stomach. This volume, combined with the amount vomited, was much more than Baby G should have been fed. In the words of Father G, this was "*an enormous amount of milk and more than her feed*". He said that the initial vomit was calculated as having travelled 3 or 4 feet away from Baby G's cot, which indicated "*the force of her vomit and the pain she must have felt with the pressure building up in her tiny little body*".

2.57 Parents G were called and told that their daughter had vomited and aspirated her vomit. They were told that blood tests had confirmed neonatal sepsis. They were not told that Baby G had collapsed. Baby G was treated for presumed sepsis with antibiotics. However, the blood test results recorded at the time were not consistent with that diagnosis. Dr Brearey accepted during his oral evidence that, whilst at the time it had been thought that the blood tests were indicating an infection, he now accepted a different cause of collapse. Mother G informed the Inquiry that Parents G "*only found out years later that the blood tests that had been done at the time showed no evidence that our daughter was suffering from sepsis*".

2.58 Baby G was transferred to Arrowe Park Hospital on 8 September, where she improved. She moved back to the Countess on 16 September. During the day shift on 21 September, Baby G was being cared for in Nursery 4 by Letby. Shortly after a feed at 09:00, Baby G projectile-vomited twice and stopped breathing temporarily. Mother G had come to see her daughter that morning. Letby told her to wait in the parents' room as she needed to carry out some tests. Mother G heard screaming. She ran back in to make sure her daughter was okay. She found "*Letby standing by our daughter's cot, looking sort of puzzled*". She continued: "*Our daughter was screaming and looking very red and I saw vomit on her.*"

2.59 Baby G was moved to Nursery 1 and Nurse W took over her care. She collapsed again at 15:30. Again, this episode was put down to sepsis. There was not sufficient evidence that this was the cause. It has subsequently been accepted by Dr Brearey that the large volume of gas and liquid that needed to be aspirated from Baby G's stomach should have been seen as significant and unusual at the time. Parents G were not told about it. They should have been.

2.60 The effect of the repeated collapses has been profound for Baby G. She has suffered a brain injury with lifelong consequences. Mother G described the impact of the collapses: "*I feel that Lucy Letby has ruined our lives. She has ruined everything. Our daughter needs 24-hour care because of Letby, we don't know how long she will live and it affects every single minute of all of our days.*" The hospital's concerns about Letby were not shared with Parents G. They found out from the police during their investigations in 2018. They did not know what Letby was accused of doing to Baby G until just before the trial.

2.61 Letby was convicted of attempting to murder Baby G on two occasions: during the night shift of 6/7 September and on the morning of 21 September. She was found not guilty of a further charge of attempted murder, relating to the afternoon of 21 September.

Baby H

2.62 Baby H was born at 34 weeks and 4 days' gestation. She weighed 2.33 kilograms. She suffered a number of collapses between 24 and 27 September 2015. During her time at the Countess, Baby H had a recurring pneumothorax and three chest drain procedures.

2.63 On 24 September, Mother H was in a wheelchair, and waited for Father H to take her downstairs to see their daughter in the neonatal unit. Mother H noticed that Baby H had deteriorated since the previous evening. She was now ventilated. No one had informed anyone in the family about this change. Mother H told the Inquiry:

> "*I asked the doctor what was going on and I was told that she had been put on a ventilator. I really couldn't understand why I'd not been informed of this earlier because we were told that she was okay. You know, I'd always check and would always ask how she was, and we were told that she was okay, you know, that she was okay. I was only upstairs.*"

2.64 Mother H made a complaint about the lack of communication. An apology was offered by Dr Gibbs. However, in an internal email, Ms Powell's first response was to criticise Mother H. She asked: "[W]*hy had it taken* [Mother H] *so long to come to the unit when she was aware how poorly her baby is.*" Ms Powell's loyalty was to the nurse. It led to unjustified criticism of a mother who had proper cause to complain. Mother H described feeling "*deeply offended*" by the comments.

2.65 Baby H suffered a collapse in the early hours of 26 September. She was resuscitated. Mother H described Baby H as very pale. She had "*sort of blue-purple marks, like a mottling, all over her body*". It was not clear to the clinicians what had caused this collapse. In the evidence of Dr Matthew Neame, a registrar who cared for Baby H, this collapse "*needed some further assessment and further investigations in order to try to identify the cause*".

2.66 Baby H collapsed again in the early hours of 27 September. She needed resuscitation and, unusually for a neonate, also required the administration of adrenaline. Again, it was not clear why Baby H had collapsed. Dr Murthy Saladi, a consultant paediatrician, stated in his written evidence: "[I]*t was not clear why Child H had deteriorated … Any* [unexpected] *deterioration in a child is worrying.*" Baby H stabilised.

2.67 Baby H was transferred to Arrowe Park Hospital on 27 September.

2.68 Mother H remembers Letby giving her a box. She described it as "*a red box, and it had a teddy bear on the top and inside the box was a cot card and her wristband from the Countess of Chester*". She said: "[T]*here was also in a plastic bag with a white sticky label on the front that said, 'For my Mummy and Daddy, xxx' and it had her CPAP hat in it, the CPAP hat and things. To me it almost seemed a bit like a memory box.*" Mother H recalled: "*I remember thinking that it was quite morbid. You know, because she was not dead … I remember not feeling entirely comfortable about that.*"

2.69 Mother H described the impact of the events at the Countess as "*overwhelming*". She said: "*What happened has affected every aspect of our lives … it really isn't easy to put into words to truly convey the enormity of it … It's affected my trust in hospitals and the health service very, very deeply … I really do find it very traumatic to have to go back to a hospital.*"

2.70 Letby was charged with two counts of the attempted murder of Baby H: the first relating to the collapse in the early hours of 26 September; the second in the early hours of 27 September. Letby was found not guilty of the first count, and the jury could not agree a verdict on the second.

Baby I

2.71 Baby I was born at Liverpool Women's at 27 weeks' gestation. She weighed 970 grams. She was transferred to the Countess on 18 August 2015. When she arrived, she was placed in Nursery 1. After a period of deterioration, Baby I returned to Liverpool Women's. She was cared for on the Level 3 neonatal unit between 6 and 13 September, before being transferred back to the Countess.

2.72 Mother I gave evidence that she felt there was a difference in care between the two units. Staff seemed stretched at the Countess, with one nurse refusing to help Mother I get Baby I out of her incubator as she was too busy. Mother I also said that, despite being told on 6 September, just before her return to Liverpool Women's, that Baby I had NEC, later that day staff at Liverpool Women's told Parents I that Baby I "*didn't have NEC and within 24 hours she went from being fully ventilated (at the Countess of Chester Hospital) to no ventilation and starting back on her feeds (at Liverpool Women's Hospital)*".

2.73 When she was returned to the Countess on 13 September, she was placed in Nursery 3. In the words of Mother I: "[I]*n a matter of a week she had gone from being critically ill on a life support machine and being rushed to Liverpool Women's Hospital, to now returning to the Countess of Chester Hospital and being placed in the room before your baby goes home.*"

2.74 On 30 September, Letby told Mother I that her daughter's stomach looked swollen and that she would keep an eye on her. Mother I agreed that it did look swollen, but that Baby I was doing really well. Mother I left the neonatal unit at about 3pm. At 16:30 she was called to come back. Baby I had collapsed. Her blood oxygen levels had fallen, as had her heartrate. Mother I saw Baby I receiving chest compressions. Mother I said: "*I wasn't told what specifically caused the collapse … The doctors and nurses told us that she was a puzzle and weren't sure why she kept having episodes.*" Baby I was then moved to Nursery 2 and quickly recovered.

2.75 By mid-October, Mother I began to feel a sense of unease: "*I had gone from feeling that our baby would be coming home to uncertainty.*" On 13 October, Parents I were called to the hospital in the night. Baby I was very unwell. "*The staff had to resuscitate her at least seven to eight times. She just kept flatlining.*" This was the worst she had been. The following night, on 14 October, Parents I slept at the hospital. Mother I felt that just as they were starting to fall asleep, they'd be woken up to come and see their daughter. In her words: "*Our baby also seemed to deteriorate when we left her alone*

and it was predominantly at night." Dr Neame was working on both 13 and 14 October. He described Baby I's collapses as "*unusual*". It was a challenging week. It was "*far more challenging than a typical week on a neonatal unit*".

2.76 On 15 October, Baby I was transferred to Arrowe Park Hospital and remained there until 17 October when she returned to the Countess.

2.77 On the night shift of 22/23 October, Ms Ashleigh Hudson, a neonatal nurse (band 5), was Baby I's designated nurse. Letby was also on shift and caring for other babies. Parents I left the unit at approximately 10.30pm. Just prior to midnight, Baby I collapsed. A crash call was made, and help was sought. Letby came to help. Dr Rachel Chang (a paediatric specialty trainee) attended, and Dr Gibbs was called. Baby I was ventilated and stabilised. At about 12.30am, Mother I woke up and realised she had missed a call from the hospital. When she phoned, she was told Baby I had collapsed. Parents I set off for the hospital. Just prior to their arrival, Mother I phoned again and was told to get there as soon as they could. Ms Hudson entered the nursery and saw Letby there with Baby I. Just after Ms Hudson arrived, at about 1am, Baby I collapsed again. The team attempted resuscitation and Parents I arrived to see these efforts. After 20 minutes of attempted resuscitation, Baby I died. She was handed to Mother I. She told the Inquiry: "[A] *part of us died with her.*"

2.78 Ms Hudson was worried about Baby I's aftercare. She asked for help. Letby volunteered. Mother I recalled:

> "*She* [Letby] *was smiling and kept going on about how she was present at our baby's first bath and how much our baby had loved it. I remember thinking at the time, 'What are you going on about, she's only ever had one bath and my husband never got to bath her'. I just felt so sorry for him because he hasn't got that memory and I wished Lucy would just stop talking. I remember thinking 'Will you just go away'. I was really uncomfortable and I just wanted her to leave. It was also weird that she kept smiling. I had never really seen her smiling before.*"

2.79 Letby was convicted of the murder of Baby I.

2.80 Mother I reflected that, at the time of the Inquiry, Baby I would have turned nine years old. She said: "*We should have been watching her grow and play with her siblings and friends. However, we have to somehow try to live with the fact all this has been taken away from her and us in the cruellest way possible.*"

Baby J

2.81 Baby J was born by caesarean section at the Countess at 32 weeks and 2 days' gestation. She weighed 1.709 kilograms. She was initially transferred to Alder Hey for an operation, before being returned to the Countess on 10 November 2015. She progressed well and was eventually moved to Nursery 4.

2.82 Parents J gave evidence to the Inquiry about the marked difference in the quality of communication they experienced at the two hospitals. Alder Hey was proactive and included parents in decision-making meetings. The Countess was reactive and less transparent. This meant that, at the Countess, Parents J were not as clear about how their daughter was progressing.

2.83 Baby J had a stoma and a Broviac line – a central line – which needed to be kept clean. There was a risk of infection, which could have serious consequences. On 15 November, Mother J went into Nursery 2 and saw her daughter covered with a small towel and her stoma bag detached. She was covered in faeces. Mother J was "*just disgusted*" and "*incredibly saddened being a mum and thinking: what's happened here, and there were two nurses in the room at the time and they could see that she was in that situation*". Mother J asked the nurses but they did not engage with her. Letby was Baby J's allocated nurse.

2.84 Parents J made a complaint. This led to a meeting with Dr Saladi and a nurse. Parents J were told to go home and rest; they must be tired. This was not an appropriate reaction to their justified complaint. The parents' complaint should have been accepted, and a Datix report should have been completed. At the Inquiry, Dr Saladi apologised for his response to the parents' justified complaint about poor care.

2.85 During a night shift on 26/27 November, Baby J had a series of sudden and unexpected desaturations which were associated with seizures. She required resuscitation. Letby was on shift and assigned to care for two babies in Nursery 2. She assisted with the resuscitations. Dr Gibbs was called, and Baby J was moved to Nursery 2. Father J said: "[W]*e were expecting to go home.*" He described it as a "*sudden unexplained collapse and we were obviously at this point I think scared*".

2.86 Some time after these collapses, Parents J spoke to Dr Gibbs. Father J relayed that:

> "[Dr Gibbs] *had said that they were investigating the possibility that it could be sepsis … epileptic seizure … sleep apnoea … Even by his own admission later on when we had contact with him he was never able to explain the collapse to us and his -- the subsequent investigations had ruled out pretty much all the things that he suggested it could be.*"

2.87 Speaking about the impact of Baby J's collapses, the lack of information from the Countess and the criminal trial, Mother J said in evidence: "*I cannot emphasise enough the impact of this on our whole family. Who we are as people, parents, work life, spouses, children …* [it] *has cast a shadow of sadness over every part of our lives.*"

2.88 Letby was charged with the attempted murder of Baby J. The jury were unable to reach a verdict.

Baby K

2.89 Baby K was born at the Countess at 25 weeks' gestation. She weighed 692 grams. She was taken to the neonatal unit. She was small, and Parents K knew that she was poorly, but they were told by Ms Joanne Williams, a neonatal nurse (band 6), that "*Child K was stable, Child K was fine*".

2.90 Father K told the Inquiry how he felt when Baby K was born: "*I went to the Unit by myself at first. I couldn't sleep because I was so excited. I have a baby girl. I just wanted someone to come and say that everything was okay. I was over the moon. Child K had just been born.*"

2.91 On the night shift of 16/17 February 2016, Ms Williams went to the delivery suite to update Parents K. She told Dr Jayaram that Letby, who was on the night shift, was "*baby-sitting*". While she was away, Dr Jayaram went into Baby K's nursery. He saw that Baby K's endotracheal tube was dislodged and that her oxygen saturation was dropping. Letby was not doing anything. Dr Jayaram and the nurses successfully resuscitated Baby K. She collapsed again at 06:15 and 07:25. Nurse W, who took over from Ms Williams as the designated nurse for Baby K in the morning following her collapses, told the Inquiry it was "*highly unlikely*" that a premature baby could have pulled out its own correctly secured endotracheal tube. In an email in 2017, Dr Jayaram said that Letby had alerted him to Baby K.

2.92 Baby K was transferred to Arrowe Park Hospital. She died some days later.

2.93 Parents K were never told about the incident with the dislodged tube and that she required resuscitation later that night. Father K told the Inquiry that they only learnt of Baby K's collapses when meeting the Crown Prosecution Service. Furthermore, the Countess was not open with Parents K (or any other parents) about any of the concerns about Letby. By the time Parents K were informed by the police that there was a suspicion of deliberate harm to their daughter, they had been grieving the loss of their daughter for over a year. Mother K told the Inquiry that the information was a complete shock. They were in denial when they heard. She said: "*Not for one minute did we ever foresee any of this at that time.*"

2.94 The impact of Baby K's death was felt keenly by both parents. Mother K said: "[Y]*ou don't only just grieve your daughter, you're grieving who you were. I grieve who we were as a husband and a wife.*"

2.95 Letby was tried for the attempted murder of Baby K. The jury were unable to reach a verdict. The case was re-tried. Letby was convicted.

Baby L

2.96 Baby L and his twin brother Baby M were born at 33 weeks and 2 days' gestation. Baby L weighed 1.465 kilograms. In Father L and M's words, "*they both seemed fine*". It was his understanding that, whilst they were small and needed extra care, he and his wife would be able to take them home within a few weeks. Baby L's parents did not know at the time that Baby L was experiencing periods of low blood sugar levels.

2.97 A blood sample was taken from Baby L on 9 April 2016 while his blood glucose levels were low and was sent for testing at Liverpool Clinical Laboratories. The sample was tested on 11 April. The test results showed that Baby L had an insulin level of 1,099 picomoles per litre and insulin C-peptide levels of 264 picomoles per litre.

2.98 A call was made by the laboratory to the Countess on 14 April, to discuss this result. This would happen when an external laboratory considered that the results were urgent, unexpected or unusual. A contemporaneous note of this call, made by Dr Shirley Bowles, a consultant chemical pathologist who took the call, stated that the test result was "[d]*ifficult to interpret without the concurrent glucose but may be inappropriate if patient was hypoglycaemic at the time of collection*". Baby L's medical records show that he had low blood sugar on the date of the blood test. Dr Bowles gave evidence that she concluded: "[I]*t looks like there is external administration of insulin.*"

2.99 Dr Bowles agreed, in oral evidence, that the most likely scenarios that could have produced the blood test results were: first, that the child was hyperglycaemic but was given too much exogenous insulin and therefore almost became hypoglycaemic; second, that exogenous insulin was given in error; and third, that exogenous insulin was given to the child deliberately. Dr Bowles did not consider the last option likely at the time. It was "*unthinkable*".

2.100 The evidence suggests that Dr Bowles called the neonatal unit to flag the surprising results. It also suggests that she was not able to speak to any clinical member of staff. She then verified the results and placed them on Baby L's electronic medical record. A day later, they were transcribed by hand into Baby L's notes by a junior doctor. These highly unusual and concerning blood test results were missed repeatedly by treating clinicians and, in particular, by Dr U, a paediatric registrar who was responsible for Baby L's care. Dr U died in July 2026.

2.101 Parents L and M were not told of the blood results until the police informed them in 2019. They told the Inquiry: "[N]*o one told us there were concerns about Child L's condition while he was in the neonatal unit. No one told us that Child L's blood results had been abnormal and had shown there was far too much insulin in his blood stream. It was never mentioned to either of us as parents.*"

2.102 The events at the Countess, and the subsequent police investigation and trial, caused an enormous amount of stress and anxiety for the family. Father L and M told the Inquiry: "*I had a seizure for the first time in my life as we approached the criminal trial. This happened in front of my children and was very distressing for them. The doctors attributed this to the stress and the pressure of what had happened to our children.*"

2.103 Letby was convicted of the attempted murder of Baby L on the day shift of 9 April.

2.104 In evidence, Mr Harvey said that the blood test results of Baby L should have been cross-referenced with those of Baby F. He said: "*I think if this had been identified and reported, it would have influenced our decision to go to the police.*" Had the results been put together, the police should have been contacted. That did not happen.

Baby M

2.105 Baby L's twin brother, Baby M, weighed slightly more than Baby L at 1.705 kilograms. Like his brother, he was doing well.

2.106 At about 4pm on 9 April 2016, Baby M unexpectedly collapsed. Letby requested that a crash call be put out. Nurse W assisted with the resuscitation until the doctors arrived. Three clinicians attended, including Dr Jayaram. After half an hour of resuscitation, they were considering whether to withdraw support, at which point Baby M recovered.

2.107 Nurse W was in the room at the time of the collapse. She reported that Baby M had been stable during the day. She said: "*I did not think what happened on that day would happen.*"

2.108 Parents L and M were on the maternity ward when they were told they needed to come quickly as something was wrong. They arrived on the neonatal unit and saw one of the doctors carrying out chest compressions on Baby M. Father L and M said: "*When we got there one of the doctors was just pressing Child M's chest. People were saying the boys were healthy yesterday and they didn't know what had happened today.*"

2.109 An echo scan was carried out to ascertain whether there was an underlying cardiac condition that had caused the collapse. The scan was normal. Dr Jayaram confirmed to the Inquiry that he had seen an unusual blotching during the resuscitation of Baby M, which was similar to what he had seen on Baby A. There was some discussion among the consultants about the sudden collapse, and some discussion of the presence of the rash. They did not act upon any concerns they had at this time.

2.110 Parents L and M were not told about the blotchy rash by Dr Jayaram when he discussed the collapse with them. They learnt about it at the criminal trial. Dr Jayaram told Parents L and M at the time that he could not explain the collapse but did not tell them about his suspicions that Baby M had been harmed deliberately.

2.111 Father L and M was candid with the Inquiry about the effects of witnessing his son collapse. He said: "*Even to this day I get flashbacks to what I saw on the unit.*"

2.112 Letby was convicted of the attempted murder of Baby M.

Baby N

2.113 Baby N was born at 34 weeks and 4 days' gestation. He weighed 1.67 kilograms. On the night of 2/3 June 2016, Baby N was in Nursery 1. His designated nurse was Mr Christopher Booth, a senior neonatal practitioner (band 6). Letby was on shift that night, despite a decision having been taken in May to leave her on day shifts for another two months.

2.114 While Mr Booth was on his break and another nurse – he could not remember who – was looking after Baby N, there was an episode of sudden brief collapse. The nursing notes record that Baby N was "*crying ++ and not settling. He became dusky in colour, desaturating to 40's. Responded to facial oxygen within 1–2 minutes … No further episodes occurred.*"

2.115 The Countess did not tell Parents N about this collapse. They were not informed that Baby N's oxygen saturation dropped significantly. In the words of Father N: "*We did not know Child N had had problems overnight … I find this disgusting. As parents we have an absolute right to know what was happening to and with our son.*"

2.116 Baby N suffered further collapses during the day shift on 15 June. The prosecution case at trial was that these collapses were the result of an inflicted injury, which resulted in heavy bleeding in the throat area. Baby N had begun to deteriorate from 1am. The first collapse occurred just before the day shift began. Letby had arrived early and was already on the unit. The second collapse happened at about 2pm. Letby was his allocated nurse.

2.117 Parents N were called to attend the neonatal unit. Mother N told the Inquiry that it "*was the worst day of our lives, from waking up that morning being prepared to take home our son to the utter catastrophic scene we arrived at has left a lasting imprint on us, seeing our tiny baby fighting for his life, medics doing CPR on his tiny body and not knowing if he was going to live or die with no obvious cause*".

2.118 Mother N told the Inquiry she kept asking herself how he could have gone from being healthy one minute and then bleeding from the mouth the next. When Father N saw Baby N, he said: "*He was blue in colour and had traces of blood around his lips like he had coughed up blood and it had splattered on him. The blood was dry and dark in colour.*"

2.119 A nurse explained that Baby N was very unwell and asked if Parents N wanted to see a priest. A priest arrived to talk to them. Father N described that he was "*shocked by this as I am not religious and we had not asked for him … It felt really inappropriate because he was a stranger.*" Father N stated that it was Letby who recommended they get Baby N baptised. They ultimately did so out of desperation.

2.120 Dr U was the night-shift registrar on 14/15 June 2016. Letby worked the day shift on 15 June. Dr U and Letby were both involved in Baby N's care. They messaged each other several times during the night, sometimes about Baby N, sometimes on personal topics. Mother N was understandably upset by this and made a formal complaint about Dr U.

2.121 Both Dr Brearey and Dr Saladi reported to the Inquiry that Baby N's collapse was very unexpected. The damage to Baby N's throat was such that it was difficult for clinicians to intubate him. Staff from Alder Hey attended to assist with the intubation. Baby N was subsequently transferred to Alder Hey and survived.

2.122 Letby was convicted of attempted murder in relation to the collapse on 3 June. The jury could not agree a verdict on either of the two counts of attempted murder relating to the collapses on 15 June.

Babies O, P and R

2.123 Babies O, P and R were triplet boys. Their father described the prospect of their birth as "*a once in a lifetime opportunity to welcome three children at once. I felt really blessed.*"

Baby O

2.124 Baby O was born by caesarean section at the Countess alongside his brothers, Baby P and Baby R. They were born at 33 weeks and 2 days' gestation. Baby O weighed 2.020 kilograms. Mother O, P and R had received her antenatal care from Dr Jim McCormack, a consultant obstetrician and gynaecologist at the Countess. He was on leave when the babies were delivered, but reported to the Inquiry that all three were born "*in excellent condition*". Mother O, P and R said that they were "*reassured that their weights were better than expected and that they had been born healthy*".

2.125 Letby returned from holiday on 22 June. She was on duty the next day. She messaged Dr U and asked: "*What gestation are the trips?*"

2.126 During the day shift on 23 June 2016, Baby O was initially in Nursery 1. Letby was his designated nurse, and Ms Taylor was also working the day shift. He was subsequently moved to Nursery 2 to be with his brothers. In Nursery 2, Ms Taylor felt uneasy (she described it as a 'gut feeling') about Baby O's condition and suggested to Letby that they move him back to Nursery 1, which she felt was better equipped if he continued to deteriorate. Letby said she wanted him to stay in Nursery 2.

2.127 Dr Brearey was on the neonatal unit and was asked by Dr U for assistance in intubating Baby O. Dr Brearey described the intubation as uneventful but noted a purpuric rash on Baby O's chest. Dr U informed Parents O, P and R that Baby O needed some extra breathing support. They were told this was not uncommon. Mother O, P and R wanted to see her son. She went down to the neonatal unit. Baby O had deteriorated and had been moved to Nursery 1. Baby O's mother described the scene that greeted her as "*complete chaos*". In her words, Dr U looked panicked and the staff looked like they did not know what was going on. She said: "*It was clear that Child O's collapse was a complete shock to them.*"

2.128 The neonatal unit did not know why Baby O had collapsed. It was an unexpected event with an unknown cause. They contacted Dr Oliver Rackham, a consultant paediatrician for the neonatal transport team at Arrowe Park Hospital, seeking to transfer him to an intensive care unit. Baby O died before this could happen.

2.129 Dr Brearey assisted with the resuscitation of Baby O. He did not see Letby do anything untoward. He had noted the rash earlier and connected this to the rashes that he knew had been seen on other babies. The rash was unusual. Father O, P and R described it as follows: "*His skin was a different colour and it looked almost like there was something pulsating through his veins.*" He also described his son having a swollen abdomen "*almost like a pot belly*".

2.130 Parents O, P and R told the Inquiry just how confused the clinicians appeared to be about the sudden collapse. Baby O's father described the doctors as seeming to be "*baffled … no one could tell us why things had suddenly gone so wrong. It was really shocking.*" This was supported by the evidence given to the Inquiry by doctors and nurses who had cared for Baby O. Dr Huw Mayberry, a paediatric registrar, and Ms Taylor both told the Inquiry how shocked they were that Baby O had died. He had been stable. According to Ms Taylor, there had been "*no clinical recordable signs that I could have said this baby is deteriorating. So his observations, such as his heart rate, breathing, stayed the same or stable as he was previously.*"

2.131 Dr U and Letby exchanged messages about the resuscitation and the debrief about Baby O. Dr U described the debrief as "*good – we didn't come up with anything missed or delayed*".

2.132 Letby was convicted of Baby O's murder.

Baby P

2.133 At birth, Baby P weighed 2.066 kilograms. Like his brothers, he was born in good condition.

2.134 On 24 June 2016, Mother O, P and R was very worried about Baby P and Baby R, after the tragic loss of Baby O. She told the Inquiry that she went down to the neonatal unit at around 6am and "*was told by the nurse that the boys were 'little angels' and that she had no concerns*". She did not find out until the criminal trial that Baby P had been unwell in the night, as he had aspirated milk from his nasogastric tube. Mother O, P and R left the unit, having been reassured. Later, a nurse came to get her and told her that Baby P was very unwell and she needed to come to the nursery now.

2.135 Baby P had collapsed. He was administered adrenaline and CPR was performed. He seemed to have improved initially, but remained unwell. When she arrived at the nursery, Mother O, P and R was confronted by the same panicked scene as the day before, when Baby O had collapsed. She told the Inquiry that, while Baby P was being resuscitated, "*I felt entirely forgotten and ignored.*" When Father O, P and R arrived, he had the same experience. He found staff panicking, and nothing was explained to him. He saw that Baby P "*had the same mottling on his skin, the same distension on his belly* [as Baby O] *and I just knew it was the same thing, even though I didn't know what that thing was*".

2.136 Arrangements were made to transfer Baby P to Liverpool Women's. Just when Dr Rackham arrived to facilitate the transfer, Baby P collapsed. Dr Rackham led the resuscitation attempt. Sadly, Baby P did not recover and he died. Dr Rackham affirmed what he wrote in his statement to the Inquiry, that "*there was no identifiable cause of death at that time, so I was surprised at the collapse and the death and unable to explain what happened*". At the time, Dr Rackham told Parents O, P and R that he did not know what had happened, and could do no more for Baby P.

2.137 Dr V, a consultant involved in Baby P's care, told the Inquiry that she overheard Letby commenting, after Baby P's first resuscitation, "*He's not leaving here alive, is he?*" Dr V said she was taken aback by what she considered an inappropriate comment. She told Ms Powell about it.

2.138 Dr V also noted that, prior to his collapse, Baby P had appeared stable and in reasonably good condition. His deterioration was very unexpected. There was no evidence at the time that suggested a reason for Baby P's sudden collapse and death. Dr Mayberry, who arrived in the evening of 24 June for his night shift, having cared for Baby P the night before, was "*devastated, shocked and bewildered*" to learn that Baby P had died.

2.139 Father O, P and R remembered that Letby was involved in the aftercare of Baby P. He recalled that Letby had dressed Baby P. She had made a "*big deal about taking photos of the boys and making memory boxes*". Letby's approach to this solemn and difficult task was described by Dr V as "*very inappropriate*" as there was an "*inappropriate jolliness, brightness to it*".

2.140 Letby messaged Dr U with a running commentary about caring for Baby P after his death. When one of her nursing colleagues came onto the ward, Letby was heard to say something like, "*You*['ll] *never guess what's just happened!*", a very disturbing way to refer to the death of a baby.

2.141 Letby was convicted of Baby P's murder.

Baby R

2.142 Baby R weighed 1.865 kilograms at birth. Like his brothers, he was in good condition.

2.143 After the deaths of Baby O and Baby P, Parents O, P and R were extremely concerned for Baby R. Mother O, P and R recalled that:

> "*Father O, P and R begged Dr Rackham to take Child R to Liverpool Women's Hospital … Father O, P and R and I did not know what was wrong at this point but I just knew we needed to get Child R out of the Countess of Chester Hospital. I didn't think anything malicious had happened at the time, but I did feel that something had gone wrong in the Unit.*"

2.144 This fear for Baby R was shared by some of the clinical staff. After helping to care for Baby P, Dr V recalled "*begging in my head*" for Dr Rackham to take Baby R, because she feared that he would die next.

2.145 There were no medical concerns regarding Baby R, but Dr Rackham agreed to transfer Baby R to Liverpool Women's out of caution, because of the deaths of Baby O and Baby P. He explained his rationale: "*The child was well but was a triplet and the other two triplets had died without any explanation … in case there was some underlying condition in that family, such that that baby was also going to have a collapse, it would be more sensible for him to be in an intensive care unit when that happened.*" The post-mortem reports made no reference to any underlying conditions, nor did the mortality reviews of either Baby O or Baby P. Baby R thrived in Liverpool Women's and remained well.

2.146 During the Inquiry, at the close of Dr Rackham's evidence, Parents O, P and R expressed their view that Dr Rackham had saved Baby R's life. They expressed their "*profound gratitude*" to him.

Baby Q

2.147 Baby Q was born at 31 weeks and 3 days' gestation. He weighed 2.076 kilograms.

2.148 On 25 June 2016, Baby Q collapsed unexpectedly. The nursing notes for Baby Q record: "*09:10 attended to by S/N* [senior nurse] *Lappalainen – He had vomited clear fluid nasally and from mouth, desaturation and bradycardia, mottled ++. Neopuff and suction applied. Doctor U attended. Air++ aspirated from NG* [nasogastric] *tube.*" Letby was Baby Q's designated nurse on the day shift.

2.149 Letby was charged with the attempted murder of Baby Q. The jury were unable to reach a verdict.

2.150 Mother Q did not know that her son had suffered a collapse at the Countess. She was told by the police when they had opened their investigation. Mother Q said of the way that the hospital managed information: "*I think that they played everything down to protect the parents and prevent panic, but I feel that this was not fair to us as we needed to know what was happening to our child.*"

2.151 In Mother Q's victim impact statement to the criminal trial, she wrote: "*One thing that I really struggle with is, this had been going on for such a long time and Child Q was the last one if she would have been caught before, this wouldn't have happened to Child Q.*"

2.152 As is plain from the accounts above, it was not just the number of deaths in 2015 and 2016 that caused concern. It was the fact that the babies collapsed suddenly and unexpectedly, and often without explanation. The consultant paediatricians and Ms Powell all said at the time that often the babies who collapsed unexpectedly did not recover as they would have been expected to. These were striking and unusual concerns, as were the skin changes/mottling/rashes.

2.153 For the parents, the worst imaginable event had happened. Over the following two years, information was withheld from them by the Countess. Even when the police were brought into the hospital in 2017, they were not aware of it. For most, the first they knew that the deaths of their babies may not have been of natural causes was at the time of Letby's arrest in June 2018. The lack of candour from the hospital was lamentable.

3. Concerns, reviews, errors

Initial concerns June to July 2015

3.1 For any family the death of a baby is a catastrophe. For the nurses and doctors caring for that baby it is hugely distressing and, at the Countess, three deaths so close together in June 2015 was outside their experience. It was shocking. It occurred to no one that the deaths were the result of anything other than natural causes.

3.2 When conducting a mortality review for Baby D on the day she died in June 2015, Dr Brearey and Ms Powell noted that Letby had been on duty for the deaths of all three babies. Neither of them thought this was anything more than the result of the rota. At that time, Dr Brearey did not believe there was any link between the three deaths.

3.3 Dr Brearey investigated the deaths of Baby A, Baby C and Baby D with a member of the Risk Team. He produced a report for the Serious Incident Panel meeting, which took place on 2 July 2015. The meeting considered whether the deaths should be the subject of a referral to NHS England via the Strategic Executive Information System (StEIS). Whilst everyone contributed to the discussion, it was the Head of Risk and Patient Safety, Ms Ruth Millward, who advised and it was Ms Kelly's role to make the decision, which was required at executive level.

3.4 Ms Millward did not think of reporting the deaths as a cluster and so did not advise that this was an option. The deaths were considered individually. There was concern about the death of Baby D since there had been a delay in moving her to the neonatal unit, a delay in administering antibiotics and it was thought she had died of sepsis. For that reason, her death was reported on StEIS. Although the post-mortem reports were awaited for Baby A and Baby C, it was thought that there were clinical explanations for their deaths.

3.5 With his report for the meeting, Dr Brearey included a list of the number of deaths annually on the neonatal unit since 2008. He did so to inform Ms Kelly that three in such a short period was unusual. He raised the point with her and they agreed to keep an eye on mortality.

August 2015

3.6 Dr ZA advised the parents of Baby E that a post-mortem would not add anything to what was known. She told the Inquiry that she did not want to cause Baby E's family even more distress. Mother E and F made the important point that decisions such as

whether to have a post-mortem are very difficult to make at the moment that a parent has just witnessed the death of their baby.

3.7 Dr ZA referred Baby E's death to the Child Death Overview Panel (CDOP) on 5 August. It was discussed later in the year and the cause of death was recorded as 'prematurity' and 'NEC' and no further action was recommended. Because the death was unexpected, it was reviewed at a Serious Incident Panel on 13 August 2015, attended by Mr Harvey, Ms Kelly, Ms Sarah Harper-Lea (Head of Legal Services at the hospital) and Ms Millward. There were no clinicians present and there are no minutes, just a note on the Datix record. This meeting appears to have been something of a formality. No referral to StEIS was made. What is surprising is that there seems to have been no connection made by any of the people involved in the review between the death of Baby E and the deaths of Baby A, Baby C and Baby D. Four deaths by August was by now as high as the highest recorded annual number of deaths in 2008. It was to double to eight deaths by the end of the year.

3.8 The insulin poisoning of Baby E's twin brother Baby F did not come to light until 2017, after the police had started investigating. Dr ZA remembered the results of Baby F's blood tests for insulin. The police were informed and the results were found in Baby F's notes. Those for Baby L were also retrieved.

September to December 2015

3.9 At a meeting of the Board of Directors on 1 September 2015, Mr Harvey gave a report on mortality within the hospital. The minutes record that: "*Mr Harvey now personally reviews every death in the Trust and then refers cases for further review where appropriate*." When giving evidence in November 2024, Mr Harvey said that this statement (which had been in the minutes for years) was incorrect. He did not review all deaths, only adult deaths. In fact, the Board did not receive any reports about the deaths of babies and children at any stage during the period I am considering. This was a serious failure of governance, which no one on the Board seems to have noticed. This is further evidence of the inadequacy of the structure, which removed the voice of children and babies from the Board, and the lack of profile of paediatrics and neonatology. At the meeting of 1 September 2015, the adult deaths having been considered, neither Ms Kelly nor Mr Harvey drew attention to the increase in deaths on the neonatal unit. That was not done for well over a year.

3.10 On the day Baby I died, Ms Powell and Dr Brearey were in email contact. Dr Brearey raised the association between Letby's presence and the deaths. Ms Powell prepared and sent to Dr Brearey a document that showed there had been eight deaths of babies in the year up to 23 October 2015. This included the death of a baby born at full term with a severe brain injury who was admitted briefly to the neonatal unit then transferred to another hospital, where she died some time later. The seven deaths which took place on the unit were of Baby A, Baby C, Baby D, Baby E and Baby I, and two babies with congenital abnormalities who died in September. The deaths of those two babies did not lead to criminal charges. Ms Powell's document showed that Letby had been on duty at the time of death, or on the shift before, in seven out of the eight deaths. She was the allocated nurse for Baby A and Baby E. Ms Powell marked her name

in red on the table. She said that, as she added Letby's name, she thought she "*was there more often by working full time and overtime*" and that there was no evidence linking her to the deaths.

3.11 Having discussed the case with Ms Debbie Peacock, the lead for neonatal risk, Ms Powell produced a further version of the table to include doctors, including Dr Harkness and Dr Gibbs. Ms Peacock acknowledged in evidence that Letby's association with the deaths was a patient safety concern but she was not suspicious because Letby was not the allocated nurse for every child who died. She had not checked whether Letby had been involved in the care of any of the other babies. She said that Dr Brearey never discussed with her any suspicions about any member of staff. This is probably correct, but she was the risk lead for neonatology. It was for her to decide whether the risk to patient safety required investigation.

3.12 Dr Brearey had not been involved in any of the deaths and had not seen the collapses or the skin changes. He moved from a "*nagging*" concern about the rise in the number of deaths to worrying about the connection between Letby and the deaths while trying, as he believed he should, to find a clinical explanation for the deaths via successive reviews. The other consultants were concerned about the increase in deaths but not about the link with Letby.

3.13 In November 2015, Dr Sara Brigham, a consultant gynaecologist and obstetrician, produced a document headed 'Review of neonatal deaths and stillbirths at Countess of Chester Hospital – January 2015 to November 2015' (the Brigham Review). The review was carried out because of concerns about the high number of stillbirths and neonatal deaths at that time. Its purpose was to establish whether any aspect of midwifery, antenatal or obstetric care had contributed to, or caused, stillbirths and the neonatal deaths. The review was carried out without reference to the consultant paediatricians. It considered 18 deaths, including stillbirths, a termination of pregnancy and 6 neonatal deaths, which included Baby A, Baby C, Baby D and Baby E.

3.14 The report, three pages long with detailed appendices, concluded that maternity and obstetric care had not contributed to the rise in the number of deaths. An external consultant reviewed and approved the work. The report was presented to the Quality, Safety and Patient Experience Committee (QSPEC) on 14 December. In light of the assurance given about the obstetric and midwifery care, it is most unfortunate that the minutes of a meeting of the primary safety committee for the Countess reveal no question from any member of the committee about what the explanation was for the six neonatal deaths. On the contrary, Sir Duncan Nichol said in evidence that the review was concentrated on obstetrics and it raised no concerns. This missed the point. The fact of an unexplained increase in neonatal deaths should have led to the committee seeking an explanation.

3.15 The Women and Children's Care Governance Board met on 18 December. The Brigham Review was considered. The minutes of the meeting were sent to the Urgent Care Divisional Board for noting. Nothing happened as a result. Ms Karen Townsend (Divisional Director of Urgent Care) admitted she had not asked to see the Brigham Review. Even if she had, it is unlikely she would have taken any action, given events six months later.

3.16 The minutes of the QSPEC meeting of 14 December were noted at the next main Board meeting in January 2016. Unsurprisingly, given Sir Duncan's view, nothing was said or done about the rise in neonatal deaths. This was a failure by the Board, following a failure by QSPEC and the Urgent Care Divisional Board.

2016

Thematic Review

3.17 There was a further death on the neonatal unit in December 2015 and another in January 2016. Neither were deaths that featured on the indictment. By that stage, Dr Brearey had decided to carry out a further and more wide-ranging review of all deaths that had occurred on the unit in 2015 and early 2016. He was aiming to identify any common themes. He invited Dr Nim Subhedar to participate. A consultant neonatologist at Liverpool Women's, he was the Clinical Lead for the Neonatal Network. He was to bring an independent external view. Dr Brearey did not tell Dr Subhedar about his concerns about Letby at that stage so as not to influence him. After the review and before the report was drafted, Dr Brearey told Dr Subhedar that he was concerned that Letby was responsible for the deaths. It did not occur to Dr Subhedar, any more than it had occurred to anyone else, that "*anyone would want to wilfully harm babies*".

3.18 On 8 February 2016, the review panel (consultant paediatricians, senior nurses and Ms Peacock) met, reviewed and discussed the medical records of the nine babies who died at the Countess. The same evening, Dr Brearey sent a first draft of the report to Dr Subhedar, who suggested an addition to make it clear that an important theme was the fact that some of the babies had collapsed unexpectedly and their deaths were unexplained. Dr Subhedar said in evidence: "*I think what we decided … was that was correct that there were certain cases that … remained unexplained and yet in the draft that Dr Brearey had created it didn't spell that out so I felt it was important to highlight that.*" As Dr Hawdon was to spell out to Mr Harvey when asked, a year later, "[c]*ompletely unexplained* [death] *on a neonatal unit is rare. So by definition more than one unexplained death does arouse suspicion*" and "*unexpected collapse in an otherwise stable baby is rare*".

3.19 At Mr Harvey's request, Dr Brearey sent him a copy of the draft Thematic Review of Neonatal Mortality (the Thematic Review). Appended to it was the updated schedule of staff on shift at the time of the deaths.

3.20 The final version of the Thematic Review was produced in March 2016. In respect of Baby A, Baby C, Baby D, Baby E and Baby I, the review team raised real uncertainty about the reasons for the collapses and deteriorations and doubts about some of the earlier conclusions about the cause of death in light of subsequent information. Under the heading 'Themes identified during discussions of all cases', the following appears:

> "*There was no common theme identified in all cases*
>
> …
>
> ***1. Sudden deterioration***
>
> *Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM* [post-mortem].

2. Timing of arrests

6 babies (from 9 deaths reviewed) had arrests between 0000 – 0400.

Action: SB [Dr Brearey] ***and EP*** [Ms Powell] ***to review all these cases focusing on nursing observations in the 4 hours before the arrests. Aim to identify if unwell babies could have been identified earlier. Identify any medical or nursing staff association with these cases***."

CQC

3.21 CQC is the independent regulator of healthcare in England. Its responsibilities include the inspection and regulation of NHS Trusts. It conducted a routine inspection of the Countess in February 2016 about which CQC witnesses gave evidence. Ms Ann Ford (Head of Hospitals Inspections, CQC (North West)) and Mr Chris Dzikiti (Interim Chief Inspector of Healthcare, on behalf of CQC) apologised for CQC's widespread failings in providing documents to the Inquiry.

3.22 CQC gave the Countess six months' notice of the routine inspection in February 2016. It included Children's and Young People's services (inspected by a team led by Ms Helen Cain, Acute Hospitals Inspector) and Maternity and Gynaecology services (inspected by a different team).

3.23 Ms Millward devoted most of those six months to the preparation of the hospital's self-assessment, to the detriment of her lead role in risk. It was a waste of time; CQC witnesses informed the Inquiry that they did not rely on the self-assessment, other than to inform themselves about how the hospital saw itself.

3.24 The inspection report was published on 29 June 2016. The hospital's overall rating was 'requires improvement'. Children's and Young People's services were rated 'good' overall and 'good' in the categories 'effective', 'caring', 'responsive' and 'well led'. The rating for the 'safe' category was 'requires improvement'; this was because of shortages of nursing staff.

3.25 The report did not identify or discuss the increase in neonatal mortality at the hospital, or the recent unexpected and unexplained deaths. There are two reasons for that. First, although CQC had relevant data about neonatal deaths appropriately provided by the hospital on StEIS and the National Reporting and Learning System (NRLS), those responsible for inspecting the neonatal services did not see it, nor were they even aware of its existence. Because the inspection team did not have the relevant data packs, they did not ask the relevant questions. This was a serious failing by CQC. There were other failures too: data about unexpected deaths provided to CQC was not provided to the specialist adviser. As a result, he did not ask relevant questions.

3.26 Ms Cain said, in answer to a question about detailed data about individual deaths, which she had seen but, I find, had not been provided to the specialist adviser:

> "*The role of the inspection is not to look at specific -- specific incidents. It's to ensure that there is from a regulatory perspective, there is a process in place to ensure incidents like this are identified, reported, identified, investigated and lessons learnt.*

So individual examples of incidents would not be pursued. But, however as part of the inspection, evidence would be requested to ensure that that mortality and morbidity process was being followed."

3.27 Whatever questions were asked here, none was asked about the number of deaths on the neonatal unit. It is not easy to see how a regulator can be satisfied about the process in place where, as here, CQC did not know and did not ask about the number of deaths and how they had been investigated and lessons learnt.

3.28 The second reason CQC were unaware of the increased deaths on the unit was because no one told them about them. The doctors and nurses were all aware the data had been provided to the NRLS and StEIS (and therefore CQC). It was reasonable therefore to assume CQC had it (they did but had not provided it to their teams). They also knew that the inspectors had seen data about the number and frequency of mortality meetings but, in the absence of any questions, no one mentioned the number of deaths on the unit. Dr Brearey said he had grappled with the question of what to say to the CQC team. At that stage, the Thematic Review was still in draft and he was expecting a discussion with Mr Harvey. He decided therefore to mention the issue if he was asked about it, which he was not.

3.29 Mr Harvey insisted in evidence that the Thematic Review had been provided to CQC. CQC denied this. Persuasively, Ms Millward, whose responsibility it was to prepare for the inspection, said that the report was not provided because it was still in draft. She is likely to be correct about that. Even had it been provided, it is likely that CQC would have asked whether there was a process for following it up and been satisfied with the answer that is likely to have been given – that there was.

March to May 2016

3.30 The final version of the Thematic Review was circulated widely among the paediatricians and obstetricians, and among the senior nurses, including Ms Powell and Ms Karen Rees (Head of Nursing), as well as to Mr Harvey and Ms Kelly. Mr Harvey and Ms Kelly were to say in evidence that the Thematic Review had identified wider concerns about the quality of care on the neonatal unit. They did not mention this at the time and it is likely that this was because, as Mr Andrew Kennedy KC said in closing submissions on behalf of the Countess, the Thematic Review made it clear that neither delayed cord clamping or hypothermia, ranitidine use or placement of umbilical venous catheters provided an explanation for the increased mortality. It did highlight that some of the deaths followed sudden and unexpected deteriorations and that no clear cause of death had been identified at post-mortem.

3.31 On 17 March 2016, Ms Powell asked Ms Kelly for a meeting to discuss how to move forward with the findings of the Thematic Review. Ms Kelly told the Inquiry that the email did not raise significant concerns with her. It should have done. Ms Powell was asking for help and her request was ignored.

3.32 Mr Harvey acknowledged that, in respect of the Thematic Review, he "*probably wasn't as worried as I should have been in retrospect*". Had he read the document carefully when he received it, he should have been worried.

3.33 At the beginning of April, Ms Powell moved Letby from nights to day shifts. She said this was for Letby's welfare in light of the number of deaths she had been involved in.

3.34 After Letby was moved from night shifts, there were no more deaths at night. There was a collapse (Baby N) in June when Letby was on duty having been asked to work a series of night shifts.

3.35 Dr Brearey contacted Ms Kelly on 4 May informing her that Ms Powell had moved from night shifts to day shifts a nurse "*who has been present* [on the unit] *for quite a few of the deaths and other arrests*". He sought a meeting before she returned to night shifts and pointed out that there was pressure on staffing. I find that Ms Kelly was alarmed by this email. She forwarded it immediately to Ms Rees, copying in the Deputy Director of Nursing, Ms Sian Williams: "*Aah!! Can you please look into this with Anne M* [Murphy]*/ Eirian* [Powell] *– if there is a staff trend here and we have already changed her shift patterns because of this, then this is potentially very serious!!*" Her alarm is underlined by the fact that two hours later she emailed Ms Rees again, this time sending a copy of the table of shift patterns, "*Lucy Letby highlighted in red!! I have not noticed this when I first reviewed. Can you please look into this as per my earlier email.*" Ms Kelly accepted in evidence that Ms Powell had already informed her about the "*staff trend*" in March.

3.36 The next day (Ms Rees having received the email on 4 May), the senior nurses met to discuss the neonatal unit. Ms Powell produced a document with the title 'Neonatal Unit Review 2015-16', which would feature at a significant meeting on 11 May. Ms Powell's Neonatal Unit Review dated 5 May 2016 began: "*There is no evidence whatsoever against LL other than coincidence. LL works full time and has the Qualification in* [Specialty] (QIS)*. She is therefore more likely to be looking after the sickest infant*[s] *on the unit. LL also avails herself to work overtime when the acuity or unit is over capacity*." She then set out her views, a number of which were on medical areas outside the scope of her expertise. It is a great pity that she did not discuss the content with any of the consultants at any point. It is also regrettable that she did not include in her document any reference to any of the incidents that she was aware of when Letby's behaviour was unacceptable (for example, her determination to be involved with Baby C when allocated to another baby, and her resistance to being taken away from sicker babies and required to look after special care babies, a task she considered boring).

Meeting, 11 May 2016

3.37 Ms Powell had sought a meeting with Ms Kelly, while Dr Brearey wanted a meeting with Mr Harvey and wanted to discuss Letby with Ms Powell. A meeting took place on 11 May 2016. Present were Mr Harvey and Ms Kelly, Ms Powell and Ms Anne Murphy (Lead Nurse for Children's Services) and Dr Brearey. As Ms Kelly accepted, in this meeting Dr Brearey raised concerns that the increase in neonatal mortality may be attributable to Letby. He did not say that he had concerns about deliberate harm but, as Ms Kelly accepted, his concerns amounted to one of two things: incompetence or deliberate harm. She knew that Dr Brearey thought there was a possibility that it was deliberate.

3.38 Mr Harvey said of the meeting: "*At no stage during this meeting did I feel that it was being reported because there was worry that Letby was responsible for the deaths*." What Dr Brearey was saying was clear to all the nurses in the room, including Ms Kelly. It came hard on the heels of information about Letby being moved from nights to

days. Ms Powell's vociferous defence of Letby would not have been necessary had she not understood Dr Brearey's concerns. Mr Harvey was in the same meeting. Either he was not listening, which seems unlikely, or he closed his mind to the reality of what Dr Brearey was undoubtedly reporting.

3.39 The outcome of this meeting was a decision to wait and see what happened or, as Mr Harvey put it, 'monitor and alert'. Dr Brearey's concerns had been shouted down by the nurses and ignored by the executives. Dr Brearey acquiesced and Ms Kelly recorded that all agreed to the decision. Letby was to remain on days for the next two months (there had been no deaths in April and there would be none in May). Baby O and Baby P were to die at the end of June, on successive day shifts.

3.40 Dr Brearey emailed his colleagues to the effect that the meeting had been "*helpful*", even though it had been nothing of the sort. He was worried and concerned by the outcome of the meeting but in agreeing with the outcome he gave the impression that he was content. He confided in Dr Gibbs that it had been a disappointing meeting and he explained to the Inquiry that he had wanted it to lead to "*something significant in terms of sort of escalation and assurance of safety*". Nothing like that had even been discussed. The forceful views of the nurses and the absence of any support for his concerns seems to have undermined his confidence in his own views. Even at this stage, he was not sure about Letby. He did not have to be sure. To take safeguarding steps (as everyone in the meeting should have known), suspicion was enough. But no one was thinking of safeguarding.

Safeguarding

3.41 Keeping children safe is everyone's responsibility. The legal framework is to be found in the Children Act 2004, which amended the Children Act 1989. It applies in NHS hospitals (and to NHS England and Integrated Care Boards). Statutory guidance under the heading *Working Together to Safeguard Children* was first published in 1999 and amended. The version published in 2015 was in force at the time of the events described in this Report.

3.42 In September 2015, the Countess produced a document entitled 'Safeguarding and Promoting the Welfare of Children' (the Safeguarding Policy). Ms Kelly was the Executive Lead for Safeguarding and her name appears on the introduction to the then new policy. There was not much help in the policy about what to do where a staff member was suspected of harming a child. This probably reflects the deeply held and misguided belief in the hospital and elsewhere that hospital staff, particularly nurses and doctors, do not harm children, still less babies.

3.43 Under the subheading 'Speak Out Safely (Raising Concerns about Patient Care) and Whistle Blowing Policy', the following appears:

> "*All concerns raised by staff about patient care will be dealt with seriously, promptly, and be subject to a thorough and impartial investigation where necessary. Managers have a particular responsibility to protect patients, and to handle concerns about their care in a way that will encourage the voicing of genuine misgivings, while at the same time protecting staff against unfounded allegations. No recriminations will follow reports which are made in good faith about low standards of care or possible abuses*."

3.44 Whilst concerns were raised about Letby with the very senior managers, they did not apply the guidance to protect patients, nor did they handle the consultants' concerns in a way to encourage them to voice genuine misgivings. They did provide significant support for Letby (see Chapter 17 in the Report) in accordance with the letter they had sent her describing her move to the Risk and Patient Safety Department as a neutral act.

3.45 There was a safeguarding team within the hospital, with Ms Kelly at the head, a Named Doctor, a Named Midwife and a specialist safeguarding children's nurse. There was also a Designated Doctor for Safeguarding and Child Deaths employed by the Clinical Commissioning Group at the time (now the Integrated Care Board). He was a member of the Pan Cheshire CDOP. The team were responsible for safeguarding training. They acknowledge that training did not include information about the possibility of a staff member harming children. This was a very significant omission. Whilst it was reported that there were high levels of safeguarding training, no one really seemed to understand that a concern about a nurse possibly acting to harm babies was a safeguarding issue. Many did not understand the basic principles that a concern that babies may have been harmed, or the possibility of a criminal offence, was sufficient to require safeguarding measures. Throughout the evidence there was a real sense that people were reticent about saying anything for fear of being wrong. It seems to prevail over the fear of being right. That is why safeguarding legislation requires action on suspicion or concern rather than leaving it to the choice of the person who is concerned. It is not for that person to decide whether or not what they are concerned about has happened, and certainly not for them to be sure it has happened. This was simply not understood at the Countess.

3.46 Ms Kelly did not make a safeguarding referral until March 2018. She had been aware of the concerns about Letby, as had Mr Harvey, since May 2016. They both knew the doctors' concerns were genuine but they thought the doctors were wrong, neither of them with any experience of neonates. Ms Kelly could not believe that one of her nurses would be harming babies. Mr Harvey believed there must be a clinical explanation for all the deaths. For both of them, the focus was on what else might be causing the deaths and not how can babies be protected. Even when Letby was moved from the neonatal unit, it was not done to protect the babies, rather, as Ms Powell said, "*to protect her wellbeing*". Only one baby died on the neonatal unit after that, in 2019. The downgrading of the unit did not explain this reduction in the number of deaths; several of the babies who Letby was convicted of murdering were of a gestation and condition that required a Level 1 unit only.

3.47 All the safeguarding guidance in the world makes no difference to the safety of babies if those to whom concerns are expressed do nothing.

3.48 The Countess produced a Safeguarding and Promoting the Welfare of Children Policy dated 1 September 2022. It specifically addresses the possibility that a member of staff may have harmed a child. In that situation, the Associate Director of Safeguarding is directed to ensure that a referral is made to the Local Authority Designated Officer (LADO). That route ensures that, where appropriate, the police may be brought in to investigate.

3.49 When the police investigate crime, they have access to powers that a hospital does not. In this case, for example, searches of Letby's home brought to light the 241 handover sheets that she had taken from the neonatal unit, searches of her phone brought to light thousands of text and WhatsApp messages, and interviews of hundreds of witnesses brought to light incidents about which managers were unaware. Had the managers acted as and when they should have, the police would have been involved much earlier.

SUDIC protocol

3.50 The SUDIC (Sudden Unexpected Death in Infancy and Childhood) protocol is a multi-agency/joint agency response to a sudden and unexpected child death. The SUDIC guidelines apply wherever a child dies, including in hospital. None of the deaths of the babies at the Countess in 2015 and 2016 were considered under this protocol. The evidence to the Inquiry made it plain that no one at the Countess understood that the SUDIC protocol applied even where a baby died in hospital without ever having left hospital.

3.51 Dr Camilla Kingdon, former President of the Royal College of Paediatrics and Child Health (RCPCH), explained that, in the Level 3 unit in which she works, when a baby dies the notion of deliberate harm is not typically considered. This candid acknowledgement, made in 2024, reflects the thinking at the Countess and by paediatricians across the country for years. The same sort of thinking used to prevail in other spheres: churches, schools, sports clubs. As Ms Fiona Scolding KC acknowledged in her closing submissions on behalf of the RCPCH, all hospitals need the kind of cultural change that has occurred in schools and social care. Dr Kingdon said that the view that SUDIC did not apply to a sudden and unexpected death in hospital meant that the RCPCH training for its members did not even include this situation. She informed the Inquiry that the RCPCH training has been updated to make the position clear.

3.52 The protocol applies to sudden and unexpected deaths, not all deaths. Some of the deaths in the Countess in 2015 and 2016 were not unexpected and the protocol did not apply. However, the SUDIC protocol should have been invoked for those that were sudden and unexpected, starting with the death of Baby A on 8 June 2015. Had this happened, it would have resulted in an independent and systematic investigation of Baby A's death, with input from the local authority and the police. The same should have happened after the deaths of Baby C, Baby D, Baby E, Baby I, Baby O and Baby P.

3.53 A review of the SUDIC guidance is long overdue, something that the Department of Health and Social Care (DHSC) acknowledged in their written closing submissions. Dr Joanna Garstang (Clinical Associate Professor of Child Protection at the School of Nursing, University of Birmingham), who gave extensive, informed and helpful evidence about the operation of SUDIC and of safeguarding, emphasised that such a review was essential. The RCPCH, DHSC and NHS England are committed to such revision. Whether, as was submitted on behalf of the RCPCH, the nature of the SUDIC response may be different where a death occurs on a Level 3 neonatal unit is something to be considered during that review.

3.54 DHSC have confirmed to the Inquiry that, as of May 2026, they are updating the Child Death Review guidelines, including a review of the SUDIC guidelines. Funding has been applied for in 2026/27 and work to review the guidelines is expected to begin in early autumn 2026 following internal approvals. This has been long delayed. I hope this work will start as this Report is published, with appropriate input from the RCPCH and, importantly, from Dr Garstang.

Events at the end of June 2016

3.55 Baby P died on Friday 24 June 2016. By Monday 27 June 2016, the 'wait and see/ monitor and alert' policy had ended. A series of meetings took place. Mr Harvey and Ms Kelly met and discussed Letby. As they were meeting so too, separately, were the senior paediatricians. From the outset there was no unified approach, notwithstanding repeated requests from Dr Brearey for meetings with the executives. Nearly a year after the deaths of Baby O and Baby P, the barrister brought in to advise on bringing in the police was to recommend that the executives work with the consultants. That never happened. On the contrary, they were shut out of investigations and were increasingly treated as the problem, rather than as professionals expressing their concerns about deaths on the neonatal unit.

3.56 The initial plan, devised by the executives and presented to the paediatricians, was for Letby to remain working on day shifts and to initiate an independent review of the neonatal unit. By 28 June 2016, the idea of downgrading the unit to Level 1 had also been raised.

3.57 Tensions were running very high. The suggestion that Letby remain on the ward resulted in Dr Brearey expressing his incredulity that Letby was to be permitted to have patient contact despite the unanimous concerns of the paediatricians about the safety of babies. By 29 June 2016, Dr Saladi had emailed his fellow consultants expressing the view that the police needed to be involved. Mr Harvey discussed the email with Mr Cross. He also unsuccessfully sought to shut down the email exchanges between the paediatricians with a peremptory command to all consultants. He recognised at the Inquiry that he should not have done so. On 29 June 2016, Mr Harvey took steps to inform Mr Chambers, and subsequently the Board, of the issues on the neonatal unit.

3.58 On 29 June 2016, the Executive Team met to discuss the neonatal unit and engaged in a wide-ranging discussion that considered referral to the police and the shutting of the unit, but which failed to ensure that the focus remained upon the safety of the babies. Later on the same day, the Executive Team met with a group of consultant paediatricians. As Ms Kelly accepted in her evidence, the consultants spoke at this meeting about their concerns of deliberate harm. Inexplicably, no safeguarding procedures were initiated. This meeting was an early example of what were to be many delays in reporting the deaths and the suspicions to the police. The meeting notes record Mr Chambers saying, "*can we explore more* [before] *police?*" Mr Harvey and Ms Kelly, who had earlier that day agreed that the police would have to be called, did not pursue their own agreed view, nor did they even express it in light of Mr Chambers' approach. They should have done.

3.59 By 30 June 2016, following further meetings, a course had been set where the unit was to be downgraded and a review by the RCPCH commissioned. Contacting the police was not part of the plan. It should have been. No steps were taken to protect babies.

July 2016

3.60 Ms Kelly sought advice from the Nursing and Midwifery Council (NMC) by phone on 6 July 2016. The adviser (who was very recently in post) recorded being told that there had been an increase in mortality, clinical reviews had produced no evidence of lack of competence by individuals or the team, one registrant had been present at nearly all these incidents, and some clinicians were concerned that the registrant "*may present a serious risk to public safety although no evidence is available at this time*". Ms Kelly also informed the adviser that the Executive Team were to meet that day to decide whether to report the registrant to the police. After a discussion, Ms Kelly was advised that the local investigation should continue. On 14 September 2017, the NMC revalidated Letby's registration. For reasons set out in detail at Chapter 18 of the Report, the NMC first took steps in respect of Letby's registration after her conviction in August 2023.

3.61 The decision to downgrade the unit to a Level 1 neonatal unit was announced publicly on 7 July 2016, stating that it was after "*an increase in our neonatal mortality rates in 2015 and 2016*". Despite its importance, only a small minority of parents were informed of this announcement prior to it being made public. This was another failure by the Executive Team at the Countess.

3.62 Having decided to invite in the RCPCH to review the unit, the executives also set about undertaking their own investigations under the badge 'Silver Command'. Mr Cross set up an incident room which was run by Dr Christopher Green, the Director of Pharmacy and Medicines Management. The purpose of this exercise was to investigate the increased number of deaths – and to do so with no input from any of the clinicians on the neonatal unit save for Dr Gibbs, who (with Ms Anne McGlade (née Martyn), Manager of the children's ward) had the task of investigating cases where babies had collapsed and were transferred to another hospital. Mr Harvey conducted his own analysis of neonatal unit mortality rates, including an examination of the acuity and activity rates. Unsurprisingly, none of these investigations was to produce an answer to the question of whether deliberate harm had been inflicted, nor did these investigations provide any reason for the rise in deaths.

3.63 On 11 July 2016, more than two weeks after the death of Baby P, the first reference to an increase in neonatal mortality was entered onto the Executive Risk Register.

3.64 By 13 July 2016, the executives succeeded in persuading the consultants that they should agree to the RCPCH review and, whilst the decision remained that Letby would continue to work on the unit on her return from annual leave, it was agreed that she would be supervised on the neonatal unit at all times.

3.65 On 14 July 2016, there was an Extraordinary Board meeting chaired by Sir Duncan Nichol. The executives presented to the Board the plan for a review by the RCPCH and the unit downgrading. It was explained that there would be no referral to the police. The minutes of that meeting bear careful reading. This was the beginning of an exercise in spin, steering the Board away from concerns about criminal acts and the necessity

of a referral to the police. Nevertheless, there was concern amongst the Non-Executive Directors, particularly in relation to the feasibility of Letby's supervision, and questions were raised about whether the hospital's actions were removing all risk.

3.66 The day after the Board meeting, one of the Non-Executive Directors, Mr James Wilkie, remained concerned that Letby would be permitted to return to work on the neonatal unit. He went to see Ms Kelly and reiterated his concerns. It had also become apparent that there was, in any event, insufficient staffing to supervise Letby, making this plan unworkable as well as flawed in principle. On 18 July, Ms Rees wrote to Letby informing her that, due to staffing constraints, she could not be clinically supervised on the unit and would instead be seconded to the Risk and Patient Safety Department.

3.67 The issue of Letby's redeployment prompted the hospital to seek legal advice, both on the issue of redeployment and on whether the police should be contacted. Ms Dee Appleton-Cairns, Deputy Director of People and Organisational Development (HR), first contacted DAC Beachcroft on 5 July and spoke to Mr Ian Pace, Associate, Employment and Pensions. She did not give a complete picture of the concerns. She did, however, inform Mr Pace that there had been a breakdown in relationships and a consultant had referred to a nurse at the hospital as 'Beverly Allitt'.* She told Mr Pace that she was satisfied there were no malicious issues. At that point, she wanted to know what the risk would be of moving a nurse to a non-clinical role, given that she was backed by her union.

3.68 When she was giving evidence about this call, Ms Appleton-Cairns was asked about a "*large number of unexplained and unexpected deaths on the neonatal unit*". Her reply was: "*At that point … it wasn't that many.*" At that point, there had been 13 deaths on the unit since June 2015, of which 7 were unexpected and unexplained. Ms Appleton-Cairns said she did not know that. She said she had not read the Thematic Review. She had seen the spreadsheet, which she asserted showed no commonality. This was very surprising, since it did. She added: "*The only Consultant that I knew of that was expressing any kind of concern for a long, long time was Dr Brearey.*" She then said: "*So for me there was -- there was nothing here other than Dr Brearey saying he had some concerns about a nurse, a specific nurse.*" This was a breathtaking set of answers given without embarrassment by a senior person in the HR department tasked with seeking advice about what the hospital should do about moving Letby. Fortunately, Mr Pace realised the potential seriousness of what she had revealed, pointed out that concerns about relationships paled into insignificance against concerns about patient safety and advised accordingly.

3.69 In a later conversation with Ms Corinne Slingo, Head of Healthcare Regulatory at the same firm, Ms Hodkinson did not give a complete picture, so that Ms Slingo did not understand that there was concern that a nurse was harming babies. When asked about this, Ms Hodkinson said Ms Slingo "*should have asked me more questions*". This too was an unfortunate remark. In any event, and no doubt partly in consequence of the partial picture that was presented, the legal advice from Ms Slingo was that it was not necessary to alert the police.

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* Beverly Allitt was a nurse convicted of four murders, three attempted murders and causing grievous bodily harm to six children at Grantham and Kesteven General Hospital in 1993.

Risk

3.70 The Risk and Patient Safety Department failed in its fundamental task to enhance patient safety, here the safety of babies on the neonatal unit. The first time entries were made on any risk register in respect of deaths on the neonatal unit was on 11 July 2016, by which stage there had been eight deaths in 2015 and five more deaths by the end of June 2016.

3.71 Even when neonatal mortality was put onto the risk registers, it was described as "*Apparent Increased Mortality*". The deaths were not apparent. They were real. The risk was of more deaths. Professor Sir David Spiegelhalter OBE, Emeritus Professor of Statistics, University of Cambridge, said it might better be described as "*increased mortality of undetermined cause*". The register said, under the heading 'Controls', that the "*Care Quality Commission inspection in Feb 2016 did not highlight any concerns regarding neonatal mortality*". This was true but only because the CQC inspectors did not know about the neonatal mortality figures at all. This was neither a control nor an action to reduce risk.

3.72 Ms Millward explained that the risk was scored at 15 out of a possible 25 because the unit had already been downgraded. There was no reference to the redeployment of a nurse.

3.73 A further entry on the Executive Risk Register on the same day was: "*Potential damage to Reputation of Neonatal Service and Wider Trust due to Apparent Increased Mortality within the Neonatal Unit.*" Ms Millward said in evidence that it was an executive decision to phrase the risk in that way. She said that it was considered high, with a score of 20, because the hospital's ability to reduce the risk to reputation was out of their control.

3.74 The risk systems and processes failed in their principal purpose of protecting patients, here the babies on the neonatal unit.

RCPCH

3.75 Since 2012, the RCPCH, the representative body for paediatricians, has offered an Invited Review Service. For a fee, a team visits a paediatric service, conducts interviews and reviews documents and the environment of the service and assesses whether the service complies with accepted standards. Dr McCormack (a consultant obstetrician) and Dr Brearey (a consultant paediatrician) both pointed out in meetings with the executives at the end of June that such a review would not deal with whether or not someone was harming babies on the unit. They would be proved right. On behalf of the RCPCH, Ms Scolding KC made the position plain.

3.76 The starting point for the RCPCH in this Inquiry was an uncomplicated and frank acknowledgement that the review team had made serious mistakes, for which the RCPCH acknowledged accountability and responsibility, including its contribution to the delay in the police being called to investigate. At the hearing, Professor Stephen Turner, now President of the RCPCH, also apologised directly to the parents for the role the RCPCH played in the delay to their finding out what had happened to their children. The apologies were genuine and reflective.

The review

3.77 On 28 June 2016, Mr Harvey inquired of the RCPCH by email whether they provided an independent review service "*for individuals practice or for departments where there are concerns*". Ms Sue Eardley, at that time Head of Invited Reviews, suggested a confidential telephone conversation. In her note of the call the same day, she summarised the key issue as: "*Outlier for neonatal deaths over last 12-18 months. Done a thematic review and nothing highlighted – no pattern. Neonatologists say they were not expected (although some might have been).*" In a further conversation, Mr Harvey told her about the doctors' suspicions of deliberate harm and the correlation with a nurse being "*on shift at the same time as some of those deaths had occurred*". She described it as a "*passing remark*". It was her impression that Mr Harvey did not consider the concerns significant. Ironically, she said: "*I think if he had thought it was a serious allegation he would have called the police sooner*." Mr Harvey said: "*I would have said that the paediatricians had raised concerns about an association of one member of staff. But that there was no other supportive evidence to go with that; that her managers and colleagues felt that it was related to her increased level of duty and that she was qualified in specialty. I probably wouldn't have been any more specific than that*." He did not mention that most deaths were at night, nor that, once the staff member was moved to day shifts only, there were no further deaths at night. Had he mentioned in those conversations that he and the Director of Nursing believed, as of 29 June, that the police should be contacted, that may have conveyed the seriousness of the situation.

3.78 Having gained the impression that Mr Harvey did not regard the doctors' concerns as significant, Ms Eardley asked nothing about them. She did not give any thought to safeguarding, even though she was appropriately trained and had experience, and at that time Letby was still in her role (although on holiday).

3.79 Mr Harvey made it clear to Ms Eardley that his request was for an urgent review. Ms Eardley cut corners in order to move swiftly. The result of haste and lack of proper discussion was a mismatch between Ms Eardley and Mr Harvey about what the review team would do and what Mr Harvey was expecting.

3.80 When asked by Counsel for Family Group 1 why the Terms of Reference did not make plain that the RCPCH could not exclude deliberate harm and were not tasked with doing so, Ms Eardley said: "*I can't say. I can only think it was too awful to contemplate*." The difficulty with that answer is that it was being contemplated, as Ms Eardley knew. And it was front and centre of the interviews with the consultants when they eventually took place.

3.81 Ms Eardley acknowledged in evidence that the review should not have gone ahead: "*Looking at it now … we should not have proceeded*." I am not persuaded that hindsight is necessary. Given what she knew at the time and the RCPCH's own guidance, Ms Eardley should have told Mr Harvey the review would not proceed.

3.82 In her closing submissions on behalf of the RCPCH, Ms Scolding KC said it was "*singularly inapposite and wrong*" to try to undertake a review of a clinical service when criminal allegations had been raised about a nurse. I accept that submission. Ms Scolding KC also confirmed in her written submission that the review was

never going to answer the question of why there was an increase in unexplained and unexpected deaths. She also acknowledged that the review did not provide those answers.

3.83 Ms Eardley asked Mr Harvey on 12 July whether the families of the babies would be expecting to meet the review team, and sought confirmation that arrangements for candour were in place. Mr Harvey did not answer directly. In his reply of 13 July, he said that some of the families had been informed before publication of the news that a report was being commissioned and that none of the families had asked to meet the team. He did not add that none of the families even knew that was an option. He did not mention that permission had not been sought for the provision of the babies' records to the RCPCH. This was another serious failing by Mr Harvey, the casual overriding of the rights of parents to be consulted about the use of their babies' medical records.

3.84 Although the intention was for an early review, it did not take place until September. There were two doctors on the review team: a retired consultant paediatrician and neonatologist, and a consultant paediatrician with a special interest in neonatology. There was a lay reviewer, who qualified as a nurse and was still on the Nursing Register but not practising and was also an unregistered barrister. Finally, there was a very experienced neonatal nurse for whom this was her first review. The team received in advance from Mr Harvey medical records of all the babies who had died, along with other documentation including the Thematic Review and a table setting out a list of the nursing staff on duty at the time of 11 deaths.

3.85 Dr David Milligan, Lead Reviewer, wrote to Ms Eardley on 26 August, setting out where he had reached in his review of the documents and bringing to her attention that the documents raised a number of questions, "*not least that one individual appears to have been present for all but one of* [the deaths]". Dr Milligan accepts that he should have recognised the potential hazards of conducting a review where potential criminality was raised. The other reviewers were not aware that concerns had been raised about Letby until they arrived at the Countess on 1 September.

3.86 It was only on the first day of the review that the team learnt that Letby had been moved from the neonatal unit six weeks earlier to a role in the Risk and Patient Safety Department. This did not cause a change of approach by the review team. Over two days, they interviewed staff from across the unit. It is clear from the interviews of the consultant paediatricians, senior nurses and executives (Ms Kelly and Mr Harvey) that they all talked about the paediatricians' concerns about Letby.

3.87 On the morning of the first day, the team first interviewed Ms Kelly and Mr Harvey. Dr Milligan told them that the RCPCH "*may not be able to explore the detail of the deaths*". Mr Harvey described this news as "*unexpected*". He accepted the RCPCH position. The notes of the interview include Mr Harvey speaking about the paediatricians' concerns. He pointed to the correlation with one nurse, Letby, and said: "*Pattern of babies collapse don't seem to follow normal pattern & respond to resuscitation in normal way*."

3.88 Ms Claire McLaughlan, Lay Reviewer, rather as Ms Eardley had earlier, said that the executives "*sort of dropped* [the allegations] *into the conversation as a 'by the way'*". The issue was presented as "*part of almost a breakdown in relations*". She had the

impression Mr Harvey did not want to contact the police and Ms Kelly was supportive of Letby. Neither of those were reasons to continue with this review given the seriousness of the allegations.

3.89 Dr Brearey and Dr Jayaram were interviewed next. They gave a very detailed account of events and of their concerns (which was recorded in writing), from the first three deaths in June 2015 (see Chapter 20 of the Report). They also included their belief that all the nurses were happy with Letby's practice, record-keeping and competence. They added: "*On since 2012 perfectly nice good in a crisis. Always there. Thinking about it – what could she be doing? PMs gave no cause.*" They said that they then went back to look at Baby A and their discussions with Dr Subhedar about the umbilical venous catheter and the long line. After that they began thinking forensically. Having looked at case studies, they considered air embolism. The note says: "*Last [observations?] – chilling*." That was a reference to what was observed on the babies: "[U]*nresponsive to any inputs … Odd skin discolouration. Blue with eyelids of pink … ?injecting air into babies*." This was the moment for the review team to withdraw. This was not a routine review. They were not in a position to deal with these serious concerns.

3.90 Instead, they continued. In their interview, the other consultants all expressed concerns that Letby was doing something deliberate to harm babies.

3.91 At lunchtime, the review team discussed different methods that might be used to kill a baby. This is shocking but the notes are clear: insulin and air embolism are both listed. The record of other methods has been redacted for reasons of public protection. Ms Alexandra Mancini (Nurse Reviewer) and Ms McLaughlan said they did not remember this discussion. Had they been there, it would have been impossible to forget. It may be that they were not there when this discussion took place.

3.92 In the afternoon, Ms Powell, Ms Rees and other nurses were interviewed. They all understood that the review team were looking at whether Letby was responsible for the deaths. They all robustly defended her.

3.93 The review team decided Letby should be interviewed for reasons of fairness. No thought seems to have been given to the risks of doing this. In the event, she was not asked about her care of the babies on the unit but only about general matters on the neonatal unit. She told Dr U by text that Ms Hayley Cooper (her Royal College of Nursing (RCN) representative) thought they should look at taking out a grievance. She said the interviewers (Ms Mancini and Ms McLaughlan), who were nice, had told her "*off the record*" that they thought an investigation into the deaths would be recommended and that she needed to prepare herself as she would play a big part in that. Ms McLaughlan and Ms Mancini could not remember an "*off the record*" conversation with Letby. However, what she said was accurate. Off the record or not, they told her what they were going to recommend. They were supportive of her. The review team also noted: "*Suspect there will be a grievance. If nothing happens good case for constructive dismissal. She knows it'll be horrid*."

3.94 On 2 September 2016, the RCPCH review team discussed their findings with the Countess executives. Police involvement was discussed but the review team did not say, as they should have, that the police should be contacted to investigate. It seems they asked Mr Harvey whether he thought the police should be involved. Mr Harvey's response was that he preferred to handle the issue internally for the time being.

The RCPCH should not have accepted that without question. They knew from early in their visit that Mr Harvey considered the police the 'nuclear option'. They should, as the RCPCH acknowledged at the Inquiry, have advised him that the police should be called. The failure to do so, in light of Mr Harvey's attitude to the police, meant that more delay occurred.

3.95 After the interview with Letby had taken place, Mr Tony Millea, Regional Officer for the RCN, emailed Ms Rees saying he believed Letby had grounds for a grievance. He pointed out that the Terms of Reference for the investigation did not "*seem to address the … concerns … in relation to the unacceptable high mortality rate on the NNU* [neonatal unit] *and our* [member's] *involvement*". He noted that the review appeared to be around general matters, such as procedure, culture and staffing levels, and therefore it would "*not solve the issues for Lucy personally*". This foreshadowed the grievance and the outcome of the RCPCH review. If Mr Millea had immediately identified what the review was directed to (and what it would not do), it is particularly surprising that this was not obvious to the Medical Director.

3.96 On Friday 2 September, the RCPCH gave what they called "*short term advice*", which was then repeated in a letter on the Monday, 5 September. The review team advised that the report would be ready in six weeks and advised the Trust to take two actions. First, immediate steps to "*formalize the actions you are taking with the nurse*". This required an HR investigation, which should set out the nature of the allegations and the process to be followed. Second, the review team recommended that, alongside the HR investigation, a detailed forensic case note review of each of the deaths since "*July 2015* [this should obviously be June]" should be undertaken, ideally using at least two senior doctors with expertise in neonatology/pathology in order to determine all the facts around the deaths. The case notes and electronic records should ideally be paginated to facilitate reference and triangulation. They set out the minimum elements to be included in the investigation: a full chronology, a view on whether escalation of a case would have made a difference to the outcome, examination of the post-mortem findings and any additional information available on the files which might identify cause of death, including rare conditions such as air embolism and severe metabolic derangement, details of all staff with access to the unit from four hours before the death of each infant, and consideration of any other "*near miss*" cases with similar chronology/presentation when the child survived.

3.97 To recommend an HR investigation when concerns had been expressed about the deliberate harm and killing of babies was a serious misjudgement. What was needed was a police investigation, with police powers to search, seize phones, interview and so on. In fact, no HR investigation took place. The executives used Letby's grievance as an alternative. This too was misconceived.

3.98 Ms Eardley prepared a report which included details of the paediatricians' concerns. She used green ink to identify matters that were sensitive and the hospital may wish to redact. In due course, two versions of the report were produced and sent to the Countess. The first, the confidential report, included reference to the concerns raised about Letby. The second, the dissemination report, had none of the redacted passages.

3.99 Mr Harvey's expectation that the RCPCH report would provide a swift and conclusive way of resolving concerns about the increase in mortality rates was unrealistic. Neither swift nor conclusive, it did not begin to resolve the concerns about the increase in the

number of deaths on the neonatal unit. Its recommendations, more than 20 in number, were: five related to managing or investigating deaths; five related to staffing; three related to the management and governance of the unit; six directed at the neonatal network, involving transport to and from other NHS units; one on managing allegations or concerns; and one on the mechanism for recording, management and reporting across IT systems. Nothing in the report, taken separately or in any combination, explained any of the deaths. Mr Harvey and Mr Chambers would characterise it as not supporting any sinister findings either. That was to overlook the point that the RCPCH had declined to investigate the deaths. Overlooked throughout the RCPCH process (after Ms Eardley's question about candour in mid-July 2016) were the parents. Some had seen the Countess press release at the time of the downgrade of the unit, which included reference to the RCPCH review. Many of the parents knew nothing about it. Most of them learnt of it only when the *Sunday Times* printed a story on 5 February 2017, which led to the publication of the report on 8 February 2017. Efforts were made to reach the families. The experience of Mother E and F was particularly remarkable. About 30 minutes before the report was published online, a letter notifying her of the report's publication was delivered to her home from the hospital, out of the blue, in a black taxi.

Further reports

Dr Hawdon

3.100 On 8 September 2016, Mr Harvey asked Dr Hawdon, a London-based consultant neonatologist, to conduct a detailed case note review of 13 recent deaths and 4 near misses on the neonatal unit. Mr Harvey did not tell Dr Hawdon that behind the request lay concerns by consultant paediatricians about a nurse deliberately harming babies. It was an unfair way to approach a colleague, particularly when the issue behind the request was so serious.

3.101 Before commencing her review, Dr Hawdon asked Mr Harvey whether parental consent to release the records of the babies was being sought. The misleading reply from Mr Harvey was that the hospital "*had informed* [parents] *ahead of the review*". In fact, the parents' consent had not been sought – neither in respect of the RCPCH report nor regarding the case note review by Dr Hawdon. Given the seriousness of this issue for parents (and doctors), he should have checked the position, if he did not know it. The parents had a right to know about this. Mr Harvey disregarded that right completely on two occasions. This was unacceptable behaviour from a Medical Director.

3.102 By 29 October 2016, Dr Hawdon had completed a case note review, despite being sent the medical records in no proper order. She delivered the report with several significant caveats which made clear that it did not comply with the requirements of the review the RCPCH team had advised. Dr Hawdon said that, due to time constraints, a full systematic chronology for each case had not been carried out and that some post-mortems had not been provided to her. Dr Hawdon also informed Mr Harvey that she had not performed any analysis of which staff had access to the unit in the four hours prior to the death of each infant. Further post-mortem reports were provided to her.

3.103 The report produced by Dr Hawdon divided the cases she had considered into two groups. In Group 1, she listed cases where she considered the death or collapse to be explained but where it may have been prevented by different care. This included Baby C, Baby E, Baby H and Baby Q. In Group 2, she placed cases where the death or collapse was unexpected and unexplained. This group included Baby A, Baby D, Baby I, Baby O and Baby P. Following sight of the post-mortem for Baby D, Dr Hawdon was to amend her view, agreeing that the cause of death was 'pneumonia'. She was to amend her view again when giving evidence to the Inquiry.

3.104 Dr Hawdon's report, along with the RCPCH report, was discussed at an Executive Directors' meeting on 2 November 2016. The notes of the meeting record "*5* [deaths] *unexplained; 1 of concern*" and Mr Harvey is recorded as advising the other directors that these cases required a secondary review. It was this that led to a further instruction to Dr Jo McPartland, one of the pathologists at Alder Hey who had conducted some of the post-mortems on the babies from the Countess.

3.105 Mr Harvey subsequently continued to correspond with Dr Hawdon. In early February 2017, he sought her views on skin mottling. Dr Hawdon responded that, if longer lasting and not merely transient, mottling reflected peripheral shut-down and warranted close observation and additional tests. Mr Harvey followed this up with a further email on 14 February 2017, providing Dr Hawdon with the key information that should have formed part of her instructions from the outset, namely that the paediatricians had made allegations against a member of staff and were worried that mottling observed in some of the babies was caused by air embolism.

3.106 Despite Mr Harvey pointedly noting in his email to Dr Hawdon on 14 February 2017 that the RCPCH had concluded that the concerns of the paediatricians were "*based on coincidence and 'gut-feeling'*", Dr Hawdon did not simply adopt what was professed to be the RCPCH view. Rather, she responded that "*unexpected collapse in an otherwise stable baby is rare*", noting "*that there have been more cases than would be expected*". Mr Harvey may not have appreciated that, in describing the concerns of the paediatricians as "*based on coincidence and 'gut-feeling'*", the RCPCH were relying only on the views of the senior nurses and ignoring the detail of the consultant group's concerns.

3.107 On 13 April 2017, Mr Harvey emailed Dr Hawdon again, explaining that a senior barrister had advised the Trust that the clinicians should be asked to set out their grounds for suspecting that a criminal offence had been committed. Despite Mr Harvey's somewhat leading question in his email saying, "*I'm sure that I know the answer, because I am sure that you would have called it out in your report, but my Chairman has asked to ask the question; were there any concerns there was anything other than natural causes in your review of the cases?*", Dr Hawdon was not led. Instead, she sent a prompt response: "*Completely unexplained* [death] *on a neonatal unit is rare. So by definition more than one unexplained death does arouse suspicion*." Mr Harvey seemed surprised by what Dr Hawdon said. Had he listened to the consultant paediatricians he would have known that many months earlier.

Dr McPartland

3.108 On 6 December 2016, Mr Harvey, having received Dr Hawdon's report on 29 October 2016 and discussed the matter at an Executive Team meeting, contacted Dr McPartland. He informed her about "*a spate of neonatal deaths*" and explained that an independent expert, Dr Hawdon, had "*suggested that in 4 of the PMs, it might be worth a follow up discussion with the pathologists to see if further light can be shed on the issues*". Significantly, and characteristically, Mr Harvey did not mention to Dr McPartland the fact that clinicians had concerns about a member of staff.

3.109 Dr McPartland, having been emailed a summary of Dr Hawdon's findings about Baby A, Baby I, Baby O and Baby P, conducted a review with fellow consultant paediatric pathologists at Alder Hey, Dr Rajeev Shukla and Dr George Kokai. The three pathologists discussed each case. They agreed that "*in three of the four cases we indicated that we didn't know why the babies had collapsed*". For Baby I, the three of them agreed with the recorded cause of death at post-mortem.

3.110 Dr McPartland emailed Mr Harvey a summary of their conclusions on 25 January 2017, noting the informal nature of the review and noting it was "*not a full and formal medicolegal review*". Dr McPartland advised Mr Harvey that a report of depth would best be performed by someone independent of the hospital. I note that all the pathologists had carried out post-mortems on the babies from the Countess. The suggestion of the need for independence was a good one. It was not taken up.

3.111 By late 2016/early 2017, Mr Harvey knew that none of the reports (from the RCPCH, Dr Hawdon or Dr McPartland) had excluded deliberate harm. The attempt to resolve the concerns about the increased number of deaths without recourse to the police had failed.

3.112 It is notable that, throughout this period, the RCPCH report, which was published in February 2017, was not shared with the parents. In April 2017, six months after it had been completed, excerpts of Dr Hawdon's report were sent to some of the parents under cover of a letter from Mr Harvey. Dr Hawdon considered the families were given insufficient covering information when they received excerpts of her report, a view endorsed in the evidence of the parents. As Mr Harvey accepted when giving evidence, "*the communication was both crass and inappropriate … It was done in completely the wrong way. It was unthinking and insensitive*." It was.

The grievance

3.113 On 7 September 2016, Letby sent a letter setting out her grievance on the grounds of victimisation and discrimination. She was supported in her claim by representatives of the RCN.

3.114 Her complaint raised the following issues:

a. She had been informed on 14 July 2016 that she was to be supervised in practice and was to redo her competencies. Contrary to what she had been told, she was the only member of staff to face such action.

b. On 18 July 2016, she had agreed to be redeployed as, due to staffing levels, the neonatal unit could not offer supervised practice. She was informed that the redeployment would last until an external review had taken place regarding the increase in mortalities.

c. The RCPCH reviewers had interviewed her and made no mention of any wrongdoing on her part. They had also told her that it would take up to eight weeks for them to complete their report. Letby wished to know what would occur during this period as she wanted to return to work on the neonatal unit.

3.115 All of those points were correct. They all arose out of the failure of senior managers to deal openly and honestly with the serious risk posed by Letby to patient safety.

3.116 Having received the grievance letter, Ms Appleton-Cairns and Ms Hodkinson sought further legal advice from Mr Pace at DAC Beachcroft. He said that the decision to remove Letby was justified in order to remove risk to the babies, but that there was a high risk of a finding of constructive dismissal. Mr Pace advised the hospital to respond to Letby in line with the grievance policy.

3.117 Dr Green, Director of Pharmacy and Medicines Management, was appointed as the investigating officer for the grievance raised by Letby. As a member of staff at the Countess, he lacked the appropriate independence, exemplified by the fact that he had recently been involved in a professional disagreement with Dr Brearey about an error made by a junior pharmacist which had affected a baby on the neonatal unit. He had been invited to take part in the Thematic Review meeting but had not participated. He had also been part of the Silver Command process in mid-July 2016. Further, as Dr Green accepted in his evidence, he lacked sufficient experience to act as an investigating officer in a case of such seriousness and complexity. Ms Annette Weatherley, Deputy Chief Nurse at the University Hospital of South Manchester NHS Foundation Trust, was appointed as Chair of the grievance process. She too lacked the appropriate skills and independence for this very difficult, if not impossible, task. As Dr Green made plain on a number of occasions, he was not making findings about the allegations about Letby but he was making findings about whether or not the consultants had called her names.

3.118 On 14 October 2016, Dr Green began conducting interviews. Letby's was first. She informed Dr Green that she had not received any formal allegations. Mr Millea of the RCN said on her behalf that she had been bullied and harassed by Dr Brearey. This allegation was untrue. It was not probed by Dr Green.

3.119 Dr Green then interviewed Ms Kelly, Ms Sian Williams, Ms Rees, Ms Hodkinson and Ms Powell during October 2016.

3.120 Ms Kelly informed Dr Green that there were no issues with Letby and downplayed the extent of the consultants' concerns about her. She misled Dr Green, informing him that the draft RCPCH report had confirmed "*nothing significant as regards Lucy*". Ms Kelly also expressed her own misplaced and premature view that Letby would be returning to the unit.

3.121 Ms Hodkinson similarly seemed to have reached her own conclusions prematurely. The day before she was interviewed by Dr Green, Ms Hodkinson informed Letby that there was not enough evidence to investigate formally or contact the police.

3.122 Ms Sian Williams was concerned at the time that the grievance hearing was being held prior to any final report by the RCPCH, a concern she raised with Ms Kelly to no avail. Ms Sian Williams had conducted a staffing analysis with Ms Julie Fogarty, Head of Midwifery, as part of the hospital's own investigations. She had discussed it with Mr Harvey as she was concerned that the police should be informed. She told Dr Green about this work, but was asked no questions about it. In giving evidence to the Inquiry, Ms Sian Williams, like Ms Hodkinson, expressed her regret at not making it clear that the consultants had genuine concerns.

3.123 In her interview with Dr Green, Ms Rees spoke of the fear that calling the police to investigate would result in the unit being shut down and people being arrested, a fear that proved unsubstantiated when the police investigation finally commenced.

3.124 Ms Powell spoke highly of Letby to Dr Green. She is recorded as informing Dr Green that she considered Letby to be "*100% innocent*" and referred to Dr Brearey and Dr Jayaram as having "*brainwashed other consultants*".

3.125 On 7 November 2016, Dr Green interviewed Mr Harvey. Mr Harvey understood that the focus of Letby's complaint was how the Trust had managed her off the unit and failed to be transparent as to their actions or the reasons for them. Nevertheless, the focus of Dr Green's questions, and of Mr Harvey's answers, was criticisms of the consultants' actions, and remarks they were alleged to have made about Letby killing babies. Mr Harvey asserted, incorrectly, that the doctors had prevented Letby undertaking supervised practice. There is no doubt that Mr Harvey's evidence to Dr Green was subsequently used against the doctors and led to the recommendation that the doctors be required to make an apology and engage in mediation.

3.126 Finally, at the end of the interview process, Dr Green interviewed both Dr Brearey and Dr Jayaram. Both doctors had been informed that any information provided by them could be used in a disciplinary hearing should that be necessary. They were both advised that they could be accompanied by a representative, advice they accepted. Dr Jayaram contacted both the British Medical Association (BMA) and Mr Cross, as he was worried that raising concerns of deliberate harm might put him at risk of disciplinary action.

3.127 Dr Jayaram explained to Dr Green that there had been an increase in unexpected and unexplained neonatal deaths. He also explained that Letby was either looking after the babies or was present at the time of death and that there was nothing in clinical practice, equipment or the environment that was relevant to the deaths.

3.128 Dr Brearey, in his evidence about the grievance process, observed correctly that the consultants raising concerns about Letby "*seemed to be turning into a narrative against us rather than concentrating on the cause of the deaths*". As he observed: "*We were in a grievance procedure where we were made to feel as though we were on trial*."

3.129 Dr Brearey offered to send Dr Green the Thematic Review, which set out the concerns about the unexpected deaths. Dr Green did not take up Dr Brearey's offer. Neither, strikingly, considering the findings and recommendations he was to make, did Dr Green question Dr Brearey or Dr Jayaram about the language they were said to have used about Letby or their honest belief in their concerns.

3.130 Dr Green produced a draft investigation report on 12 November 2016, and a final version on 22 November 2016. His findings included that the Trust had not been open and honest with Letby regarding the nature of the consultants' accusations. He also concluded that the consultants' concerns were not clear, honest or objective. This was a finding about which Dr Green expressed particular regret at the Inquiry hearing.

3.131 Dr Green made recommendations that included that Letby be given the opportunity to return to the neonatal unit in her substantive role, and this be managed in tandem with the final reports commissioned by the Trust. Further, he recommended that the Trust should take action to investigate the behaviour of Dr Brearey and Dr Jayaram in line with the Trust's disciplinary policy. Dr Green also concluded that the Executive Team should have done more to communicate with Letby and could have been more open and honest about why she had been redeployed, noting, however, that their intentions were "*positively directed*".

3.132 Following Dr Green's investigation report, the grievance was heard by Ms Weatherley on 1 December 2016. In her outcome letter following the hearing, Ms Weatherley adopted and quoted extensively from Dr Green's report. She found that having looked at the rotas Letby could have had supervised practice after all. It is not clear how she came to that conclusion but if it is correct it is not something that had been shared with the paediatricians or nursing managers at the time, since they were all under the impression supervision could not be provided. Ms Weatherley concluded first that the Chief Executive and a Non-Executive representative should apologise to Letby in the presence of her parents. Second, subject to any finding to the contrary in the final RCPCH report, Ms Weatherley found that Letby had no case to answer. Ms Weatherley had not seen the RCPCH report and so was unaware that it was not directed to the question of whether or not Letby had a case to answer. It was a report about services, not the conduct of an individual.

3.133 Finally, Ms Weatherley held that Dr Brearey and Dr Jayaram were to engage in mediation with Letby and provide her with an apology. Failure to do so was to result in disciplinary action.

3.134 Ms Weatherley read the papers far too quickly, came to a view before she began the hearing and permitted Ms Appleton-Cairns from HR, and in turn the executives, to become involved in decision-making and the drafting of her report. She rubber-stamped the investigator's findings without question. She then made recommendations as to what the doctors should do that were unjustified, unfair and offensive. The fact that she recommended disciplinary action should they refuse to comply with her recommendations makes it clear that she did not consider the Speak Out Safely Policy. The consultants were to be forced to apologise when they had nothing to apologise for, and were required to mediate. The way the grievance and its consequences were handled was deplorable.

3.135 On 22 December 2016, in accordance with Ms Weatherley's recommendation, a meeting was held with Letby and her parents, Mr and Mrs Letby, as well as Ms Hayley Cooper, Ms Rees, Mr Chambers, Mr Harvey, Ms Kelly and Ms Hodkinson.

3.136 In this meeting, Mr Chambers made the entirely inappropriate commitment to return Letby to working on the unit, in the full knowledge that there had been no detailed investigation of the allegations against Letby. Mr Harvey, present at the meeting, failed to speak up to say that the consultants had genuine concerns about Letby.

3.137 Notes of this meeting, and the fact it even occurred, demonstrate how far adrift the hospital had come from the correct course of a responsible and prompt response to serious concerns raised by consultants about patient safety.

The coroners

3.138 The Senior Coroner for Cheshire, Mr Rheinberg, was aware of the increase in the number of deaths on the neonatal unit in 2015 and 2016 because all the deaths were referred to his office. There was no post-mortem for Baby E. The inquest into the death of Baby C was closed once the post-mortem report was received. Baby D's inquest was adjourned in 2017 and was reopened in February 2026 and adjourned again. Inquests were opened and adjourned for each of Baby I, Baby O and Baby P. They too have been reopened and adjourned again.

3.139 The inquest into the death of Baby A was opened on 23 December 2015, shortly after receipt of the post-mortem report. Baby A's mother read the report and wrote to the coroner's office in January 2016. The email was forwarded to Dr Jayaram, who provided a point-by-point answer to her questions with explanations for all that had been done. The hearing of the inquest did not take place until October 2016 because of delays by the hospital in providing information. Mr Rheinberg had suggested that the hospital should complete a Serious Untoward Incident report. Mr Harvey considered that the Thematic Review would be the equivalent of such a report.

3.140 Baby O and Baby P died in June 2016. Mr Rheinberg said that it was after these deaths that he became concerned about neonatal mortality at the hospital. By this stage, he had been notified of the deaths during 2015 and during 2016.

3.141 Mr Cross spoke to the Assistant Coroner, Mr Alan Moore, in early July, to inform the coroner's office that the RCPCH were being commissioned to prepare a report that would be sent to Mr Rheinberg on completion.

3.142 It was Mr Cross's written evidence that he told Mr Moore about everything he was aware of at the time, including the suspicions relating to Letby. Mr Moore denied that. In light of other evidence about other conversations at that time, I have found that the concerns about Letby were not mentioned in this call. This represented a breach of the duty of candour owed to the coroner by the hospital.

3.143 In August, Mr Cross informed an Executive Team meeting that the coroner was pushing for statements in respect of the inquest for Baby A. He noted an action to "*prepare* [statement] *bundle for AK/IH*". Ms Kelly and Mr Harvey have no memory of this but further statements from junior doctors were provided to the coroner at his request and on 19 August the obstetric secondary review on Baby A and a version of the Thematic

Review (with the deaths of babies other than Baby A removed) were sent to the coroner. The themes remained. The first page of Dr Brearey's summary of cases dated 1 July 2015, relating to Baby A alone, was also sent on that date. The coroner's office sent that single page to the solicitors for Baby A's parents on 28 September 2016. Baby A's parents expressed their strong disappointment at the document and sought an adjournment unless a fuller report was received by 3 October 2016. Mr Rheinberg refused to adjourn the inquest. He said he had no power to order a hospital to conduct an investigation and still less give directions to the nature and extent of any investigation that was undertaken. He did not refer to the Thematic Review, which his office had received on 19 August.

3.144 Mr Rheinberg thought the Thematic Review "*almost certainly*" was not in front of him at the inquest. It should have been. It should have been sent to the solicitors for the parents of Baby A. Had that been done, the solicitors would have been in a position to read it and explore the themes identified. This was a significant failure by the coroner's office – not, on this occasion, the hospital.

3.145 The inquest hearing for Baby A took place on 10 October 2016. Mr Cross instructed Mr Louis Browne KC to represent the hospital. Mr Browne KC had a conference with Mr Joshua Swash, an employee of the hospital's legal department, and two junior doctors on 27 September. There was reference in the conference, as noted by Mr Swash, to a nurse. Mr Browne KC said: "*I suspect that it was said that a nurse … appeared to have been on duty at the time of some of these deaths*." He asked Mr Swash to check whether the nurse was on duty at the time of Baby A's death. If so, that fact should be disclosed. All of this is in Mr Swash's note of the meeting. Letby was on duty but that fact was never disclosed to the solicitors for Baby A, nor was it disclosed, as it should have been, to the coroner. Mr Browne KC trusted Mr Cross to do as he was asked, as he always had in the past. The Countess accepted in their closing submissions that this was a failure of candour by the hospital. Responsibility for it lay, in fact, with Mr Cross. As a result, this important information was withheld from the solicitors for the parents of Baby A. This was, as the Countess accepted, a serious failing.

3.146 The doctors had all been provided by the hospital with a document entitled 'Guidance on Writing Statements'. Part of the guidance is unobjectionable. The second part is objectionable. It advises the doctor who is writing the statement "*to avoid criticism of colleagues/other departments*" and not to "*give opinions*" but rather "*just stick to facts*". Such guidance is not consistent with candour and should not have been given.

3.147 At a telephone conference on 6 October, with Mr Cross, Mr Swash, Dr Jayaram, Dr Saladi, Dr Harkness and Dr Teresa MacCarrick (a junior doctor), Mr Swash took a note. He recorded: "*Still to this day Ravi* [Jayaram] *doesn't know why this happened. In 27 years in paediatrics, never seen this kind of situation*."

3.148 Under the heading 'Dr Saladi', the note records:

> "*- If review is outside the remit of your knowledge, then say so.*
>
> *Don't say anything unless you know. REVIEW IS ONGOING* [capitals in original]."

3.149 Mr Browne KC could not understand why no one at the hospital told him that the consultants were concerned that Letby had killed Baby A. He said he would also have wished to have known about the discolouration on the baby's body.

3.150 On 6 October, Mr Cross informed Mr Rheinberg that the hospital were awaiting the RCPCH report and that the review team were "*entirely satisfied … and raised no concerns*"; however, they had recommended that a detailed case note review be undertaken which, he said, was in progress. He did not inform Mr Rheinberg that Letby had been moved off the unit in July, nor that the RCPCH had recommended an HR process to investigate the nurse.

3.151 Other information that should have been but was not provided to the coroner (or the parents) was the letter of instruction to Dr Hawdon and the fact that there were concerns in the hospital that a nurse may be deliberately harming babies.

3.152 Dr Jayaram understood, reasonably, that the coroner was aware of the detailed reviews going on and that he was aware of the concerns that the consultants had. It was Mr Cross's written evidence, which I do not accept, that he had fully briefed the coroner about the concerns. It is likely that he told the consultants the same thing.

3.153 The focus of the hearing on 10 October was on the long line and whether there was a link between it and the death of Baby A. In addition to his post-mortem report, Dr Shukla gave evidence confirming his view that he "*had not found anything to suggest a natural disease but then there was no evidence that there had been anything unnatural either*" and that "*it would be very difficult for him to conclude that it was more likely than not natural causes because there was no evidence of it either way*".

3.154 Dr Jayaram was recalled in order to give some paediatric knowledge. He said in evidence that normally neonates can be resuscitated. He confirmed that there had been similar cases of neonates dying in similar circumstances on the unit which they had not been able to explain. He confirmed the unit had been downgraded and an independent review had been requested, but the feedback from this was that nothing could be found that was wrong with any of the training, any of the practices or any of the equipment. Dr Jayaram was also noted to have said "*there is a potential issue with staffing*". The reference to 'staffing' was a reference to Letby. The same word was used in emails between Dr Brearey, Ms Kelly and Ms Rees on 4 May 2016.

3.155 Dr Jayaram described what he was doing as 'throwing out breadcrumbs'. Hindsight makes it very plain that is what he was doing, believing as he did that the coroner was aware of all the deaths, and understanding that the consultants' concerns were "*on the Coroners' radar*" – as they should have been. He had obviously spent years thinking about many aspects of this event, including his evidence to the coroner: "*I just didn't have the courage to say it and I think part of this … was already … influenced by the … pushback that we were getting that, 'There's nothing to see here' and … I regret not explicitly saying that … on many, many levels because it should have been said*." Dr Saladi said: "[I]*f the coroner has asked me, I would have probably said. But because it wasn't asked, because what I didn't know is what is speculation at that stage.*" He too believed, reasonably, that the coroner was aware of the deaths, because the deaths had been referred to the coroner. Mr Rheinberg said that, if the concerns had come out at the inquest, by which I think he must mean had they been spelt out, he "*wouldn't have gone on any further, and probably sought police involvement*".

3.156 The inquest ended with a narrative conclusion: "*It cannot be determined what caused Child A's collapse and subsequent death and further it cannot be determined whether this was due to a natural or unnatural event*."

3.157 The underlying approach from the executives may be gleaned from Mr Cross's notebook entry: "*Narrative Verdict 'Unascertained' No negative comments No press.*" Mr Cross recorded briefing Ms Kelly to the same effect. They were informed that there were no press present. That was what mattered. There was no reference to concerns for the parents of Baby A or the fact that the death was still unexplained. No press meant no damage to the hospital's reputation.

3.158 More than three months later, on 8 February 2017, when the RCPCH report was published, Mr Rheinberg met Mr Harvey and Mr Cross. Mr Cross's note records Mr Rheinberg asking whether anything had come out of the investigations. Mr Harvey's reply is recorded as: "*No theme has emerged*." Mr Cross said in his witness statement that Mr Harvey "*fully briefed the Coroner on the neonatal matters to date*". What that meant is not included in the statement.

3.159 On 10 February, the consultant paediatricians sent a letter to Mr Chambers, copied to Mr Harvey. For reasons set out in detail, the letter asked Mr Chambers to "*urgently ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses that occurred on the neonatal unit between June 2015 and July 2016*". This was because they had not been reassured that "*all these deaths and collapses are explicable by natural causes*". In a meeting of the executives on 14 February, the consultants were considered to have "*gone backwards*" and were "*firmer*" in their position about unnatural causes. Mr Harvey "[w]*ondered what they were plotting*". In evidence, he explained that he had a "*degree of frustration*" with the consultants.

3.160 The following day, Mr Harvey and Mr Cross met Mr Moore and Mr Rheinberg. They brought a covering letter of 15 February 2017, the letter from the consultant paediatricians to Mr Chambers of 10 February, the portions of the RCPCH report that had been redacted from the one previously provided to the coroner and Dr Hawdon's report. The documents were handed to Mr Rheinberg. In evidence, Mr Rheinberg said he did not remember the meeting but had made a note. The note records that there was discussion of the consultants' request that the coroner undertake an investigation into the deaths and unexpected collapses. Mr Rheinberg said that he explained he did not have jurisdiction to carry out a general review, only to hold an inquest into a specific death. That is undoubtedly correct but there are situations in which an inquest or inquests may be reopened under section 13 of the Coroners Act 1988. That this did not occur to Mr Rheinberg supports my conclusion that he was not told anything about the consultants' concerns about a nurse's involvement in the deaths. That was his firm evidence. Mr Harvey's evidence was equally firm to the opposite effect and Mr Cross's statement said that Mr Harvey "*fully briefed the Coroner on all matters*". It is overwhelmingly likely that, had Mr Rheinberg been told about the concerns about the nurse in the meeting, he would have written this down and would, as he said, have contacted the police.

3.161 Mr Rheinberg said that he had not seen the pages from the confidential (unredacted) report until they were sent by the Inquiry but he accepted that they were given to him and that Mr Cross and Mr Harvey may have expected him to read them. He did not read any of the documents after the meeting, nor did he pass those documents on to Mr Moore, who was about to take over as coroner. Mr Moore's contribution to the meeting was recorded as, "*AGM* [Mr Moore] *asked what the clinicians hoped to achieve by seeking Inquests and wondered whether there were reputational motives* [for] *there*

being no right of 'appeal' from the Royal College's findings" – which Mr Moore had not seen at that stage. The answer to his question might have been 'because they are concerned about the actions of a nurse', but Mr Moore was as firm as Mr Rheinberg in his evidence that nothing was said about the nurse. I find that nothing like that was said by Mr Harvey or Mr Cross. This conversation was in the last weeks of Mr Rheinberg's tenure as coroner. He was dealing with many cases and was clearly trying to complete as much work as possible. In the result, another three months would pass before the police were contacted.

NHS England and the Countess

3.162 NHS Improvement (and its predecessor, Monitor) considered the Countess a high-performing organisation. That is because the Countess's self-reported performance to Monitor did not suggest it was an outlier, and NHS Improvement's primary focus was on financial management. It relied on CQC and NHS England commissioners to assess quality and safety.

3.163 The North West Neonatal Operational Delivery Network knew about the deaths on the Countess's neonatal unit. Three deaths were mentioned in the meeting on 16 September 2015. Baby E's death was discussed on 12 November 2015; Baby I's death was noted in the minutes of the meeting on 21 January 2016.

3.164 NHS England witnesses said they were not aware of the concerns relating to neonatal mortality at the Countess until after the deaths of Baby O and Baby P. The deaths of Baby O and Baby P were reported to StEIS on the days they died. In subsequent meetings, and in correspondence in early July between organisations within NHS England and senior personnel within the Trust, including Ms Kelly, there were mentions of both "*the police*" and "*safeguarding*". There was no mention of the consultants' concerns that deliberate harm may have been caused. No safeguarding or police referral was made.

3.165 When the neonatal unit was downgraded to Level 1 on 7 July 2016, the Serious Incident report on StEIS recorded the reason as "*an increase in neonatal mortality rates for 2015 and 2016*". The association with those deaths of a member of staff was not mentioned.

3.166 There was a meeting on 7 July 2016. Present were Mr Harvey, Ms Kelly, Ms Townsend and Ms Millward from the Countess. In attendance from the NHS England commissioners were Ms Paula Wedd (Director, Quality and Safeguarding, NHS West Cheshire Clinical Commissioning Group (CCG)), Ms Lisa Cooper (Deputy Director Quality and Safeguarding, Cheshire and Merseyside) and Ms Sue McGorry (Quality Lead, North West Hub, Specialised Commissioning, NHS England). It is lamentable that none of those present from the Countess even mentioned the concerns raised by the consultants. A number of matters were discussed, according to Ms Kelly's notes, finishing with a reference to Detective Chief Superintendent (DCS) Nigel Wenham (Cheshire Constabulary) and "*Police Route*". The obvious inference from the notes is that safeguarding was discussed, including the involvement of the police, but no safeguarding steps were taken.

3.167 On 8 July 2016, Ms Kelly spoke to Ms Gill Frame, Independent Chair, Cheshire West and Chester Local Safeguarding Children Board, informing her that the unit had been downgraded. Again, there was mention of the police in that conversation but Ms Kelly did not mention the consultants' concerns.

3.168 Mr Harvey and Ms Kelly should have informed NHS England and should have made a safeguarding referral to the Local Safeguarding Children Board at this stage. Ms Kelly's failure to do the latter was particularly egregious given her role as Executive Lead for Safeguarding in the hospital. At the first meeting of the Local Safeguarding Children Board following the deaths of Baby O and Baby P, there was no discussion of any issues concerning the Countess.

3.169 On 12 August 2016, Ms Kelly attended a teleconference with Mr Andrew Bibby, Assistant Regional Director, Specialised Commissioning (North). Representatives from NHS England's Cheshire and Merseyside team and NHS West Cheshire CCG were present. Ms Kelly reported the fact of the RCPCH report and that nothing significant had been identified during the Trust's internal review. The latter assertion omitted mention of the work of Dr Gibbs and Ms McGlade, or of Ms Sian Williams and Ms Fogarty, which had identified, respectively, six babies in whose cases something unexpected or unusual had occurred, and that Letby was on duty more often than other staff when a baby died or collapsed.

3.170 In September, commissioners (unnamed) from Specialised Commissioning (North West) requested a copy of the RCPCH report. It was not provided but the commissioners were informed of Dr Hawdon's forensic review. They were not provided with Ms Eardley's letter of 5 September 2016. Nor was it provided to NHS England or NHS Improvement.

3.171 On 16 December 2016, Ms Kelly wrote to Mr Bibby in response to his request for the RCPCH report, asserting that the Trust had only just received the final approved copy. This was not true, as Ms Kelly knew. The final version of the RCPCH report had been received three weeks earlier. Ms Kelly also assured Mr Bibby that the RCPCH had "*assured*" the Countess that "*there were no immediate actions or concerns*". When she wrote this, Ms Kelly sought to mislead Mr Bibby. Ms Kelly said it was "*a collective decision from the Executives*" not to give NHS England the RCPCH report at this time.

3.172 Mr Bibby was concerned, but not surprised, by the refusal to provide the RCPCH report. He sought help from NHS Improvement. A meeting took place between Mr Vince Connolly, Medical Director (North), NHS Improvement, and Mr Harvey on 3 January 2017. Mr Harvey was misleading about: the extent of the involvement in the reviews of the families of the babies who had died; and the extent to which the CCG, Specialised Commissioning and NHS England had been informed of the issues. He also said that it was intended to meet the staff and the parents of the babies who had died, on 10 January 2017. That meeting did not take place.

3.173 An article was published by the *Sunday Times* on 3 February 2017. It was about the RCPCH report. On the same day, a copy of the dissemination version of the RCPCH report was provided to NHS England.

3.174 There was a meeting on 27 March 2017. Present were Dr Brearey, Dr Jayaram, Dr Subhedar, Ms Hodkinson, Mr Chambers and Ms Julie McCabe, Director of the North West Neonatal Operational Delivery Network. Ms McCabe learnt that the consultants believed that "*on the balance of probability, illegal activity has caused the deaths*". She informed Mr Bibby the following day of the consultants' concerns. She mentioned a police investigation to him. It was Ms McCabe's evidence that she believed that, by 27 March 2017, the Trust had made the decision to call the police (something Mr Chambers confirmed in evidence).

3.175 Mr Bibby's response was that his understanding from the Trust was that the paediatricians had "*gone maverick*". Ms McCabe disabused him of this and, as a result, Dr Michael Gregory, Clinical Director, Specialised Commissioning (North), spoke to Mr Harvey on 29 March 2017. There is a dispute of fact between them as to exactly what was said. Dr Gregory's position, supported by his subsequent email, was that when pressed Mr Harvey refused to be drawn on what was going on.

3.176 Two weeks later, Dr Gregory chased Mr Harvey, seeking an update following the 13 April 2017 Board meeting. Mr Harvey replied to advise that the Trust intended to approach the CDOP. Dr Gregory's attempt to get hold of Dr Hawdon's report at this stage was rebuffed by Mr Harvey, who, ironically, cited concerns over patient confidentiality. At this stage, Mr Robert Cornall, Regional Director, Specialised Commissioning (North), said: "*It all feels a little evasive again*."

3.177 By late April 2017, the position taken by Ms Margaret Kitching, Regional Chief Nurse (North), NHS England, was that the Trust should be given a little more time to respond. The same day, a meeting was offered to Dr Gregory by Mr Harvey, but only once the Trust had "*completed* [its] *process*". This led to further internal emails between Dr Gregory and his colleagues which drew attention to the delay. By this stage, a consensus was developing within the regional NHS England team that the police needed to be involved.

3.178 However, Ms Kitching said a call with Mr Chambers was the better course. She made this call to Mr Chambers on 27 April 2017, and he informed her that there was no evidence to suggest any criminality or unnatural causes. Mr Chambers' position in that call was that two consultants were the problem. When this led to the revelation that those consultants were making an allegation against a member of staff, Ms Kitching told Mr Chambers to call the police.

3.179 In a subsequent meeting between Mr Harvey, Mr Cross, Ms Kitching and Mr Connolly that same day, Mr Harvey pushed back against the suggestion that he had not been forthcoming. He characterised the position in relation to Letby (albeit not by name) by saying that it "*was determined*" that her association with the deaths was "*probably not unusual*". He did not mention the consultants' concerns that she was causing deliberate harm.

3.180 Following the second meeting with the police on 12 May 2017, Mr Harvey wrote to Ms Kitching to tell her that the police were not minded to investigate. He went on to say that, if the consultants were unable to evidence criminal activity, leading to the police not investigating, "*the issues of culture etc*" would need to be dealt with. Ms Kitching interpreted this as the Trust still being focused on the consultants being the problem.

3.181 Overall, witnesses from NHS England were highly critical of the approach by the Trust to providing information. Mr Chambers was equivocal about whether more information should have been provided. Whilst employees of NHS England should not have agreed to repeated delays and were too ready to accept assurances, the principal responsibility for the failure to ensure that NHS England knew about the possibility of deliberate harm being caused to babies lies with Mr Chambers, Mr Harvey and Ms Kelly.

Contacting the police

3.182 Over the course of late February and early March 2017, the consultants, principally through Dr Brearey, continued to raise their concerns. At a meeting on 28 February, attended by Mr Harvey, Dr Brearey, Dr Jayaram, Dr Gibbs and Dr Subhedar (from the Neonatal Network), the paediatricians told Mr Harvey that the increase in neonatal deaths could not be explained by the factors mentioned in the Silver Command review in July 2016. Dr Subhedar pointed out that other Level 2 units had similar issues.

3.183 The consultants explained in writing the limitations of the RCPCH review (namely, that it did not investigate the causes of the deaths or collapses) and Dr Hawdon's review (namely, that it was not multidisciplinary) and that they had identified four more cases in addition to Dr Hawdon's four that they considered needed further review.

3.184 Mr Harvey was dismissive of the consultants, including Dr Subhedar. It seems he was not interested in being told something that ran contrary to his preferred narrative. This was disrespectful of the consultants but also foolish since he had no expertise in neonatology and, as recently as 14 February 2017, he had learnt from Dr Hawdon, in answer to a question from him, that "*unexpected collapse in an otherwise stable baby is rare*", adding that there had been more cases than would be expected. This seems to have made no difference to his approach to the paediatricians at the Countess.

3.185 At the same time as they were endeavouring to explain their concerns, Dr Brearey and Dr Jayaram were under pressure to engage with mediation after the grievance. Mr Harvey added to this pressure by mentioning referral to the General Medical Council (GMC) in an email to both of them, characterising their cooperation as a way to protect against that. They continued to try to resist this pressure, with Dr Jayaram pointing out that it was inappropriate given the lack of resolution of their concerns.

3.186 Dr Brearey was unable to attend the first proposed mediation meeting date in early March. Ms Rees sent an intemperate email about him to Ms Kelly, Ms Hodkinson, Mr Harvey, Ms Hayley Cooper and Letby.

3.187 By 13 March 2017, in response to the pressure he was under, Dr Jayaram asked for a meeting with Ms Hodkinson, which took place two days later. Dr Jayaram disclosed his recollection of three occasions about which he had specific concerns. Ms Hodkinson said in evidence that the police should have been contacted at this point. She did not do so. It is likely that this was because she did not quite believe what she had been told and wanted to see if there was any support for his account.

3.188 The executives met the following day. They discussed what Dr Jayaram had said and his suggestion for a meeting. Ms Hodkinson raised with her colleagues the fact that Dr Jayaram felt bullied. She suggested the relationship between the consultants and executives had broken down. What followed in the meeting was good evidence of that.

The minutes contain the first record of Mr Chambers raising the possibility of contacting the GMC. Ms Kelly's reaction to Dr Jayaram's disclosure was one of disbelief. In the meeting, she proposed that Letby should go back to the neonatal unit.

3.189 Mr Chambers, Mr Harvey and Ms Hodkinson met Dr Brearey and Dr Jayaram on 27 March 2017. Also present were Ms McCabe and Dr Subhedar. By this point, having lost faith in the executives, Dr Jayaram had decided to be explicit. An email from Dr Michael McGuigan was read out. He was a consultant paediatrician who had joined the Trust at the start of 2017 and had no involvement in any of the deaths or collapses. He expressed the view that the only proper investigation would be one led by the police. Dr Brearey said that in this meeting he and Dr Jayaram had asked or told Mr Chambers to contact the police. Mr Chambers' reaction was to point out that the doctors should call the police. This was a misguided approach by a Chief Executive. He was in charge. Nevertheless, by the end of the meeting, as all participants understood, and Mr Chambers agreed in evidence, it had been decided that the police would be contacted.

3.190 The police were not contacted for some time. Instead, there were yet more meetings, which involved various executives and Sir Duncan Nichol. They discussed contacting the police. They also discussed Letby's return to the neonatal unit, which was scheduled for 3 April 2017. In a meeting on 28 March 2017, it was recorded that Ms Hodkinson and Ms Kelly's position remained that Letby would be returning to the neonatal unit on that date (despite what Ms Hodkinson had thought on 13 March).

3.191 Two days later, Ms Hodkinson spoke to Ms Slingo of DAC Beachcroft. It is clear from the record of that conversation that the executives were still thinking about reporting Dr Brearey and Dr Jayaram to the GMC.

3.192 At about the same time, the executives were considering seeking advice from an experienced criminal barrister, Mr Simon Medland KC, whom Mr Cross had worked with in the past. By 3 April 2017, two significant documents were created. First, Mr Cross prepared a document with the heading 'Rationale'. It contained a selective history of what had happened over the previous year, opening with the line that there was no evidence to justify a criminal investigation. It did say, however, that the matter was going to be reported to the police. It reads like a last attempt to persuade people that there was nothing in the consultants' concerns.

3.193 The second document was produced by Mr Harvey. It followed similar lines and included an eye-catching statement about how open the Trust had been. It had not.

3.194 Mr Medland KC was instructed by Mr Cross to advise the hospital. He met Sir Duncan, Mr Harvey, Mr Cross and Mr Chambers on 4 April 2017. By the end of the meeting, Mr Medland KC understood that he was being asked to advise on whether there was sufficient evidence to justify a report to the police. He asked for a meeting with the consultants.

3.195 That meeting took place on 12 April 2017. At that meeting, it was clear that there was a difference in understanding about the purpose of bringing in Mr Medland KC. In contrast to his understanding, the doctors thought, with good reason, that the decision to contact the police had already been made. They discussed Beverly Allitt and what

the police's expectations might be. Mr Medland KC advised the consultants to prepare a document setting out their best points. He also raised the possibility of a private discussion with DCS Wenham, who sat on the CDOP.

3.196 On 13 April 2017, Mr Medland KC attended an Extraordinary Board meeting. He repeated his advice about contacting DCS Wenham and advised the executives to work with the consultants. This never happened. The meeting agreed that Dr Hawdon should be asked what she meant by a "*forensic review*". Sir Duncan recalled Mr Medland KC advising that he "*didn't find any evidence of -- of criminality*" but that "*if events are still unexplained and if well-minded people still have concerns, then the police should be called*". Sir Duncan expressed the wish that they had had that advice in July 2016.

3.197 The following week, on 20 April 2017, Mr Harvey telephoned Ms Hayley Frame, the Independent Chair of the Pan Cheshire CDOP. Her recollection was that the purpose of the call was to raise the RCPCH's concern that the SUDIC protocol was not always followed. There was no reference to the police in the call.

3.198 One week later, on 27 April 2017, a meeting was held. Present were Ms Hayley Frame, DCS Wenham, Mr Harvey, Mr Cross, Dr Jayaram and Dr Holt. At some point, the focus of the meeting shifted to discussing staff rotas. Ms Hayley Frame's immediate reaction was one of grave concern. It became clear to her that the reviews had not excluded deliberate harm. DCS Wenham's position at the meeting was that this was a matter for the police. Following the meeting, DCS Wenham notified Mr Harvey that he had briefed Assistant Chief Constable (ACC) Darren Martland of Cheshire Constabulary and that certain documents were required.

3.199 On 2 May 2017, after an Extraordinary Board meeting, Mr Chambers wrote to the Chief Constable of Cheshire Constabulary. The request he made was oddly phrased. It was to "*conduct a forensic investigation into the circumstances surrounding the deaths with a view to excluding unnatural causes*". Such an investigation is not what the police do. The language was more of the same from Mr Chambers, who had spent almost a year trying to exclude unnatural causes.

3.200 Two meetings took place between senior police officers on the one hand, and Mr Chambers, Mr Harvey and Mr Cross on the other. Those meetings were on 5 and 12 May 2017. In both meetings, Mr Chambers failed to set out the consultants' concerns at their highest.

3.201 At the second meeting, on 12 May, a document prepared by the consultants on 10 May 2017 was discussed. This was the same day as Mr Harvey wrote to Ms Kitching to the effect that the consultants were the problem. Mr Chambers was dismissive of the document. Mr Harvey characterised the concerns as "*a HR issue*", echoing the approach of the RCPCH in their letter of September 2016. DCS Wenham's view of Mr Chambers and Mr Harvey's approach was it was "*like indeed doors* [were] *trying to be shut*". It was agreed that the police would meet Dr Jayaram. Whether or not the police would investigate was left open. Based on what ACC Martland said at the meeting, there was a realistic prospect at that stage that they would not.

3.202 Mr Chambers went back to the Countess after the meeting with the police and had a scheduled meeting with Ms Hodkinson. In that meeting, he made a plan for the consultants, noted by Ms Hodkinson, predicated on his hope and expectation that the

police would not investigate. The plan was to refer Dr Brearey and Dr Jayaram to the GMC, to take steps to avoid them being able to rely on the Speak Out Safely Policy and, ultimately, manage them out of the hospital. His plan was consistent with his approach throughout the previous 11 months, namely that the doctors were the problem. He had lost all objectivity.

3.203 On 15 May 2017, following a meeting between DCS Wenham, Detective Inspector (DI) Paul Hughes, Dr Brearey, Dr Holt and Dr Jayaram, DCS Wenham telephoned the executives to inform them that the police were opening an investigation. At that meeting, the doctors had set out the same concerns as they had set out 11 months earlier when they met the executives.

3.204 The police should have been notified earlier than they were. Ms Kelly and Mr Harvey should not have allowed themselves to be persuaded against it by Mr Chambers on 29 June 2016, without even attempting to speak in favour of it. Mr Chambers' intention throughout was to stall or obstruct a police investigation and he had succeeded for almost a year.

3.205 Over the 11 months from June 2016, Mr Cross had raised more than once the potential disruption of a police investigation. Nothing about his description of the potential consequences came true when the police were contacted. The unit remained open, the police were discreet, and doctors and nurses diligently did their best to support the police investigation after working hours and without disrupting patient care.

3.206 The Inquiry heard evidence from parents who had heard nothing about the concerns and suspicions about Letby until the police contacted them when Letby was arrested in July 2018. It was unforgivable that this was allowed to happen. To the extent the executives thought about the parents at all, they considered it better to say nothing in the belief that the police investigation would lead nowhere. The parents should have been informed by the hospital as soon as the police were notified. They had a right to know.

2018

3.207 On 30 April 2018, all eight consultant paediatricians met Mr Cross and Mr Harvey. There had been no meeting since the police had become involved at the hospital a year earlier. In a letter handed over at the meeting, the consultants made plain that they felt their views had been treated with contempt by the Chief Executive and some members of the Board. Mr Chambers consulted Sir Duncan Nichol about his response. In his draft, he included the following: "*He … genuinely and sincerely wants the neonatal team to know they have his full support and respect and that of the entire board and colleagues throughout the trust and this has never changed*." This did not reflect what Mr Chambers thought at all. He had expressed views directly to the contrary in his conversations with the Letby family and with other executives in meetings in 2017. His aim had been to bring the consultants to heel or move them out.

3.208 Mr Harvey retired, as long planned, in August 2018. Dr Susan Gilby started at the Countess as Medical Director in early August, shortly after Letby had been arrested. She described people in the hospital as shocked. It was her impression that it was thought that nothing would come of it. She said: "[T]*he focus continued to be on the people who had raised concerns*." She was told that the RCPCH review had not found evidence of

deliberate harm and a detailed specialist review of the cases had not come up with any evidence of deliberate harm. Mr Harvey did not say, as he should have done, that neither review had ruled it out. At that stage, Dr Gilby had been given none of the reports. Once she read them, she explained to Sir Duncan that in her view the Board and the Executive Team "*had got this wrong*" and she explained why.

3.209 At about the same time, the Medical Staff Committee of the hospital were seeking a vote of no confidence in Mr Chambers. Mr Chambers was looking to move from the Countess and wished to avoid a vote of no confidence. In his appraisal with Sir Duncan, he had agreed that "*he would be looking for … a new job, the best years possibly behind him*". He was given assistance in seeking a new role by the Executive Regional Managing Director (North) at NHS Improvement, Ms Lyn Simpson. In the event, Mr Chambers found an alternative role without her help. His new employers received from the Countess full funding of his salary package for a period of nine months. Mr Chambers and Sir Duncan drafted an announcement, which was published on 19 September. It included the following passage: "*Tony's stepping down as CEO at the Countess is as a result of extraordinary circumstances and is not a judgment on his ability as a CEO but more a reflection of his integrity as a leader.*" This was another exercise in spin. He was stepping down to avoid a vote of no confidence and so preserve his career.

The Inquiry

3.210 The Inquiry was announced in Parliament by the then Secretary of State for Health and Social Care, the Rt Hon. Steve Barclay MP, on 4 September 2023. The Terms of Reference were set by the Secretary of State, after consultation with me and with the parents of the babies who died or were injured and with other Core Participants. The Inquiry was formally established on 19 October 2023. The Terms of Reference are on the Inquiry's website and in Appendix 1.

4. Part Two

4.1 The following brief summaries of each chapter in Part Two set out the principal issues. Further reading of the chapters is necessary to understand the detail.

Chapter 31: Implementation of recommendations of inquiries

4.2 The first detailed work carried out by this Inquiry was a review of all recommendations made in all inquiries into the NHS in the last 30 years. The review shows that, whilst some significant changes have been introduced in response to inquiry recommendations over the last 30 years, most have not been implemented.

4.3 Even where recommendations are accepted, there is no clear or easily accessible mechanism to track their progress or enforce their implementation over a reasonable period of time. The problem is exacerbated in the NHS because of repeated structural change. Several other reasons can be identified for the failure to implement recommendations: first, the sheer number of recommendations made; second, lack of clarity about who is responsible for implementation; and third, lack of political will.

4.4 In September 2024, the House of Lords Statutory Inquiries Committee recommended that the House of Commons Liaison Committee facilitate the formation of a joint committee of Parliament to ensure that inquiry recommendations are followed up and implemented. Provided the committee is given sufficient time, resources and flexibility to carry out this work, this could and should work.

4.5 Within government, there is a need for effective independent monitoring of the implementation of recommendations from statutory inquiries. I recommend that responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office.

Chapter 32: Medical examiners

4.6 In July 2003, Dame Janet Smith DBE, in her third report of the Shipman Inquiry, recommended a system whereby there would be an effective cross-check on the account given by a doctor in respect of the death of a patient. The government of the day proposed a system of medical examiners and the proposal stood still. In February 2013, Sir Robert Francis KC expressed his support for a system of medical examiners. The statutory system of medical examiners came into effect on 9 September 2024. It should have been introduced a decade earlier, by mid-2014 at latest, ten years after it had been agreed.

4.7 The statutory scheme provides for medical examiners – doctors independent from the primary, treating physician – to review those deaths not taken for investigation by the coroner. Part of the role of medical examiners is to identify patterns of poor care, including care that is negligent or deliberately harmful. They should operate as an early warning system, identifying any issues and referring them to the coroner, clinical governance processes or the National Medical Examiner, as appropriate. This is a positive development. The NHS should review the adequacy of funding for medical examiners, including whether the funding should be ring-fenced. I also make a number of recommendations as to how the system could be improved.

4.8 The Rt Hon. Jeremy Hunt MP, former Secretary of State for Health, was of the opinion that the medical examiner system would have prevented a number of the deaths at the Countess. The deaths of Baby A, Baby C, Baby D and Baby I were reported to the coroner and post-mortems were ordered and received, so the medical examiner would probably not have been involved. However, it may well be that the medical examiner would have been informed of, or otherwise become aware of, the unusual rise in the number of neonatal deaths. The system would also have allowed the clinicians to talk about their concerns with someone external to the Trust. Such discussions would probably have led to action to protect babies by May 2016.

Chapter 33: CCTV and monitoring

4.9 From the outset of the Inquiry, Core Participants and witnesses were asked for their view on whether the Inquiry should make recommendations about CCTV monitoring of neonatal units. I summarise some of the responses provided in Chapter 33. The parents were firmly of the view that CCTV would protect babies on the neonatal unit. I agree. Parents of very young babies will find this reassuring. It will also deter those rare people who seek to harm babies. I am not persuaded that the cost, training and 'workload' implications outweigh those benefits, if those implications are of any real weight at all. I am sure that all cots and incubators in all neonatal units should be fitted with in-cot cameras with live streaming video, so that parents may observe the baby remotely at any time. The modest funding required for this should be centrally managed and ring-fenced.

Chapter 34: Insulin

4.10 Letby poisoned Baby F and Baby L by administration of insulin. Insulin poisoning is a method of deliberate harming and killing of people in hospital. The cases of Beverly Allitt, Victorino Chua and Colin Norris are some more examples in the UK. It was one of the methods of killing discussed by the RCPCH review team in September 2016.

4.11 Insulin is not a controlled drug and so not subject to the tight processes and procedures applied to controlled drugs. No one suggests it should be. However, it is agreed that there should be effective systems to prevent and detect unauthorised access to, and use of, insulin. There was broad support amongst Core Participants for expanded use of technology for these purposes.

4.12 NHS England has taken steps to achieve this. In January 2026, the NHS issued a Getting It Right First Time guide called *GIRFT Neonatology: Guide to safe insulin use*. This sets out a delivery checklist for safe access, storage, handling, prescription, administration

and disposal of insulin. This includes individually identifiable and auditable access controls, and locked fridges or cupboards. It mandates two-person checking for insulin preparation and administration, and working towards implementing 'closed loop' administration systems.

4.13 I recommend that digital devices be used to restrict access to authorised people and to record access to insulin storage units. All neonatal units should meet the requirements set out in the Getting It Right First Time guide by 31 March 2027. Until access is restricted by biometric data (and so prevents card swapping), each Trust should install a CCTV camera focused on the insulin storage cupboard or unit, storing recordings for at least 28 days.

4.14 I welcome the October 2025 publication of the Getting It Right First Time laboratory handling guidance for high insulin low C-peptide results. The guidance directs that local protocols be set up for when high insulin low C-peptide is found. I suggest that serious consideration be given to producing a single step-by-step template protocol. The protocol should explicitly mandate immediate discussion between laboratory and treating clinicians and between the laboratory head and the medical director of the hospital. Senior managers must inform NHS England and CQC and, in the absence of a complete explanation for the finding, the police must be contacted.

Chapter 35: Data – reading the signals

4.15 The increase in the number of neonatal deaths at the Countess in 2015 was significant data. It was sufficient to generate an alert signal. The alert signal is clearly found in the crude and stabilised and adjusted mortality rates for babies born at the Countess in 2015, as recorded in MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) surveillance data. However, the MBRRACE-UK data analysis for 2015 was not reported until June 2017, by which time the police had been contacted. The figures for 2016 were reported in June 2018. The utility of the alert signal provided by the data was lost to time.

4.16 When it comes to the early detection of a member of staff causing deliberate harm, it is real-time monitoring or continuous monitoring that will be of most value. In 2019, MBRRACE-UK provided all NHS Trusts with access to a real-time or continuous data viewer, enabling more immediate and ongoing monitoring of the stillbirths and neonatal deaths reported to it. The multiplicity of electronic systems within the NHS, many of which do not talk to each other, continues to complicate real-time data reporting. I recommend that NHS England and/or DHSC undertake to provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS, so that by December 2028 data relating to babies and neonates in hospital may be entered and reviewed in a timely manner and on a continuous monitoring basis.

Chapter 36: The NHS

4.17 The NHS is a large, complex constellation of organisations, which together provide a national healthcare service. It has undergone successive reorganisation, with all the attendant upheaval. Countless resources have been expended on tasks and documents that ultimately make no difference to the quality of patient care. Time

(managerial, medical, nursing or other) and money should not be devoted to any task that does not improve patient care, or at least maintain it to a good standard. That is true of administrative reform (which should not be pursued for its own sake), targets mandated (which are too many in number) and documents circulated (which people spend too much time producing and reading). The practical abolition of NHS England should also include a significant reduction in the number of regulatory bodies. An informed analysis of what they all do should be prepared and reviewed. Decisions should be taken about which bodies are necessary, which can be amalgamated and which can be abolished so that those working in them may be directed to those parts of the NHS that need their skills to improve patient care.

Chapter 37: Training and regulation of managers

4.18 The core purpose of a hospital is to diagnose accurately and treat effectively patients with illnesses, conditions and diseases, and to care for those patients with kindness and respect. The role of senior managers in a hospital is to make sure the core purpose of the hospital is achieved. Managers need to understand what people working in the hospital actually do, and collaborate with them to make sure the hospital is fit to meet its core purpose. Recruitment and training of managers must reflect this. At present there are too many managers who do not meet the standards that should be expected of them. The need to improve the quality of people recruited and to retain excellent managers is urgent.

4.19 The Terms of Reference require me to consider whether, and if so how, the accountability of senior managers should be strengthened. One way to do this is to regulate. The question as to whether to regulate managers has been considered, ignored and reconsidered for decades.

4.20 The Inquiry heard ample evidence of the 'revolving door' employment provided for NHS managers about whom serious concerns had been raised. The NHS must be prepared to dismiss senior managers for serious misconduct. Such managers should not be able to secure employment as a manager in the NHS again. Those are basic propositions. The time for profound change is long overdue.

4.21 The current government proposal on regulation is to introduce a statutory barring system for board-level directors and their direct reports. Whilst a barring system may go some way to removing offending and poorly performing NHS managers, the current proposal has limitations. It is not clear how regulating only the most senior managers will help professionalise NHS leaders generally.

4.22 More fundamentally, the fact that full professional standards are not, and under the government proposals will not be, required for NHS managers should ring alarm bells. The essential step is to raise standards. A statutory barring system for managers should be introduced but, having been introduced and operated, it should be reviewed with a view to moving to a full statutory regulation system.

Chapter 38: Duty of candour

4.23 All NHS organisations owe a statutory duty of candour. The statutory duty does not apply to individuals, although organisations inevitably discharge their duty through the actions of their staff and directors. Clinical staff who are registered healthcare professionals have a professional duty of candour, overseen by their respective professional regulators, such as the GMC, the Nursing and Midwifery Council and the General Dental Council. Non-clinically qualified managers owe no equivalent duty.

4.24 The government's response to the consultation on proposals to regulate managers failed to deal with the question of introducing a professional duty of candour for NHS managers. So does the NHS Leadership and Management Framework Code, published in July 2026. I am in no doubt that non-clinical managers should be subject to a duty of candour. Hospital managers control all the resources and make decisions that affect all aspects of the running of the hospital and patient care. An individual duty should be imposed on managers, mirroring the duty on nurses, doctors and other healthcare professionals.

Chapter 39: Culture of the NHS

4.25 Culture has been a repeat theme of inquiries into the NHS in the last two and a half decades. A heavy focus has been placed on improvement in NHS culture. Despite this, patients have still suffered avoidable harm through the actions of NHS staff and shortages of resources.

4.26 The move towards a 'no blame' culture in the NHS, starting in 2000, was a mistake. The focus on system faults rather than the failings of individuals, coupled with a learning culture that omitted acknowledging responsibility or blame, meant difficult conversations about conduct were avoided. This undermined patient safety.

4.27 Fundamentally, the concept of 'culture' is limited. It is behaviours that need to change. The starting point for everyone must be patient safety. It must be the top priority for all managers. Managers looking to drive up standards must be guided by the fundamental principle that patients are at the centre of all that is done in a hospital.

Chapter 40: Freedom to Speak Up Guardians

4.28 Freedom to Speak Up (FTSU) Guardians work alongside Trust leadership teams to ensure staff have the capability to speak up effectively and are supported appropriately. They became part of the standard NHS contract in 2017, following Sir Robert Francis's 2015 Freedom to Speak Up Review. The National Guardian's Office (NGO) came into being in 2016. It provided mandatory training, offered support calls to Guardians and collected anonymised data. It was a small organisation, with limited resources and powers. The NGO was abolished at the end of June 2026 and its functions transferred to NHS England.

4.29 There is significant variability in how individual Trusts operate their FTSU Guardian system. There are still many NHS staff who do not feel it is possible to raise patient safety concerns without experiencing a detrimental effect on their careers, including threat of referral to a regulator and threat of disciplinary proceedings. This occurred

at the Countess. It is in that context that there remains a need for a national oversight body. The NGO's functions should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include: (a) investigating complaints that whistleblowing in the NHS has not been dealt with adequately; and (b) assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Chapter 41: Patient safety, safeguarding and employment law

4.30 In the Countess in 2016, patient safety and safeguarding concerns were relegated below a flawed HR investigation of Letby's grievance. This was wrong. Where safeguarding or other concerns about patient safety are raised in good faith, the balance to be struck by a responsible NHS employer, between the risk of an employment claim and the risk to patient safety, comes down firmly in favour of protecting the patient.

4.31 Where concerns about or suspicions of deliberate harm are raised against healthcare staff, the most usual and correct response is to move the person about whom the concern has been expressed to a post where they can do no harm, or to suspend them altogether while the matter is investigated. This is a neutral act essential to protect patient safety.

4.32 If suspicions of murder have been raised in a hospital, the police must also be called. Where there is insufficient information to lead to suspicion, but there is an emerging concern, the ideal way forward would be to take the concern to a suitable expert or experts from another hospital, who can review the case and give their views. They must be provided with full and frank disclosure of the concern and the material required to consider it.

4.33 Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently. The precise make-up of the panel should be determined by DHSC but could include, for example:

- two doctors and two nurses from each clinical specialty
- four senior managers
- paediatric and perinatal pathologists
- other experts as decided by DHSC.

Where necessary, a small team (always including clinicians from the relevant specialty/specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting the police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings which may follow.

4.34 The Inquiry heard evidence about the lack of clarity in employment policies for handling serious concerns. All employment policies should include a clearly stated overriding objective, which is the safety of patients. Trusts should be required to embed the Suspicion of Deliberate Harm Protocol and guidance (see Recommendation 9 in Chapter 45). No member of staff, clinical or managerial, should be in any doubt about what to do when suspicions are raised that a member of staff (or any other person) has caused harm to a child.

Chapter 42: Care Quality Commission

4.35 CQC's purpose is to ensure that health and care services provided are safe, effective, compassionate and of a high quality. This includes a duty to conduct inspections of health and social care service providers and publish a report of their findings.

4.36 CQC initially took a generalist approach to inspections. This changed in 2013 to inspecting and rating NHS hospitals, using larger and more specialist teams of inspectors. The change was triggered by several high-profile failures of care. In 2015, *The Report of the Morecambe Bay Investigation* was published by Dr Bill Kirkup CBE. It found there was significant organisational failure on the part of CQC. This ought to have alerted CQC to the urgent need to ask more questions, and to probe the answers given, during their inspections, including that of the Countess in 2016. Such an approach may well have uncovered the rise in the mortality rate on the neonatal unit at the Countess.

4.37 Further changes in CQC strategy followed in 2016 and 2021. In October 2024, Dr Penny Dash published her review into the operational effectiveness of CQC. Dr Dash found significant failings in the internal working of CQC, which had led to a substantial loss of credibility and a deterioration in CQC's ability to identify poor performance. In the same month, Professor Sir Mike Richards published his review of CQC's 2021 strategy. The report found that the changes had major adverse consequences and failed to deliver the benefits that were intended. CQC accepted these findings.

4.38 CQC has not often achieved its purpose since it was set up in 2009. It now needs to focus on its core purpose and develop teams who work to achieve that purpose. The new Chief Executive must be an exceptional leader and manager, who is supported by an outstanding team. CQC must not be allowed to fail again.

Chapter 43: The Health Services Safety Investigations Body

4.39 The Health Services Safety Investigations Body (HSSIB) was established under the Health and Care Act 2022. Their role is to carry out independent investigations that identify risks to patients and facilitate the improvement of systems and safety practices in the provision of healthcare services in England. Investigations are focused on patient safety issues that occur in multiple places across the country, and on issues where HSSIB consider they can add value and address inequalities. Learning lessons about safety is prioritised over individual accountability.

4.40 The issue at the Countess was one of concern about a particular nurse on a particular unit. However, as set out elsewhere in this Report, the Inquiry has revealed issues at the Countess that were almost certainly more widespread. Staff and managers misunderstood, and failed to follow, guidance and procedures. There was inadequate

training about what to do when concerns were raised about a member of staff harming a child. Staff did not feel able to raise concerns. Doctors, with good reason, feared disciplinary action or referral to the GMC. The need for an external body such as HSSIB remains. HSSIB continue to fulfil a needed function and require the resources and staff to carry on doing this effectively.

Chapter 44: Memorandum of Understanding

4.41 A Memorandum of Understanding (MoU) is meant to establish a formal framework for effective cooperation and communication between public agencies. An MoU entitled 'Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and Health & Safety Executive' was published in February 2006. It appears to have fallen out of use at about the time the Association of Chief Police Officers was replaced by the National Police Chiefs' Council in 2015.

4.42 In December 2024, a new MoU was agreed between a number of police, criminal justice and healthcare bodies. It applies when more than one of the signatories needs to investigate any incident where there is reasonable suspicion that a criminal offence has or may have been committed by an individual who is providing healthcare services, which leads to or significantly contributes to the death or serious life-changing harm of a patient or service user. The MoU provides useful and comprehensive guidance. However, it is aimed at executives or senior managers in the signatory organisations. It is not directed at, and does not provide useful information to, healthcare professionals who may have suspicions of their colleagues. It is also premised on the ability of internal reporting processes to identify those concerns that trigger further response. For the MoU to be effective, hospital executives must be respectful of clinicians' genuinely held views.

4.43 The current MoU reflects no input in respect of safeguarding but I understand that is to be remedied. Nor does it contain explicit advice that it is best practice to make early contact with the police. This too should be remedied. I also consider an accompanying, shorter document is essential to guide those faced with one of the situations identified in the MoU.

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