Thirlwall Inquiry

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

Volume I

September 2026

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

Chair: The Rt Hon. Lady Justice Thirlwall DBE

Presented to Parliament pursuant to section 26 of the Inquiries Act 2005

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Note on references

Endnotes are in the following format.

- **Documents published on the Inquiry website:** Document reference number/page number/ paragraph number (where applicable).
- **Oral evidence:** Name of witness Date of oral evidence Transcript page/Transcript line number(s).
- **Publicly available documents:** Author or organisation, title, date (URL).

Where a particular element of a reference is not applicable or is unavailable, it is omitted.

Foreword

The year 2026 marks the eleventh anniversaries of the births and deaths of Baby A, Baby C, Baby D, Baby E and Baby I, the births and collapses of Baby B, Baby G, Baby H and Baby J, and the injuries to Baby F. It marks the tenth anniversaries of the births and deaths of Baby K, Baby O and Baby P, the births and collapses of Baby M, Baby N and Baby Q, and the injuries to Baby L.

The parents of those babies have waited years to know the detail of what happened at the Countess of Chester Hospital between early June 2015, when Baby A died, and 2018, when Lucy Letby was arrested. In August 2023, after a ten-month trial, Letby was convicted of the murders of seven babies (Baby A, Baby C, Baby D, Baby E, Baby I, Baby O and Baby P) and the attempted murders of a further six babies (Baby B, Baby F, Baby G, Baby L, Baby M and Baby N). She was convicted at a retrial in June and July 2024 of the attempted murder of Baby K. Two applications for leave to appeal were dismissed in July and October 2024 respectively. An application was made to the Criminal Cases Review Commission (in February 2025) seeking a referral of the case back to the Court of Appeal.

This Inquiry was set up in October 2023. Witnesses were identified, documents were obtained. Evidence hearings began in September 2024. A total of 134 witnesses gave oral evidence over five months. In March 2025 I heard closing submissions and an application to pause the Inquiry, which I refused. My ruling on the application, on 19 March 2025, may be found on the Inquiry's website.

At the beginning of the hearings, I said that the experience of the parents would be at the heart of the Inquiry. The evidence about this appears in Part One of the Report. Part Two deals with the wider NHS. Part Three contains Recommendations and Appendices.

I would like to thank the parents of all the babies who died or were injured. Their evidence, generously given, was amongst the most thoughtful and moving any person will ever hear. Throughout a very difficult and prolonged process, the parents have conducted themselves with dignity and determination, with the aim that no other parents should have to experience such grief and heartache.

The Rt Hon. Lady Justice Thirlwall DBE

Part One

Chapter 1. Background

1.1 The Countess of Chester Hospital (the Countess) forms part of an NHS Foundation Trust (the Trust) that includes the Countess, Ellesmere Port Hospital and Tarporley War Memorial Hospital. The Trust was authorised as a Foundation Trust in 2004, which means that it operates as an independent public institution that is not subject to direction by the Secretary of State for Health and Social Care or the performance management requirements of the Department of Health and Social Care (DHSC). It is responsible for setting its own strategy and is subject to regulatory oversight by the Care Quality Commission (CQC). The Trust provides a range of services to the communities of Chester, West Cheshire and the Deeside area of Flintshire, including acute and emergency services and obstetric services. Most of the Trust's services were provided at the Countess, which in 2015 was a 600-bed hospital with over 4,000 staff.

1.2 It is clear from the annual report for 2015/16 that the hospital was involved in a large-scale change project designed to cut expenditure: "*Within the next two years, The Countess needs to transform itself and reduce its annual running costs by £20million.*" The explanation of how this was to be achieved concludes with the following:

> "*The principle here is about gaining momentum, getting The 'Model Hospital' off the ground in a supportive way that does not disrupt staff focus on patient care and safety. However, at some point it will impact on our time at all levels through what we prioritise, the way we work and what we do here at The Countess.*"[1]

The impression given is of a lot of planned activity and a warning that there would not be time for everything. It is uncontroversial to observe that change programmes absorb large amounts of time.

Governance framework

Council of Governors

1.3 Only NHS Foundation Trusts, such as the Countess, have a Council of Governors. Other NHS Trusts do not. The purpose of the Council of Governors is to hold the Board of Directors to account and to represent local interests. Council members do not have a management role but carry out their functions by reviewing performance reports, challenging assumptions and raising questions as appropriate. They hold, in public, formal quarterly meetings attended by members of the Board of Directors. Council members are elected members of local communities or members of partnership organisations. They are elected for three years.

1.4 Responsibilities of the Council of Governors include: the appointment of the Chair and other Non-Executive Directors; determination of the remuneration and allowances of the Chair and other Non-Executive Directors; and approving the appointment of the Chief Executive. Councils of Governors were introduced at a time when it was believed that Foundation Trusts would have greater financial autonomy and so required a further layer of governance. In the event, financial autonomy did not take place.

Board of Directors

1.5 The Board of Directors at the Countess, as elsewhere, is responsible for the oversight of all hospital business. It provides strategic leadership within a governance framework that should enable risk to be assessed and managed. Key issues for the Board of Directors include:

- strategy, policy and quality standards
- response to performance issues
- governance and compliance
- financial strategy, annual report and plans
- property acquisitions/disposals
- Private Finance Initiatives and major contracts
- risk management and clinical governance.

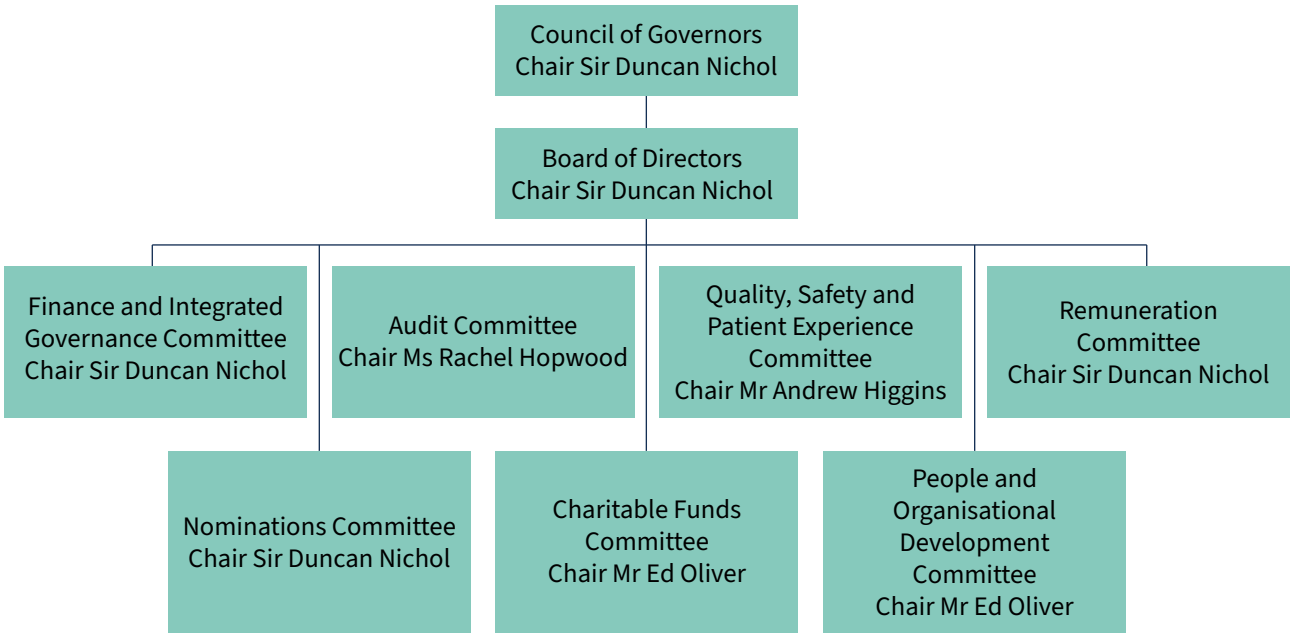
1.6 The Board of Directors may delegate any of its powers to a Committee of Directors or to an Executive Director.

1.7 At the time of the events this Inquiry is looking at, the Board committees included:

- the Finance and Integrated Governance Committee
- the Quality, Safety and Patient Experience Committee (QSPEC)
- the People and Organisational Development Committee
- the Audit Committee
- the Charitable Funds Committee
- the Remuneration Committee
- the Nominations Committee.

1.8 All committees were chaired by a Non-Executive Director. The Board received the minutes of all committee meetings. Figure 1 illustrates the committee structure at the time of these events.

Figure 1: The Countess of Chester Hospital NHS Foundation Trust committee structure, 2015 to 2017



1.9 The Board of Directors holds regular public meetings to discuss hospital business. In addition to these meetings, during the relevant period a number of Extraordinary (Private) Board Meetings took place at which the neonatal unit was discussed. These meetings took place on 14 July 2016, 10 January 2017, 13 April 2017, 2 May 2017 and 24 July 2018.

Membership of the Board of Directors

1.10 Non-Executive Directors, including the Chair, are appointed by the Council of Governors. All sit on the Trust Board and on other committees.

1.11 Independent Non-Executive Directors during the relevant period, who were allocated three days per month for their duties, were:

- **Sir Duncan Nichol CBE, Chair:** Between 2012 and 2020, Sir Duncan was Chair of the Board at the Countess. He had a long career in the NHS, including serving as its Chief Executive between 1989 and 1994. He was in that position when the nurse Beverly Allitt was convicted of four murders, three attempted murders and causing grievous bodily harm to six children at Grantham and Kesteven General Hospital in 1993.
- **Mr Andrew Higgins:** A chartered accountant, Mr Higgins became a Non-Executive Director at the Countess in November 2011. During the relevant period, Mr Higgins was Chair of QSPEC and a member of both the Audit Committee and the Finance and Integrated Governance Committee. Mr Higgins was also a Designated Officer under the Speak Out Safely (Raising Concerns about Patient Care) and Whistleblowing Policy (known as the Speak Out Safely Policy) and a member of the Speak Out Safely Committee/Freedom to Speak Up Steering Group.

- **Ms Rachel Hopwood:** Also a chartered accountant, Ms Hopwood became a Non-Executive Director at the Countess in December 2011. She was Chair of the Audit Committee and a member of QSPEC. In July 2016, she became the Deputy Chair to Sir Duncan.
- **Mr James Wilkie:** With a background in local government, he was a Non-Executive Director at the Countess from April 2013 until late 2017. This was his first Non-Executive Director role. Mr Wilkie sat on the Finance and Integrated Governance Committee and the Audit Committee.
- **Mr Ed Oliver:** His career predominantly consisted of managerial roles in the retail and business sectors. He was a Non-Executive Director at the Countess between 2013 and 2019. Mr Oliver was Chair of the People and Organisational Development Committee, Chair of the Charitable Funds Committee and a member of the Audit Committee.
- **Ms Ros Fallon:** A former nurse and midwife, Ms Fallon served as a Non-Executive Director at the Countess between May 2016 and 2024. This was her first Non-Executive Director role. During this period, she sat on QSPEC and on the People and Organisational Development Committee.

1.12 Ms Fallon was the only Non-Executive Director with any clinical experience.

Executive Directors

1.13 The Executive Directors are responsible for the operational management of the Trust. The Directors who were members of the Board during the relevant period were:

- **Mr Tony Chambers, Chief Executive:** A former nurse who moved into management, he worked in director roles in the NHS from 2004. His first Chief Executive role was at the Countess between December 2012 and September 2018.
- **Mr Ian Harvey, Medical Director and Deputy Chief Executive:** An orthopaedic surgeon, Mr Harvey was a Divisional Medical Director from 2011 and Medical Director from July 2012 to August 2018.
- **Ms Alison Kelly, Director of Nursing and Quality:** A nurse, Ms Kelly worked in lead nursing roles from 2003 and was Director of Nursing from March 2013 to June 2021.
- **Ms Sue Hodkinson, Director of People and Organisational Development (Human Resources (HR)):** Ms Hodkinson had a background in administration and HR. She was Director of HR from August 2013 to August 2019.
- **Ms Lorraine Burnett, Director of Operations:** Ms Burnett was a nurse and then moved into management roles. She was Director of Operations from February 2016 to December 2019.
- **Ms Debbie O'Neill and Mr Simon Holden, Chief Finance Officers:** Both have backgrounds as accountants. Ms O'Neill occupied the role from September 2013 and Mr Holden from January 2016 to March 2024.
- **Mr Stephen Cross, Director of Corporate and Legal Affairs:** A former police officer and qualified solicitor, he joined the Countess as Trust Secretary in 2007. His job title was changed to Director of Corporate and Legal Services in 2012. He retired from the Trust in June 2019. After a prolonged period of ill health Mr Cross died in December 2025.

Regional commissioning structure

North region

1.14 NHS England was the responsible statutory body for commissioning neonatal services. The Countess was part of the NHS England North region, which commissioned and managed contracts in the region on behalf of NHS England. The North region was divided into sub-regional hubs. The Countess came under the North West Hub and was managed by an Assistant Regional Director.

1.15 Management of the neonatal services contract with the Trust was delegated to the NHS England Regional Specialised Commissioning Team for the North. The Specialised Commissioning Team was led by a Regional Director, Mr Robert Cornall; a Clinical Director, Dr Michael Gregory; and an Assistant Regional Director, Mr Andrew Bibby. Dr Gregory and Ms Lesley Patel, the Director of Nursing, were responsible for monitoring and managing contractual performance. The Chief Nurse for the North was Ms Margaret Kitching.

Operational Delivery Networks

1.16 Operational Delivery Networks support NHS England in the provision of neonatal critical care services by coordinating care across hospitals and ensuring patients have access to specialist resources and expertise. They are also a mechanism for clinicians to share learning and are responsible for benchmarking and auditing using national data and via their sub-groups. Membership of an Operational Delivery Network was mandatory for all providers of neonatal critical care. The Northwest Operational Delivery Network was organised into three localities, one of which was the Cheshire and Merseyside locality. This included the Countess. Dr Nim Subhedar from Liverpool Women's University Hospital was the Clinical Lead for the Cheshire and Merseyside Neonatal Network.

Clinical Effectiveness Group

1.17 A key sub-group of an Operational Delivery Network is its Clinical Effectiveness Group.

1.18 Clinical Effectiveness Groups are chaired by the Network Clinical Lead and attended by the Network Quality Improvement Lead, Clinical Leads and Nursing Managers from each of the care providers in their area. The role of a Clinical Effectiveness Group is to coordinate incident reporting across the network, review mortality cases across the network and share learning gained from the reviews. The Inquiry was told that the group does not receive full presentations of individual cases and does not perform detailed reviews but assists with the development of clinical guidelines, audits and pathways of care.

1.19 The Chair of the Clinical Effectiveness Group that included the Countess was Dr Subhedar. Dr Stephen Brearey (Neonatal Unit Lead Clinician) and Ms Eirian Powell (Neonatal Unit Manager) attended the meetings on behalf of the Countess.

Child Death Overview Panel

1.20 A Child Death Overview Panel (CDOP) is a multi-agency and multi-professional panel. England is divided into geographical regions with a panel for each region. Wales has its own system. A panel will consider all child deaths from families living within its geographical region. A CDOP review takes place only once all other reviews of the death have been completed, including internal hospital mortality reviews, coronial investigations and inquests. This means the CDOP process will often occur long after a child has died.

1.21 CDOPs typically meet quarterly to review child deaths from families living within their region. An important and express purpose of the panels is to identify wider public health or safety concerns and patterns emerging from the deaths.

National organisations

DHSC

1.22 DHSC is a government department led by the Secretary of State for Health and Social Care. Its role is to support and advise ministers and to develop and implement policy for the health and social care system. DHSC oversees the NHS and has a statutory duty continuously to improve public health services. It is also responsible for legislation and funding within the public health sector.

NHS England

1.23 NHS England was set up in 2012 as part of government reforms of the NHS. It is a non-departmental public body sponsored by DHSC, and is responsible for commissioning critical care services, including neonatal services. NHS England commissions hospitals to provide care for their local communities.

1.24 In March 2025, it was announced that NHS England would be abolished and its functions centralised within DHSC. The current plan is for the transition of NHS England into DHSC to be completed in 2027. In the meantime, NHS England and DHSC are working closely together. This announcement was made just before closing submissions from the Core Participants in the Inquiry, including NHS England and DHSC.

CQC

1.25 CQC is the independent regulator of healthcare in England, established in 2009 by the Health and Social Care Act 2008. It is an executive non-departmental public body sponsored by DHSC and is accountable to Parliament through the Secretary of State for Health and Social Care. CQC is responsible for the registration, monitoring, inspection and regulation of NHS Trusts. Its purpose is to ensure that the health services provided are safe, effective, compassionate and high quality.

1.26 Regulation principally consists of monitoring and inspection. Monitoring involves ongoing review of the performance of a Trust via data, attending 'engagement meetings' where CQC inspectors meet with representatives from the Trust, and internal CQC 'management review meetings' where decisions are made about any issues for

investigation. At inspection, services provided by a Trust are assessed through five questions: are they safe?; are they effective?; are they caring?; are they responsive?; are they well led? Each of those questions is broken down into key lines of enquiry, containing questions and prompts, to be used by inspectors at inspection. An inspection report is prepared in which the services inspected are given one of four ratings: outstanding, good, requires improvement or inadequate.

1.27 CQC has been the subject of significant criticism in a number of reviews, to which I shall refer later in this Report.

Endnotes

1 Countess of Chester Hospital NHS Foundation Trust, *Annual Report 2015/16*, May 2016, page 8 (**https://www.coch.nhs.uk/media/133225/abdb_3091_coch-annual-report-2015-16-min-1-.pdf#page=8**)

Chapter 2. The neonatal unit, 2015 to 2016

2.1 Until July 2016, the neonatal unit at the Countess was designated a local neonatal unit Level 2. It provided care for babies born at or after 27 weeks' gestation and with a birth weight of 800 grams or above. As a Level 2 unit, it was also equipped to treat twins and triplets from 28 weeks' gestation or above. Babies who were born earlier than 27 weeks or those needing the highest level of care would generally be cared for in a Level 3 unit. There were Level 3 units at Alder Hey Children's Hospital and Liverpool Women's Hospital. Level 1 units provide special care and continuous monitoring, usually for babies born after 32 weeks' gestation.

2.2 The Countess was one of the larger Level 2 units in the Cheshire and Merseyside Neonatal Network and had intensive care cots. It was equipped to provide intensive care to any baby for up to 48 hours. Longer-term or more complex care would require a transfer to a Level 3 unit. Because of the unpredictability of birth, there were occasions when, due to a lack of cots elsewhere, a Level 2 unit would need to provide short-term intensive care to babies until a transfer to a Level 3 unit could be made.[1]

2.3 The neonatal unit was a separate unit within the Paediatric Department. The department had a paediatric inpatient ward with 34 beds for children up to 16 years of age, an outpatient clinic for the same aged children, clinics for babies who had required care on the neonatal unit, and clinics to which GPs and the Accident and Emergency Department could refer babies and children on an ad hoc basis.

2.4 The neonatal unit had 16 cots: 3 short-term intensive care cots, 3 high dependency care cots and 10 cots to deliver special care. There were four nurseries. Nursery 1 usually dealt with babies requiring intensive care. Nursery 2 was for high dependency babies and Nurseries 3 and 4 were allocated to special care and transitional care, that is, for babies who were being prepared to go home. Occupancy of the neonatal unit varied according to need. There were four additional transitional care cots on the maternity ward, which were looked after by midwives.

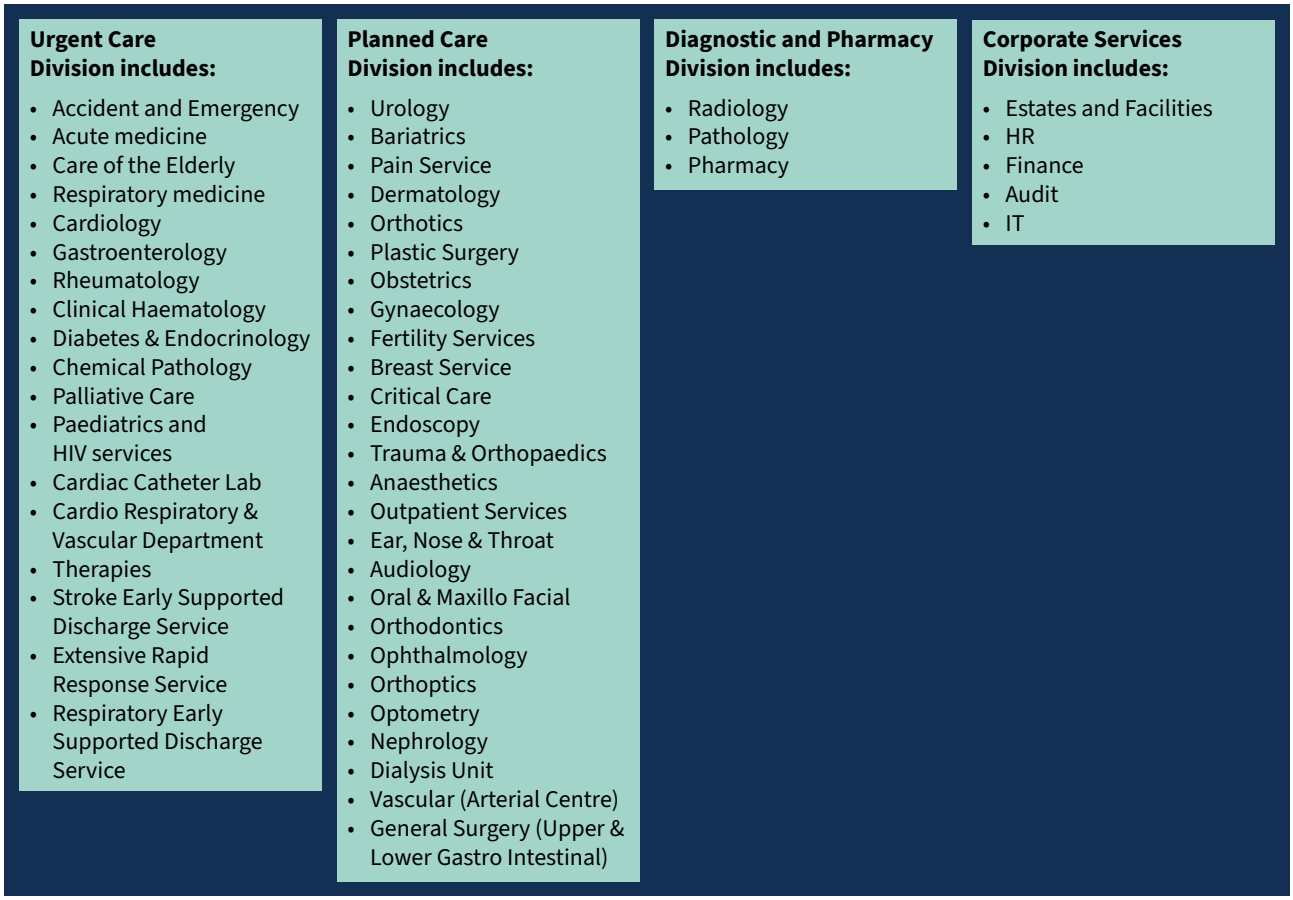
2.5 At the time of these events, the neonatal unit was cramped and outdated, had repeated problems with the plumbing and lacked facilities for mothers to stay with their babies. It was very inconveniently located on a different floor from the post-natal ward. The findings of the 2025 NHS Maternity and Neonatal Infrastructure Review show that such conditions are still common across the NHS.[2] In the absence of funding for better facilities at the Countess, a fundraising appeal, BabyGrow, was launched to raise £4 million for a new unit. Letby was the public face of the campaign. By the end of June 2016, the fundraising had stalled at £2 million, and the appeal was closed in 2017.

Funding was later 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 (see Chapter 28).

Divisional structure

2.6 When the hospital was reorganised in 2009, the Women and Children's Division was abolished along with the post of Clinical Director for Women and Children. Paediatrics (including neonatology) was placed in the Urgent Care Division with the very much larger Accident and Emergency Department. Maternity services, including obstetrics, were separated from paediatric services and neonatology, and were included in the Planned Care Division. Thus, at the time of these events, the Countess had three clinical divisions: Urgent Care, Planned Care, and Diagnostics and Pharmacy (see Figure 2). There was also a Corporate Services Division, which included estates, facilities, HR, IT and finance, as well as other corporate services.

Figure 2: The Countess divisions, 2015 to 2017



Sources: Countess of Chester Hospital NHS Foundation Trust, *Annual Report 2015/16* (https://www.coch.nhs.uk/media/133225/abdb_3091_coch-annual-report-2015-16-min-1-.pdf); Countess of Chester Hospital NHS Foundation Trust, *Annual Report and Accounts 2016/17* (https://www.coch.nhs.uk/media/145316/rjr_chester_annual_report_and_accounts_2016-17_wit.pdf#page=135)

2.7 The Inquiry heard evidence which suggested there were broadly three issues with this structure. First, it led to problems in communication and cooperation between maternity services and paediatric services. Second, it resulted in mothers and their babies being admitted to and treated in separate divisions. Third, paediatric services, and in particular neonatology, found itself as a low-priority service within the Urgent Care Division.

2.8 In his oral evidence, Dr Ravi Jayaram, a consultant paediatrician and Lead Clinician for Children's Services, described the issues as follows:

> "*We were allowed to keep a governance board but it was never clear to me where lines of escalation would go because obviously neonates sat in Urgent Care and maternity sat in Planned Care.*
>
> *It also meant that as a specialty, paediatrics and neonatology had a much smaller voice.*"[3]

2.9 Ms Yvonne Griffiths, Deputy Manager, neonatal unit (band 6 nurse), described how the structural separation affected relationships between midwives and nurses: "*Unfortunately we were in different directives so we never really mixed in any meetings together … we didn't have that cohesion that we do have now.*"[4]

2.10 Some of these problems were identified and raised at the time. For instance, at a QSPEC meeting on 20 July 2015, the minutes of the meeting recorded Dr Brearey as saying:

> "*The Trust is well placed strategically to continue and improve its maternity/ neonatal/paediatric services, however the current Divisional structure may hinder this. Colleagues continue to work across both Planned and Urgent Care Divisions with two sets of Managers and Matrons, who manage separate finance streams. There is usually no paediatric representation at the Urgent Care Divisional Board. Medical staffing concerns are agenda items but do not include paediatric medical staffing problems.*"[5]

2.11 As Figure 2 shows, at a divisional level, paediatrics was grouped with HIV services and other unrelated services, such as rheumatology and palliative care. At an administrative level, as well as HIV services, paediatrics was also grouped with human milk bank and neurology.[6] I am informed by the Countess that these services were all grouped together because there was a single business performance assistant who oversaw the management of the HIV service. I infer that this was not considered to be a full-time role and so the assistant also supported the other services, including paediatrics. It is not difficult to see how paediatrics could be overlooked.

2.12 Under the previous arrangements, the Clinical Director for Women and Children attended Board and management meetings, and regularly met the Medical Director and other clinical directors. When the post of Clinical Director for Women and Children was abolished in 2009, it was replaced by a Lead Clinician (for children's services, at the time this was Dr Jayaram), who liaised with colleagues and managers in the Urgent Care Division but had no regular meetings with the Medical Director. Nor was he part of Board management and he did not attend any other Board meetings. I find it difficult to understand how that could have been thought a wise approach. This arrangement downgraded paediatrics and neonatology in terms of management and influence. They had no direct link to the Board. At least as important, probably, was the lack of personal contact, support and discussion between paediatrics/neonatology, senior managers and

other Board members. There was almost no contact between senior managers and the neonatal unit – and reduced contact between the people working in maternity/obstetrics and paediatrics/neonatology.

2.13 The overall effect of the changed structure and administrative arrangements was to marginalise paediatrics and neonatology.

Women and Children's Care Governance Board

2.14 The Women and Children's Care Governance Board was introduced at the time of the reorganisation in 2009. I assume this was an attempt to maintain links between maternity services and paediatrics but it was not part of the governance structure of the hospital. This was a significant drawback.

2.15 The Chair of this board was Dr Jim McCormack, a consultant obstetrician and gynaecologist. The Deputy Chair was Ms Julie Fogarty, Head of Midwifery. As witnesses recognised, it would have been better had the Chair and Deputy been from different specialties. Obstetrics and maternity services were undoubtedly the bigger department, and this was reflected in their discussions, which tended to focus on obstetric and maternity issues.

2.16 Where the Women and Children's Care Governance Board wished to do so, it could refer concerns to the Executive Team via the QSPEC. Ms Kelly received minutes of the meetings. The minutes of the meetings were also provided to the Urgent Care Divisional Board, on which Ms Karen Townsend, Divisional Director of the Urgent Care Division, sat. There was very little evidence before the Inquiry that either QSPEC or the Divisional Board was effective in bringing concerns to the Executive Team.

2.17 Ms Fogarty made the point that, before the reorganisation, obstetrics and paediatrics would jointly discuss issues.[7] During 2015 and 2016, with the departments reporting through different divisional lines, silo working resulted, which hampered communication. This was entirely foreseeable. Ms Fogarty expressed the view that midwifery and obstetric staff would have been alerted to concerns on the neonatal unit sooner if they had been in one division, because there would have been more joint working and better communication.[8] She is probably right about that.

2.18 Ms Anne Murphy, Lead Nurse for Children's Services at the time, said she regarded paediatrics and neonatology as being in a "*little bubble* … [that was] *segregated from the rest of the Trust*".[9] One neonatal nurse observed, in her response to the questionnaire from the Inquiry: "[W]*e felt like we were on our own. I think people were frightened to come and help because it was such a niche area of nursing.*"[10] This was echoed by other nurses on the unit. It is understandable that an adult or children's nurse would feel diffident about looking after very small neonates, but the greater problem for the neonatal unit was its absence of profile at Divisional and Trust Board level.

2.19 Ms Yvonne Farmer, a neonatal practice development nurse (band 7) and a neonatal nurse (band 6), told the Inquiry that when neonatology was part of the Women and Children's Division, she "*personally knew*" the management.[11] However, when it was placed into the Urgent Care Division, "*there was a management tier that were quite unknown to me*".[12] She added that the management tier of the Urgent Care Division predominantly worked within adult medicine and "[s]*o I felt they didn't really know the needs of our*

unit".[13] There was also a practical change in that the senior managers responsible for neonatology were now in a separate building from the neonatal unit.[14] Proximity is usually good for relationships within an organisation. Whilst these changes would not necessarily have affected the day-to-day running of the neonatal unit, physical distance and the ill-judged structure reduced the profile of an already small unit and led to it being isolated and overlooked.

2.20 Dr John Gibbs, the longest-serving consultant paediatrician and former paediatric Lead Clinician, said: "[W]*e didn't have a good relationship with the urgent care management, not because there was anything wrong with them but we were removed from them*."[15] He also said that the consultants did not have a close relationship with the Executive Directors, whom the clinicians saw only occasionally.

Staffing levels: Nursing

2.21 The British Association of Perinatal Medicine (BAPM) had set out appropriate nursing staffing levels for use in NHS hospitals in 2010. Although the BAPM guidelines were issued to all units in 2010, there was no additional funding to help hospitals achieve these levels. The nursing staffing levels on the neonatal unit at the Countess were closer to target levels than the average across the network in the NHS North West region but did not achieve BAPM levels. Across the region, neonatal units were 27% below BAPM recommended nursing staffing levels. The figure for the Countess was 21% below the BAPM recommended levels.

2.22 The BAPM guidelines were used to support a business case to the Board for additional nursing staff for the neonatal unit in 2013/14 to no avail, and by 2015/16, changes to the staffing levels on the unit had still not been implemented.[16] Ms Powell acknowledged that the risk described as 'not compliant with staffing' had been added to the divisional risk register in June 2010, that it was an ongoing feature, and that it had been an issue for as long as she had been the Manager of the neonatal unit.[17] She encouraged nurses to file Datix forms about staffing whenever it arose. (Datix is a web-based system for incident reporting widely used by providers of NHS healthcare as part of local incident management arrangements.) Many of them did so. Ms Anne Murphy knew that there were concerns about the staffing levels within paediatrics, including on the neonatal unit.[18]

2.23 The pressure on staffing at the hospital generally (not specifically the neonatal unit) was identified by the Royal College of Nursing (RCN), which wrote to CQC pointing out staffing concerns in December 2015. CQC, which inspected the hospital in February 2016, noted the high level of bank staff (temporary staff available to take shifts when necessary) being used across the hospital generally.[19] Again, this was a feature of staffing in many NHS hospitals.

Nursing team

2.24 A small team of nurses worked solely on the neonatal unit. A day shift on the neonatal unit usually had four or five nurses on duty: two experienced band 6 nurses, one or two band 5 nurses and a band 4 nursery nurse.[20] During night shifts, there would be fewer nurses on duty, usually four.[21] The unit operated on the basis that a baby would always

have a designated nurse. Nurses who were not allocated to a particular baby would support the designated nurses, taking their place during breaks and assisting whenever necessary.

2.25 As at the beginning of 2015, Ms Powell, a senior band 7 nurse, had been managing the unit since 2011. The other band 7 nurse on the unit was Ms Farmer. Ms Farmer had that banding for 50% of her time to devote to practice development for the nurses. This involved the induction of staff, educating nurses on the unit to further their practice and facilitating the undertaking of courses. For the rest of her time, she practised as a band 6 nurse. Ms Griffiths was the Deputy Manager.

2.26 All qualified nurses on the unit (bands 5, 6 and 7) were required to undertake the Foundations in Neonatal Care course and would progress after a few years to the Qualified in Specialty (QIS) course, a neonatal nursing qualification.[22] In 2015 to 2016, there were approximately 18 band 6 nurses working on the unit; all had completed the QIS course, with some having additional qualifications (such as R23, Enhancing Neonatal Practice course). Band 6 nurses with an R23 qualification could act as shift leaders. Letby was one of two band 5 nurses who were QIS. There were also ten band 4 nursery assistant/nursery nurses.[23]

2.27 The QIS was subject to a national review in 2021 by Health Education England in light of concern about a lack of consistency across the providers in training content, standards, length and other matters.[24] There is no suggestion that any of the nurses who had achieved QIS at the Countess had received substandard training. There was good evidence that nurses were competent and encouraged to develop their skills.

Doctors

2.28 I have retained the titles used by doctors at the relevant time. The neonatal unit was served by consultant paediatricians, middle grade junior doctors (registrars) and other junior doctors who were in their early years of postgraduate training for paediatrics or general practice. Paediatric trainees were on six-monthly rotation and GP trainees on four-monthly rotation. Dr Brearey was the Lead Clinician of the neonatal unit. As I have set out above, Dr Jayaram was the Lead Clinician for Children's Services. All the doctors were based on the main paediatric ward and spent most of their time there.

2.29 There were seven consultant paediatricians supported by seven tier 1 doctors (i.e. qualified and in their third year of specialist training) and eight tier 2 doctors (i.e. qualified and in their first or second year of specialist training in paediatrics or general practice). The consultants operated a 'consultant of the week' rota, whereby each covered the children's ward and the neonatal unit once every seven weeks, Monday to Sunday. There was a consultant ward round of the neonatal unit twice a week – on Wednesday and one day at the weekend. On the other days a registrar conducted the ward round and discussed findings and decisions with the consultant of the week later in the morning. There was an on-call consultant who covered nights for the children's ward and neonatal unit from 16:30 to 08:30 Monday to Thursday. From July 2015, the consultant of the week undertook the role of on-call consultant for the children's ward and neonatal unit on a Friday night and for 24 hours on a Sunday; Saturday was covered by another consultant.

2.30 All registrars and other junior doctors worked shifts: days, weekends and nights. At night, there was always a registrar on duty whose duties were spread across paediatrics (including the main paediatric ward), the neonatal unit and the Accident and Emergency Department. Whilst some nurses said that on occasion they had to wait for a doctor to attend when called, particularly at night, because the doctors were dealing with something else on the main paediatric ward or in the Accident and Emergency Department, the overwhelming preponderance of the evidence was that, whenever there was an urgent bleep, the doctor arrived swiftly.[25] It was plain from the evidence of the junior doctors that they were able to speak to consultants at any time, including at night when the consultant was on call. Consultants also attended the neonatal unit when asked, including at night.

2.31 There was a shortage of junior doctors and consultants, as in other NHS hospitals. In late 2015, Dr ZA, a consultant paediatrician, complained vociferously to Mr Chambers about the workload in the Paediatric Department. By that stage, the consultants had already made a business case to the Executive Directors for two additional consultants for the Paediatric Department, but they had been refused. Mr Chambers visited the neonatal unit (part of the Paediatric Department) in December 2015 and saw how busy it was. Subsequently, on 27 January 2016, the Executive Directors approved a business case for the two additional consultants.[26] Dr Susie Holt, a consultant paediatrician, joined the Countess in March 2016.[27] On 20 September 2016, Dr Jayaram followed up on the delay in appointing the second consultant, and was informed that this had been put on hold but would be reviewed again after the Royal College of Paediatrics and Child Health (RCPCH) had delivered its report.[28] This report is the subject of Chapter 20. Agreement to appoint an additional consultant was given in early 2017, and Dr Michael McGuigan, a consultant paediatrician, joined in January 2017.[29] He was the Clinical Lead for the Paediatric Department from December 2018 to December 2023.

2.32 The shortage of junior doctors could not always be covered by locums as the North West region had imposed a cap on their rates of pay. Most hospitals in the region had lifted the cap and so locum doctors tended not to choose the Countess.[30] In the absence of junior doctors, consultants covered those shifts in addition to their own duties.

2.33 I heard evidence from many junior doctors who had worked at the Countess for long or short spells at this time. Their views of the neonatal unit were almost all positive, emphasising the good and supportive working relationships across the unit, including between doctors and nurses. Only two doctors expressed reservations about the culture there and felt less supported. Whilst there was some suggestion from doctors that nursing staff felt consultant ward rounds were too infrequent, the overwhelming tenor of the evidence from doctors was a perception of good relationships with nursing staff, whom they viewed as dedicated and competent.

2.34 I accept the evidence from the junior doctors that – notwithstanding the pressures, none of which were unusual for NHS hospitals – the Countess was a popular choice for junior doctors because of its location and that it was friendly, supportive and caring. The consultants were, without exception, always available to and supportive of the junior doctors.

Workload

2.35 The nurses also often worked under pressure. Ms Farmer and Ms Griffiths described peaks and troughs. Others described the workload in similar terms. All the nurses acknowledged that everyone worked to keep the unit safe. People came in to do extra shifts, worked on rest days and were as flexible as possible to make sure that there was always adequate nursing staff cover on the unit.

2.36 Some nurses described the demands on the unit as particularly high during 2015 and 2016. Mr Christopher Booth, a senior neonatal practitioner (band 6) who had worked on the neonatal unit for over 20 years, described it as:

> "*an incredibly busy period with high acuity, and it was a demanding time for all team members … I do remember team members being asked to show greater flexibility with shifts worked and indeed, even being asked to work extra shifts on a regular basis. I do remember grumblings of us needing more registered nurses to help cope with the increased workload, but that did not seem to be forthcoming.*"[31]

2.37 A band 4 neonatal nursery nurse, who had worked in Nursery 3 since 2008, recalled the period as being "*very busy and stressful on the unit … We would sometimes miss breaks because it was that busy.*"[32] Ms Minna-Maria Lappalainen, a senior neonatal practitioner (band 6), expressed the same view in rather more stark terms: "*Our staffing levels remained poor at times, especially during busy periods. This period was stressful and exhausting at times.*"[33]

2.38 A band 6 neonatal nurse noted: "*At times, it felt staff were allocated infants above their capabilities due to the workloads occurring within the unit, relying on the nurse in charge or senior nurses to oversee their work.*"[34] This concern was felt by another band 4 nursery nurse, who described being "*asked to complete tasks that I was under qualified for i.e. babies that required a band 5/6 nurse. When I raised these concerns to fellow colleagues I felt very under supported.*"[35]

2.39 A band 6 neonatal nurse in her oral evidence to the Inquiry said that, in 2015 to 2016, "*we were short-staffed*", and she went on to describe "*a lot of pressure to deliver care during that time*".[36] She explained that nursing staff would often work through their breaks and stay behind after their shift to write up notes that they did not have the chance to record during the shift. However, she also referred to manageable shifts and, like others, to "*peaks and troughs*".[37] Ms Farmer also mentioned some "*quite stressful shifts*".[38]

2.40 A band 6 senior neonatal practitioner described the unit as "*busy*" but noted that "*most of the time it was manageable*".[39] This echoed the evidence of Ms Melanie Taylor, a neonatal nurse (band 6), who described the unit as "*busy but manageable*".[40] Ms Taylor felt that the babies on the neonatal unit were all "*within our realms of knowledge and care*".[41]

Relationships in the neonatal unit

2.41 Relationships between the nurses were generally very good and supportive. Many of them socialised outside work and they formed a cohesive team on the neonatal unit. I heard evidence and read statements from qualified nurses (bands 5 (entry level),

6 and 7) and from several nursery nurses and nursing assistants, who were designated at band 4 (and were not qualified or registered nurses). Some had been on the unit for many years, were very experienced and had good insight into the functioning of the unit.

2.42 Ms Powell, the unit Manager, was well regarded by most of the nurses working on the unit. There were some complaints that she had favourites amongst the nursing staff, including Letby, and there were some nurses she did not like. As a result, nurses perceived that her favourites were given more opportunities for training and development than others. As a matter of fact, Ms Powell held Letby in high regard. She considered her highly competent, willing to work hard and to volunteer for additional shifts. She liked her and she encouraged her. I note that Ms Powell's Deputy Manager, Ms Griffiths, considered that Ms Powell was "*very neutral*" with the nurses on the unit and was a very good manager.[42] A number of nurses commented positively that Ms Powell was very supportive of them. I accept that, generally speaking, Ms Powell was a very good manager and supportive of her nurses.

2.43 I am confident that the relationships between the nurses were generally very good, as they were between the junior doctors, between the consultants and between both groups of doctors. As part of the CQC inspection in February 2016, Ms Helen Cain (Acute Hospitals Inspector, CQC) interviewed Ms Powell. The notes of her interview record Ms Powell saying, "[b]*rilliant relationship with consultants*".[43]

2.44 By the time she wrote her statement for the Inquiry in 2024, Ms Powell's tone and content were somewhat different. She wrote: "[T]*he Consultants felt that all staff members worked cohesively but that was because the staff did exactly what they were told to do by the Consultants and did not challenge them*."[44] Counsel put that comment to Dr Gibbs, the most senior consultant in the Paediatric Department. Dr Gibbs said he was "*disappointed and rather surprised*" to hear that and did not agree. In his view, Ms Powell's comment was a product of the "*strong and unpleasant difference of opinion* [held by consultants and senior nurses] *about what was happening on the neonatal unit*".[45] I accept Dr Gibbs' evidence about that, not least because almost every other nurse said the relationships with the doctors were very good until the suspicions about Letby were raised, when relationships gradually frayed. Given that Ms Powell described relationships as "*brilliant*" in 2016, it is clear that hindsight has distorted her recollection.

2.45 Most nurses considered that the generally positive culture of teamwork amongst the neonatal nurses extended to the relationships between nurses and doctors working on the unit. The view of Ms Griffiths, the Deputy Manager, was that there were no issues between the nurses and the doctors. Ms Ashleigh Hudson, a neonatal nurse (band 5), described the doctors as "*approachable*", noting they had a presence on the unit or would respond to their bleep if called.[46]

2.46 Ms Kathryn Percival-Calderbank, a senior neonatal practitioner (band 6), considered that the nurses got on well with the doctors, and commented that she felt able to tell the doctors if she disagreed with the management of a baby when such a situation arose.[47] This view was shared by Nurse W, a neonatal nurse (band 6), who described the relationships between doctors and nurses as "*professional*" and noted that the consultants were "*respectful to the nurses*" and that "*they would listen to you as a nurse and respect your opinion*".[48] Ms Taylor also considered that doctors and nurses on the

neonatal unit worked well together. She had no concerns about the communication between the two groups, viewed the consultants as approachable and "*always felt listened to by the Consultants, even as a junior nurse*".[49]

2.47 Ms Laura Eagles, a senior neonatal practitioner (band 6), recalled that nurses worked well with the doctors, particularly the registrars and senior house officers, and described the consultants as "*approachable*".[50] Ms Abigail Lever, a neonatal nurse (band 5), likewise stated that there had "*always been a really good working relationship between doctors and nurses*".[51] Ms Joanne Williams, a neonatal nurse (band 6), commented on the close working relationship the nurses had with the registrars and senior house officers, whom she recalled were present on the neonatal unit most of the time when acuity was high.[52]

2.48 Nurse Y, a neonatal nurse (band 6), described the registrars who were allocated to the neonatal unit as very experienced and as having a good rapport with the nurses.[53] As regards the nature of the relationship with the consultants, she said: "*I have worked on the unit for a long time. From a personal point of view, I feel I have a good rapport with consultants.*"[54] Ms Farmer shared these views, stating that nurses worked well with the medical team and that "*on a personal level I didn't have any problem with the Consultants*".[55]

2.49 Two nurses were less positive about the relationship with the doctors. Nurse T, a neonatal nurse (band 6), said that if she expressed a differing view to a doctor about the management of a baby, "*sometimes you felt you hadn't been listened to*".[56] Another neonatal nurse expressed frustration that, in very busy periods, the medical team was slow overnight, "*or if the team became busy on A&E* [accident and emergency] *or on the paediatrics unit*".[57] That, however, is about staffing rather than relationships, a view reinforced by Ms Ailsa Simpson, a senior neonatal practitioner (band 6):

> "*Sometimes when a baby required a senior review by a doctor, they wouldn't always be available to attend straight away as they would be reviewing patients on the Children's Ward first. Overall, despite the* [busyness] *of the NNU, the doctors and nurses on the NNU collaborated well together as a team and the atmosphere was happy at times, despite the stressful phases.*"[58]

2.50 Mr Booth, whilst considering that the unit "*could have benefitted from the expertise of a neonatologist*", described the relationship between all the professionals during this period as good: "*We were a strong, mutually supportive team and all worked well together for the wellbeing of our babies and their families.*"[59]

2.51 Having heard and read evidence from so many nurses and doctors who were working on the unit in 2015 and early 2016, I am confident that those working on the unit (doctors at all levels, nurses at all levels) respected and trusted each other and were engaged in a common endeavour to care for the babies on the unit to the best of their collective ability. Some had remarkable levels of empathy. I was particularly struck by the evidence of Ms Taylor, whose account of the way she looked after tiny babies in life and in death was very moving.

Relationships with midwives

2.52 The separation of neonatology and maternity services undermined relationships between nurses and midwives. Ms Eagles, having spoken positively about relationships between doctors and nurses on the neonatal unit, described the relationship between the neonatal unit and the obstetric teams as "*more complex*":

> "*We, as nurses, would directly liaise with midwives. There was very little communication between us and the Obstetricians. If we had challenging conversations to have, we would ask our Consultants to speak with them. We would sometimes face discord from some senior midwives and ourselves. This would be in relation to when we were heading to full capacity or already at it and the midwifery team not valuing our concerns. It could be quite a struggle sometimes when we were full and them wanting to deliver a baby that would need our care and us not having room. We would ask them for help and some appreciation of our situation but would not get it. I cannot say this was all the time but it was quite common to have a struggle when we were getting full and or closed. If we, as a NNU team, felt the best thing for the pending admission was a transfer out, it would be very difficult to make this heard by the Obstetric team.*"[60]

2.53 Ms Caroline Oakley, a neonatal nurse (band 6), also discussed the strain in the relationship between the neonatal unit and obstetric teams, particularly when the midwives/obstetricians did not accept that the neonatal unit was at full capacity and could not admit any more babies. She said that neonatal nurses would report such incidents via the online reporting system, Datix.[61]

2.54 Nurse W gave evidence that "*the senior midwives I didn't feel were very approachable*"; however, she said that some midwives were helpful and kind. She recalled receiving reports from parents that midwives would often not be available to take them to the neonatal unit to see their babies or participate in their babies' ward rounds.[62] This was also a concern expressed by some of the parents who gave evidence.

2.55 One of those parents was Mother H. She gave birth to Baby H via caesarean section and spent time as an inpatient on the maternity ward while Baby H was on the neonatal unit. Mother H required support travelling downstairs from the maternity ward to the neonatal unit until she recovered from the caesarean section. She said: "*I wasn't allowed to go on my own* [to see Baby H] *and I always had to let the midwives know if I was leaving.*"[63]

2.56 Mother H told the Inquiry there was an occasion where she had asked the midwives to take her to visit Baby H; however, she "*was told there were no midwives available because again, it was a very, very busy time*".[64] Mother H said: "[I]*t kind of felt like it was a bit of an inconvenience for me to ask somebody.*"[65] She had to wait until Father H arrived at the hospital so he could accompany her to the neonatal unit.

2.57 By contrast, other parents had a positive experience with midwives facilitating visits to see their babies. Mother E and F told the Inquiry that, when Baby E was being resuscitated, the midwife took her down to the neonatal unit. She reflected: "*I don't think I would have been with Child E if it hadn't have been for the midwife, because I heard her talking to the staff, saying, 'It's not fair, it's not right. She's his mum. She should be there with him. This isn't right. She's sat in a corridor.'*"[66]

2.58 In 2015/16, Ms Taylor "*felt intimidated*" and "*overlooked*" by the midwives and consultant obstetricians. However, she acknowledged that her perception of these colleagues has now improved.[67]

2.59 Ms Kate Bissell, a neonatal nurse (band 6), described the relationship between nurses and midwives as "*sometimes sort of difficult relationships*". In the context of dealing with babies and mothers, she explained that both professional groups "*had their agenda*" and "*communication wasn't always as good as it could be*".[68] Nurse T also described the relationship between neonatal nurses and midwives as being strained at times.[69] Ms Elizabeth Marshall, a neonatal assistant (band 4), also explained that, whilst the relationship between midwives and nurses had changed over time and was now improved, it was formerly "*them and us*".[70]

2.60 Ms Griffiths expressed the view that the relationship between midwives and nurses was not particularly strong because "*we were in different directives so we never really mixed in any meetings together … we didn't have that cohesion that we do have now*".* [71]

2.61 Ms Fogarty, the Head of Midwifery, did not accept that there were tensions between nurses and midwives. She said she did not experience any issues when she was a midwife working on the labour ward and no concerns were escalated to her subsequently as Head of Midwifery. Ms Fogarty also said she had no problems with Ms Powell, the neonatal unit Manager. Tellingly, however, she noted that they "*didn't see each other very much*" and that communication would be "*very, very infrequent*".[72]

2.62 Ms Powell described neonatal unit staff going to the labour ward for the morning update on expected admissions to the unit and being ignored.[73] Ms Fogarty acknowledged that the organisational structure, which placed the maternity unit and the neonatal unit in different divisions, was problematic, describing maternity and neonatal services as working "*independently*".[74] She also expressed the view that placing the neonatal unit in the Urgent Care Division, a large unit encompassing the Accident and Emergency Department, meant there were a lot of competing pressures within the division.[75] Her observation reflected the lowly position the neonatal unit occupied within the division and the separation of maternity and neonatal services.

2.63 Whatever the experience of the more senior midwives, it is plain on the balance of the evidence that, at this time, from the perspective of the neonatal unit, the relationship between them and the midwives was not easy. Apart from the senior midwives to whom I refer in the course of this Report, I did not hear from midwives about their relationships with the neonatal unit and I make no findings about the midwives' conduct. Some tension between units and between neonatal nurses and midwives was perhaps to be expected when, from time to time, a baby was delivered and there was no cot available in the neonatal unit. However, lack of good relationships and poor communication, both at individual level between nurses and midwives and at management level, risks compromising patient care and patient safety.

* The structure has now changed.

Relationships between nurses and senior management

2.64 Nurses' perceptions were that the executives visited the neonatal unit "*very, very infrequently*".[76] They felt that senior managers were not listening to their concerns about the workload on the neonatal unit. Staff were completing Datix forms (as directed by Ms Powell), but "*we just felt that nobody was really listening to us*".[77]

Letby

Training

2.65 Letby began her pre-registration child nursing (BSc) programme at the University of Chester on 22 September 2008. The course consisted of university-based study and clinical placements with academic staff who were registered children's nurses. Practical mentorship was provided by nurses, midwives or health visitors.

2.66 Throughout her training, feedback on Letby's performance was mixed. Early assessments pointed out areas for improvement, particularly in relation to enthusiasm, communication with families and drug calculations. Academically, her personal tutor reported no concerns.

2.67 During her second and third years, Letby was mentored by Nurse T on the neonatal unit at the Countess. Nurse T consistently praised Letby's knowledge, communication skills and engagement, stating she was among the best students she had mentored and noting no concerns about her skills or practice.

2.68 However, during her final placement in 2011, under the mentorship of Ms Nicola Lightfoot, Deputy Ward Manager of the Children's Unit, significant concerns were raised. Ms Lightfoot observed that Letby was quiet, withdrawn and struggled to build relationships with children, families and colleagues.[78] Despite Letby's efforts to address these issues, she failed a mid-year assessment and OSCE (Observed Structured Clinical Examination), and Ms Lightfoot ultimately concluded that Letby's progress remained insufficient and did not sign off on her final assessment.

2.69 After discussions and an accelerated retrieval programme, Letby passed the OSCE and qualified as a registered children's nurse in September 2011. She began working on the neonatal unit at the Countess in January 2012, initially on a temporary contract. A permanent band 5 post became available within days of her appointment. Ms Powell offered the permanent post to Letby, who accepted it.

Work and appraisals

2.70 Competencies and skills were assessed regularly at the hospital. These were usually signed off by Ms Farmer, who was responsible for training and development. The Inquiry has seen evidence that Letby passed all her assessments.

2.71 The Inquiry has seen copies of Letby's appraisals covering the period from 2011 to 2017 – with the exception of 2014/15, of which no record has been found despite extensive searches by the hospital and the Inquiry. Overall performance was assessed by Ms Powell as 'meeting expectations' for 2011/12, by Ms Griffiths as 'meeting expectations' for

2012/13, and by Ms Farmer as 'exceeding expectations' for 2013/14. She had that year completed courses in resuscitation and in ITU, with a placement in the intensive therapy unit (ITU) of Liverpool Women's Hospital.

2.72 The appraisal for 2015/16 was conducted in December 2016 by Ms Griffiths. She notes that Letby had undertaken a six-month secondment with the Risk and Patient Safety Department "*in order to develop understanding and expertise within the Neonatal Unit*". This put a positive gloss on the move off the unit in July 2016, which is dealt with later in this Report. The appraisal also records that Letby had completed a placement at a Level 3 neonatal unit. This, I believe, is a reference to observations at Alder Hey. I deal with this in Chapter 17.

2.73 It is clear that Letby was considered to be a competent nurse by those assessing her. A morphine infusion error was not mentioned in her 2012/13 appraisal.

Morphine infusion error, July 2013

2.74 On 22 July 2013, at the end of a night shift, Letby and a senior nurse set a pump to infuse ten times the prescribed amount of morphine to a baby. Whilst no harm was in fact caused, the consequences could have been extremely serious. Ms Farmer confirmed it was Letby who incorrectly inputted the rate into the pump and the second nurse checked it.[79] The error was noted by Ms Shelley Tomlins, a neonatal nurse (band 5), at the start of the morning day shift. Ms Tomlins created a Datix report for the incident.[80]

2.75 At the time of the incident, Ms Powell was on annual leave and Ms Griffiths was acting neonatal unit Manager. Ms Griffiths described the error as a "*very serious incident*" and one that could have been fatal.[81] Ms Powell gave similar oral evidence. She told the Inquiry that the consequences, if not rectified, "*could have been catastrophic*" and caused a death.[82]

2.76 Ms Griffiths commented on the difference between the responses of the two nurses. She said, "*I just remember the comparison because I know the other lady was very distraught and very upset, to the point where she was going to leave nursing. Letby, I think she was upset but not to the same extent.*"[83] Ms Griffiths pointed out that the other nurse came to find her on the day of the incident to discuss it; Letby did not.[84]

2.77 The next day, on 23 July 2013, Letby and Ms Griffiths had a meeting about the incident. Before the meeting, Ms Griffiths sought advice from her matron on how to handle the situation.[85] One of the action points from the meeting was that Letby would "[refrain] *from checking any intravenous infusions requiring additives and any controlled drugs until incident reviewed*".[86] Ms Griffiths gave evidence that she thought it was "*safe practice to stop*" Letby from doing the intravenous infusions until the incident was reviewed by a more senior member of staff.[87] This was obviously appropriate.

2.78 A further action point was for Letby to "*complete intravenous competencies/drug calculation with practice development nurse (Yvonne Farmer)*".[88] Ms Griffiths explained that the normal process following a medication error was for staff to redo their competencies before they were permitted to do the relevant activity again.[89] In Ms Farmer's view, the incident was a "*very serious error*".[90] She thought Ms Griffiths had made a "*good decision*".[91]

2.79 Ms Griffiths told the Inquiry that Letby "*wasn't happy*" about the action points of the meeting.[92] Given the severity of the error, Ms Griffiths did not deem it appropriate that Letby was unhappy.[93] Ms Farmer was asked about Letby's reaction. She could not recall a previous situation where a nurse had responded like Letby.[94] She said that the other nurse almost resigned over the error and had a number of meetings with Ms Powell.[95] Perhaps surprisingly, Ms Farmer did not explore with Letby the reasons for the error.

2.80 Ms Farmer gave evidence that she did not undertake the practice calculations with Letby until 6 September 2013.[96] On 30 July 2013, Ms Powell had a meeting with Letby and determined she could "*continue to care for infants* [with …] *infusions*" and "*is able to check CD's* [controlled drugs]".[97] Ms Griffiths stated that Ms Powell had not spoken to her about these action points. She agreed that Ms Powell's decision was a countermand to what she had decided.[98] This was an ill-judged decision given the seriousness of the error, the attitude of Letby and the clear action points set out by Ms Griffiths.

2.81 Letby's text messages provide a degree of insight into her meeting with Ms Powell. At 14:07 on 30 July 2013, Letby messaged Nurse Z, a neonatal nurse (band 5):

> "*Eirian* [Powell] *was lovely. Feels it's been blown out of proportion. Everything can go back to normal just need to do extra training on pump and have 3rd checker if setting up a CD* [controlled drug] *infusion for couple of weeks but otherwise carry on as I was.*"[99]

2.82 On 1 August 2013 at 09:18, Letby received a text message from 'Ruth', which read:

> "*Hi lucy how are you? What happened over the drug error?*"

2.83 At 09:26, Letby responded:

> "*Thankfully Eirian felt it had been escalated more than it needed to be. Everything is back to how it was I just have to have more training on using the pumps and it will be on my record for* [six] *months. She was very supportive, a case of learning to live with it now and getting my confidence back.*"[100]

2.84 I accept that drug errors are made in hospitals, but it is not easy to see how a requirement that a nurse should be asked to practise the required competencies – having been involved in the administration of a potentially fatal dose of morphine – could be described as out of proportion to the error. Ms Griffiths did not think it had been escalated more than it needed to be.[101] Letby was a very junior nurse and yet she achieved the downgrading of the response to her error.

How Letby was perceived by her nursing colleagues

2.85 The Inquiry legal team sent formal requests to 30 nurses who were involved in the clinical care or management of babies whose names appeared on the indictment around the time of an unexpected collapse and/or death. Questionnaires were sent to a further 20 nurses who worked on the neonatal unit and all 14 midwives who appeared in the hospital staff list.[102] None of the nurses or midwives had any suspicions or concerns about Letby's conduct in relation to harming babies while she worked on the neonatal unit.[103]

2.86 Some nurses spoke positively about Letby and defended her. Ms Janet Cox, a nursery nurse (band 4) in 2015 to 2016, described Letby as "[a]*n exemplary nurse who is completely innocent of all the alleged crimes*".[104] In her view, "*certain Consultants, in particular Brearey, appeared to be trying to make Lucy a scapegoat for the increased number of deaths/collapses*".[105] Nurse Y sought to point out to the Inquiry that: "*As a full time Band 5 neonatal practitioner who also worked regular overtime shifts with the relevant qualifications to care for intensive and high dependency care patients, Letby was regularly allocated the sicker infants on shift.*"[106]

2.87 Ms Ailsa Simpson, a band 6 nurse, did not have any concerns about Letby, but recalled:

> "*Letby involved herself with more babies than she needed to be involved in: For example, if a baby collapsed or required cardiopulmonary resuscitation but* [Letby] *wasn't caring for that baby she would involve herself anyway despite being told by a shift leader that she needed to look after her own babies … After the death of the third or fourth baby it was generally noted that she (Lucy Letby) was involved in each case. This was the only point that the NNU staff observed. At that point, I did not consider that she was the cause of the issues and I thought that her involvement might just have been a coincidence.*"[107]

2.88 Ms Vicky Blamire, a band 4 nurse, commented:

> "*It wasn't until finding out about more and more fatalities that questions were asked about which members of staff were present at the time as this would have had a big impact on their mental health. Hearing Lucy's name with every occasion made me feel very uncomfortable as she didn't show any kind of emotion. I remember feeling very shocked and confused as to why she didn't seem to be upset. This was very unnerving.*"[108]

Deaths on the unit

2.89 Dr Gibbs, then the most experienced and longest serving of the paediatricians, said in evidence that in the 20 years he had worked at the Countess prior to 2015, there might have been up to four or so neonatal deaths each year, although one year there had been no deaths. In the three to four years immediately before 2015, he recalled that there had been either two or three deaths each year.

2.90 In the years preceding 2015, the number of deaths on the neonatal unit was consistently low. The number of deaths against admissions from 2010 to 2014 were as follows:[109]

- 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.

2.91 In 2015, there were eight deaths on the unit from 468 admissions. Letby was charged with and convicted of murdering five babies – Baby A, Baby C, Baby D, Baby E and Baby I – between June and October 2015. She was also convicted of attempting to murder three babies: Baby B, Baby F and Baby G.

2.92 In the first six months of 2016, another five babies died. Letby was charged with and convicted of murdering two babies: Baby O and Baby P. She was also convicted of attempting to murder four babies: Baby K, Baby L, Baby M and Baby N.

2.93 Because of the increase in deaths on the neonatal unit, it was downgraded to a Level 1 unit in July 2016. The same month Letby was moved from the neonatal unit. The consultant team did not change. The next death of a neonate at the Countess was in September 2019.[110] There have been no deaths on the neonatal unit since then.

2.94 Professor Sir David Spiegelhalter OBE, Emeritus Professor of Statistics at the University of Cambridge, gave evidence to the Inquiry. He said that the probability of a neonatal unit experiencing eight deaths in 2015 was 0.008; that is, there was a less than 1 in 100 chance of that number of deaths happening by chance. It followed that eight deaths did not render the neonatal unit an outlier in neonatal mortality rates, in statistical terms. He expressed surprise at the consistently low level of deaths in the preceding five years (from 2010 to 2014). He pointed out that the increase from two or three deaths a year to eight in one year called for an investigation.[111]

2.95 It is to the events of 2015 that I now turn.

Endnotes

1 Witness statement of Jane Tomkinson OBE INQ0017158/6/para 19.2.4

2 NHS England, *Maternity and Neonatal Infrastructure Review Findings*, 11 September 2025 (https://www.england.nhs.uk/long-read/maternity-and-neonatal-infrastructure-review-findings)

3 Dr Ravi Jayaram 13 November 2024 5/21 to 6/1

4 Yvonne Griffiths 16 October 2024 77/11-15

5 INQ0003211/2

6 INQ0002594

7 Julie Fogarty 15 October 2024 169/8-17

8 Julie Fogarty 15 October 2024 65/19 to 66/9

9 Anne Murphy 21 October 2024 10/17-20

10 INQ0101068/2

11 Yvonne Farmer 16 October 2024 9/4

12 Yvonne Farmer 16 October 2024 9/14-15

13 Yvonne Farmer 16 October 2024 9/7-8

14 Yvonne Farmer 16 October 2024 9/19-23

15 Dr John Gibbs 1 October 2024 18/12-14

16 Yvonne Griffiths 16 October 2024 81/19-21

17 Eirian Powell 17 October 2024 42/7-22

18 Anne Murphy 21 October 2024 9/13-14

19 CQC, *The Countess of Chester Hospital: Quality Report*, 29 June 2016 (https://api.cqc.org.uk/public/v1/reports/7d84e4fd-bdbe-4e99-839d-df83baa36adc?20210123080129#page=4)

20 Nurse T 14 October 2024 5/23 to 6/4

21 Nurse T 14 October 2024 8/4-12

22 Nurse W 14 October 2024 75/22 to 76/10

23 Staff analysis INQ0003835

24 NHS Health Education England, *Neonatal Qualified in Specialty (QIS) Education and Training Review*, June 2021 (https://www.hee.nhs.uk/sites/default/files/documents/RSM%20Neonatal%20QIS%20Review.pdf)

25 For example, Nurse T 14 October 2024 8/13 to 10/25

26 INQ0017868/5

27 Dr Susie Holt 3 October 2024 129/20-25

28 INQ0003133/2

29 Dr Michael McGuigan 8 October 2024 77/24 to 78/3

30 Dr Huw Mayberry 2 October 2024 120/19 to 121/7

31 Witness statement of Christopher Booth INQ0098315/1/para 5
32 Witness statement of Lisa Walker INQ0017161/2/para 5
33 Witness statement of Minna-Maria Lappalainen INQ0101319/1
34 Witness statement of Belinda Williamson INQ0107824/3/para 11
35 INQ0015456/2
36 Kate Bissell 10 October 2024 174/21-23
37 Kate Bissell 10 October 2024 175/8
38 Yvonne Farmer 16 October 2024 8/4-6
39 Kathryn Percival-Calderbank 10 October 2024 127/4-8
40 Melanie Taylor 10 October 2024 10/3
41 Melanie Taylor 10 October 2024 10/21
42 Yvonne Griffiths 16 October 2024 78/19-23
43 INQ0017339/200
44 Eirian Powell 17 October 2024 22/2-8
45 Dr John Gibbs 1 October 2024 17/8-25
46 Ashleigh Hudson 10 October 2024 71/15-24
47 Kathryn Percival-Calderbank 10 October 2024 143/11-21
48 Nurse W 14 October 2024 85/19 to 86/7
49 Melanie Taylor 10 October 2024 16/25 to 17/1
50 Witness statement of Laura Eagles INQ0017489/2/para 11
51 INQ0102615/2
52 Witness statement of Joanne Williams INQ0107028/3/para 16
53 Witness statement of Nurse Y INQ0107683/12/para 45
54 Witness statement of Nurse Y INQ0107683/12/para 46
55 Yvonne Farmer 16 October 2024 7/9-10
56 Nurse T 14 October 2024 14/19
57 Witness statement of Belinda Williamson INQ0107824/3/para 12d
58 Witness statement of Ailsa Simpson INQ0018064/2/para 5
59 Witness statement of Christopher Booth INQ0098315/2/para 7
60 Witness statement of Laura Eagles INQ0017489/2/para 13
61 Witness statement of Caroline Oakley INQ0101334/2-3/para 12
62 Nurse W 14 October 2024 86/20 to 88/15
63 Mother H 19 September 2024 11/6-7
64 Mother H 19 September 2024 11/16-19
65 Mother H 19 September 2024 11/25 to 12/2

66 Mother E and F 18 September 2024 13/4-16
67 Melanie Taylor 10 October 2024 14/19 to 15/13
68 Kate Bissell 10 October 2024 179/7-13
69 Nurse T 14 October 2024 14/2-8
70 Elizabeth Marshall 10 October 2024 199/14-16
71 Yvonne Griffiths 16 October 2024 77/11-15
72 Julie Fogarty 15 October 2024 68/23 to 69/7
73 Eirian Powell 17 October 2024 13/6
74 Julie Fogarty 15 October 2024 169/8-17
75 Julie Fogarty 15 October 2024 73/9-12
76 Nurse T 14 October 2024 82/15
77 Kathryn Percival-Calderbank 10 October 2024 144/22-23
78 Nicola Lightfoot 15 October 2024 46/10-25
79 Yvonne Farmer 16 October 2024 71/14 to 72/6
80 INQ0014469
81 Yvonne Griffiths 16 October 2024 91/25 to 92/9
82 Eirian Powell 17 October 2024 61/21 to 62/1
83 Yvonne Griffiths 16 October 2024 96/20-24
84 Yvonne Griffiths 16 October 2024 93/15 to 94/3
85 Yvonne Griffiths 16 October 2024 91/20-24
86 INQ0008961/47
87 Yvonne Griffiths 16 October 2024 95/1-24
88 INQ0008961/47
89 Yvonne Griffiths 16 October 2024 96/5-17
90 Yvonne Farmer 16 October 2024 21/2-5
91 Yvonne Farmer 16 October 2024 34/1-4
92 Yvonne Griffiths 16 October 2024 99/21-22
93 Yvonne Griffiths 16 October 2024 99/23 to 100/13
94 Yvonne Farmer 16 October 2024 28/14-19
95 Yvonne Farmer 16 October 2024 72/4-13
96 Yvonne Farmer 16 October 2024 31/14-19
97 INQ0008961/45
98 Yvonne Griffiths 16 October 2024 102/1 to 103/6
99 INQ0012033/164
100 INQ0012033/171

101 Yvonne Griffiths 16 October 2024 105/4-17

102 Summary of evidence of nurses and midwives 15 October 2024 193/9-15

103 Summary of evidence of nurses and midwives 15 October 2024 211/10-12 and 213/25 to 214/1

104 Summary of evidence of nurses and midwives 15 October 2024 213/4-6

105 Summary of evidence of nurses and midwives 15 October 2024 213/9-12

106 Summary of evidence of nurses and midwives 15 October 2024 212/19-23

107 Summary of evidence of nurses and midwives 15 October 2024 211/13 to 212/2

108 Summary of evidence of nurses and midwives 15 October 2024 212/3-11

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110 Countess of Chester Hospital, 'NNU Deaths 2010 2022 deaths only' (https://www.whatdotheyknow.com/request/reconciliation_of_2018_foi_neona/response/2978208/attach/html/3/NNU%20Deaths%202010%202022%20deaths%20only.pdf.html)

111 Prof. Sir David Spiegelhalter OBE 15 January 2025 42/17 to 44/20

Chapter 3. June 2015: Baby A, Baby B, Baby C and Baby D

Baby A

Mother A and B: "*2015 was going to* [be] *the best year of our lives. We were going to become parents ... Everything was perfect.*"[1]

3.1 On 8 June 2015, just before 9pm, Baby A died in Nursery 1. Baby A was the older of twins and considered the stronger baby.

3.2 Baby A and Baby B were delivered at 31 weeks and 2 days' gestation by caesarean section in the maternity unit of the Countess. Baby A weighed slightly over 1.66 kilograms. Mother A and B remembered being told "*that my baby, for a pre-term baby, was in one of the best conditions that they'd ever seen and then hours later,* [Baby A] *died*".[2]

3.3 Baby A and Baby B were taken to the neonatal unit shortly after birth. Mother A and B, after spending time in recovery, was taken to her room. Father A and B took photographs of the babies so she could see them. Mother A and B was told to rest but was, naturally, desperate to see her babies. She was told that the doctors were trying to get lines into Baby A, so she would have to wait.

3.4 Ms Taylor was an experienced neonatal nurse (band 6) who had completed her intensive care training. She was Baby A's designated nurse for the day shift on 8 June 2015. She told the Inquiry that she had no concerns about Baby A. Baby A had had a period of respiratory support earlier in the day. Baby A was stable throughout the shift, including at handover to Letby, a band 5 nurse, who was Baby A's designated nurse for the night shift.[3]

3.5 During the course of the day, an umbilical venous catheter (UVC) was put in position for the administration of fluids. An X-ray showed it was not in the right position. It was replaced on the advice of Dr Jayaram, but the correct position was still not achieved. Dr David Harkness, a paediatric registrar, therefore inserted a long line at about 7pm.

Collapse

3.6 Nurse T, a neonatal nurse (band 6), was the night shift leader. She arrived on the unit at 19:30 for handover. Shortly after 8pm, she walked through Nursery 1. She noted that Letby was standing at Baby A's incubator with her back to Ms Taylor, who was writing up her notes.[4] Ms Taylor noticed Baby A begin to deteriorate.[5] A crash call was put out and Dr Harkness, Dr Jayaram, Dr Rachel Lambie (a paediatric and neonatal registrar)

and Dr Christopher Wood (a GP trainee) arrived. Dr Harkness removed the long line, and nurses and the doctors were involved in Baby A's resuscitation.[6] Nurse T explained she had left the unit for a "*few minutes*" and "*in the time I had been off the unit* [Baby A] *had collapsed,* [Baby A] *had no heartbeat and needed full resuscitation*".[7] In her written statement to the Inquiry, Ms Caroline Bennion, a senior neonatal practitioner (band 6), confirmed her police statement that she had worked in neonatal care for 22 years and had experienced sudden collapses before. She said that Baby A was an exception. Baby A deteriorated within minutes – within half an hour Baby A had deteriorated, then died. She described it as an "*absolute shock!*"

3.7 Ms Taylor described Baby A's death as "*extremely traumatic and difficult*".[8] She too described being in shock. In her oral evidence to the Inquiry, she described Baby A's death as "*very unexpected*".[9] Nurse T said "*it was completely unexpected*",[10] adding: "[W]*e just didn't understand how this baby that was so well had collapsed in such a catastrophic way.*"[11]

3.8 Mother A and B told the Inquiry that, prior to Baby A's death, Father A and B heard nurses "*say there's something wrong with Child A, and discussing whether they should come and get me and my partner*".[12] She went on to say: "[T]*hey came to get me when* [Baby A had] *already crashed and there was nothing more that could be done.*"[13]

3.9 The first time Mother A and B held her child was after Baby A had died. She described feeling "*traumatised*" and that there was a "*gaping hole where Child A should be*".[14]

3.10 Not only was Baby A's death sudden and unexpected; it was also unexplained. In evidence Nurse T said: "[I]*n what's now 25 years of neonatal nursing experience, I have never witnessed a deterioration in that manner that fast. And we didn't have any explanation for that.*"[15]

Skin changes

3.11 Before Baby A's death, a number of doctors and nurses had noticed an unusual rash across Baby A's body. Dr Harkness described the rash as "*an unusual blotchy pattern of well perfused pink skin over the whole of Child A's body, coupled with patches of white and blue skin*". He is also recorded as saying: "*In my professional career, this spans over 10 years. I have never witnessed or seen that pattern of discolouration on the skin prior to the collapse.*"[16]

3.12 Nurse T said of the skin changes: "*I had never seen anything like that previously and I had been doing neonates for over 15 years at that point. And I have never seen anything like it since except on* [Baby B]."[17]

3.13 The rash was something that Dr Harkness says he discussed in "*multiple conversations following Child A's death*" with registrars, senior house officers and "*possibly the consultants*".[18] Dr Lambie had been crash called to Baby A and arrived a few minutes into Baby A's resuscitation. She recalled subsequently speaking to Dr Harkness about the unusual rash that neither of them had seen before.[19]

3.14 Dr Jayaram described the rash: "*These patches seemed to appear and disappear. It wasn't like [a] rash … it would flit and reappear and disappear. It didn't fit with anything I'd ever seen before.*"[20] In oral evidence to the Inquiry, Dr Jayaram accepted that he failed

to record the unusual discolouration he observed on Baby A in the medical notes. In retrospect, he wished he had.[21] Dr Jayaram also failed to refer to the discolouration in his statement to the coroner about Baby A's death, dated 24 July 2015.[22] These were two significant failings by Dr Jayaram, not least because this was something he had never seen before, the junior doctors had also noticed it, were puzzled by it and were raising concerns about it at the time. I accept that he observed the discolouration. Whilst he may not have understood its significance at the time, he should have recorded it. At the end of his note, made at 23:25, Dr Jayaram wrote: "*Will need notes, all prescription charts and X rays for PM* [post-mortem]." There was no question of anything being held back from the coroner.

3.15 Baby A's parents were not informed about Baby A's rash. Mother A and B told the Inquiry they did not find out about it until the inquest in October 2016. She heard then that "*staff had witnessed blotching/mottling, travelling across Child A's chest and body. I was not aware of this at the time of Child A's death.*"[23]

3.16 The doctors considered whether placement of the long line or the UVC had contributed to Baby A's death, and also whether Mother A and B's blood disorder may have contributed. Dr Murthy Saladi, a consultant paediatrician, completed a coroner's authorisation form, drawing attention to a number of matters, including the siting of the UVC and of the long line.[24] Blood samples were sent to a haematologist at a London teaching hospital where Mother A and B had been treated for some time. The results were discussed with doctors at Great Ormond Street Hospital. There was agreement that Baby A's death was unrelated to Mother A and B's blood disorder. Dr Rajeev Shukla, a consultant paediatric pathologist, performed the post-mortem on 10 June 2015. He produced two post-mortem reports. He 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, which he did not consider had any role in Baby A's death. He also considered the placement of the long line and reviewed the literature, and found that it had not contributed to Baby A's death. In each report, he concluded that the cause of Baby A's death was 'unascertained'.

3.17 An inquest was opened on 23 December 2015. The inquest hearing was originally listed to be heard on 23 March 2016 but was adjourned as the evidence had not yet been received. The inquest hearing took place on 10 October 2016 before Mr Nicholas Rheinberg, Senior Coroner for Cheshire, who, having heard evidence, found the cause of death to be 'unascertained'. I deal with the inquest in detail in Chapter 24.

3.18 Letby was convicted of Baby A's murder.

Baby B

3.19 As well as being traumatised by the death of Baby A, Parents A and B were "*riddled with fear for ... Child B*".[25] Baby B weighed just over 1.66 kilograms. On 9/10 June 2015, the night shift following the death of Baby A, Baby B collapsed and required resuscitation. Baby B survived. Letby was convicted of the attempted murder of Baby B.

3.20 Baby B was being cared for in Nursery 1. Nurse T was Baby B's designated nurse. Letby had been allocated two babies in another nursery.

Collapse

3.21 At 20:00, Nurse T was satisfied with the observations and Baby B was active. In oral evidence, Nurse T described Baby B's collapse later that night as "*sudden*".[26] She said that prior to midnight, Baby B had knocked out the continuous positive airway pressure (CPAP) prongs, which were passing oxygen into the nose. As a result, Baby B's oxygen saturation dropped and an alarm sounded. The prongs were put back into position by Nurse T, who asked Dr Lambie to have a look at Baby B: "*Dr Lambie was on the unit, so we were all satisfied that it had just been because the prongs had come out.*"[27] Baby B seemed to recover. Shortly afterwards, Baby B's CPAP machine alerted again, indicating the pressure had been lost and the prongs had come out. Nurse T was drawing up antibiotics and had gloves on, so Letby attended to Baby B. Nurse T recalled Letby saying: "'*Nurse T, come over,* [Baby B] *looks like* [Baby A]*' and I went over and* [Baby B] *did have that blotchy rash and had collapsed in a similar manner.*"[28] Nurse T recalled "*worrying that we were going to be in a similar situation that we had been in the night before*".[29]

3.22 Dr Lambie received a crash bleep to attend the neonatal unit soon after midnight.[30] She attended and assisted in the ventilation of Baby B. She recorded in the medical notes: "*Had acute apnoea with no warning. Widespread purple discolouration of skin with white patches.*"[31] In oral evidence, Dr Lambie vividly described Baby B's collapse as "*so acute and so unusual*".[32] She recalled that Baby B was "*covered in a very unusual rash*" that was moving.[33] She considered whether it could be a meningococcal septicaemia, but "*that diagnosis didn't fit in this situation so nothing made sense*".[34] As Dr Lambie examined Baby B, a nurse commented: "[T]*his is the same thing that happened to Child A yesterday.*"[35] Dr Lambie successfully intubated Baby B, who improved.

3.23 Dr V, the consultant paediatrician on call, was contacted at home shortly after 12.30am. She said in evidence that Baby B's deterioration was unexpected.[36] She arrived on the unit at 00:50, shortly after Dr Lambie had successfully intubated Baby B. Dr V's clinical notes read: "*Upon my arrival purple blotchiness.*"[37] Later, at 02:40, she noted: "[P]*urple discolouration almost resolved – ?? cause – stabilised at present.*"[38] She confirmed she was puzzled by what had happened, hence the two question marks. She described the rash as "*florid and widespread*" and "*blotchy*".[39] At the time, Dr V's differential diagnosis for the rash was that it was caused by Mother A and B's blood disorder or an infection. Both were subsequently eliminated.

3.24 On the morning of 9 June 2015, Dr Gail Beech, a paediatric registrar, had discussed matters with the specialist registrar for haematology at the Level 3 unit at Alder Hey. This was just before Dr Saladi examined Baby B. That afternoon, the registrar at Alder Hey spoke again to Dr Beech. The registrar had spoken to "*'a couple' of ... consultants*" and "*they have recommended we send a coagulation screen*" for Baby B. Later on, Dr Katherine Davis, a paediatric registrar, took a call from a consultant obstetrician who had discussed the case with Professor Hannah Cohen, a consultant haematologist in London. Professor Cohen had liaised with a consultant at Great Ormond Street Hospital and said: "*feel death* [of Baby A] *is unrelated to* [Mother A and B's blood disorder] – *would advise <u>against</u>* [emphasis in original] *any clotting or antibody screening*". Another junior doctor discussed the matter with Dr V, who advised holding off on the clotting

screen that night.[40] It is likely, therefore, that Dr V was aware of the death of Baby A by that stage. Dr V conceded that she did not take any steps to investigate Baby B's deterioration.[41]

Discussions

3.25 Dr Lambie said in evidence:

> "*I do recall speaking with Dr Harkness after Child B had collapsed … because we were both very concerned about the similar nature of the collapse but particularly the unusual rash that neither of us had seen before. The children were also in very close proximity to each other, so we did discuss those concerns, were they related.*"[42]

3.26 The unusual rash/blotching on both Baby A and Baby B was a topic of wider discussion amongst the consultants. Dr Gibbs had heard about the rashes seen on both Baby A and Baby B during their collapses. In oral evidence to the Inquiry, he said: "*The rashes in Child A and Child B were very strange and worried my colleagues and some of the Registrars.*"[43]

3.27 Dr Katherine Lyddon, then a relatively inexperienced junior doctor, now a consultant paediatrician, said: "*I do recall discussions between the paediatric trainees … and NNU* [neonatal unit] *nursing staff that the rashes/skin changes seen in both babies was unusual and no one had seen anything similar before.*"[44]

3.28 Mother A and B told the Inquiry: "*When Child B collapsed, I saw mottling/blotching on* [the skin]*, as did the doctor.*"[45] She was made aware by a consultant that the rash on Baby B was unusual. She did not know then that Baby A had a similar body rash when Baby A died. In evidence, she said that if she had been told about the similarity in rashes on Baby A and Baby B at the time of collapse, she:

> "*would have demanded that something was done … for some -- a consultant to tell me they had never seen this before, that indicates that something is seriously wrong. Seriously wrong. Seriously wrong. And for it -- it wasn't just a one-off; it happened with Child A and then the very next day with Child B.*"[46]

Text messages from Letby

3.29 On 9 June at 19:03, Letby messaged Ms Taylor:

> "*Oh don't feel like that, I'm sorry you had to end your shift like that. I've said to Nurse T that I can't look after* [Baby B] *because I just don't know how I'm going to feel seeing the parents. Dad was on the floor crying Saying please don't take our baby away when I took* [Baby A] *to the mortuary, it's just heartbreaking. Glad the photos are nice X.*"[47]

3.30 From 11 June 2015, Letby sent separate text messages to a number of her nursing colleagues about Baby A's death and about wanting to be back working in the intensive care unit. This would become a pattern of behaviour.

3.31 On 11 June 2015 at 14:08, Letby messaged Ms Griffiths: "*Are you okay for staffing over the next few days? I don't have anything on if you need extra or need to change my nights X.*"[48]

3.32 At 17:35, Ms Griffiths replied to Letby that staffing was okay until Saturday, 13 June 2015.

3.33 At 17:42 and 17:46, Letby wrote: "*Ok. Think I need to throw myself back on Sat … think from a confidence point of view I need to take an ITU* [intensive therapy unit] *baby soon.*"[49]

3.34 At 17:50, Ms Griffiths replied: "*yes it does knock us a bit when things like that happen. but its ok to have time out as well.*"

3.35 Ms Griffiths told the Inquiry that she "*wouldn't really tend to have a lot of conversations like this over the phone … I don't have that experience on the unit that people say, 'Can I get back into ITU'.*"[50]

3.36 On 12 June 2015, Letby texted Ms Hudson at 10:01: "*Hi Ashleigh. You may have heard by now but wanted to let you know that we lost little* [Baby A] *on Mon. Know you looked after* [Baby A] *when* [Baby A] *was born so thought you should know xx.*"[51]

3.37 At 10:05, Ms Hudson responded: "*I didn't know actually, thanks for letting me know Lucy. That's terrible! How is* [Baby B]*? xx.*"

3.38 At 10:08, Letby replied: "*It was awful.* [Baby A] *died very suddenly & unexpectedly just after handover. Not sure why, it's gone to the coroner. Child B went off Tue night & was intubated but back on cpap now. They are querying a clotting problem. Very sad. X.*"

3.39 At 10:23, Ms Hudson responded: "*Oh god,* [Baby A] *was doing really well when I left.*"

3.40 At 10:27, Letby replied: "[Baby A] *had a really good day on Mon then I took over Mon night &* [Baby A] *passed away at 20:58 after 30 min resus. Just collapsed very suddenly.*"

3.41 At 10:37, Ms Hudson replied: "*It's so terrible, and I'm sorry it happened while you were taking care of* [Baby A]*. You're not having a great run at the moment!*"

3.42 At 10:41, Letby wrote:

> "*I wasn't supposed to be in either, Yvonne* [Griffiths] *swapped my night as unit busy! But these things happen unfortunately. Parents were there during resus. They had them both baptised then spent the night sitting with them both. I took pictures, hand/ foot prints etc. They are beside themselves worried that they will lose Child B too.*"

3.43 In her evidence, Ms Hudson said she could "*vividly remember*" the text message exchange because it was "*the first time a patient that* [I'd] *looked after had then passed away. I was also a bit angry because I didn't think it was appropriate to get this information by text.*"[52] She explained that she "*felt like it was too much information … that process afterwards is a very important and sensitive time. I don't -- didn't feel like I needed that information.*"[53]

3.44 On 13 June 2015, at 21:48, Letby wrote to Ms Jennifer Jones-Key, a neonatal nursery nurse (band 4): "*I just keep thinking about Mon. Feel like I need to be in* [Nursery] *1 to overcome it but Nurse W said no x.*"[54]

3.45 At 21:51, Ms Jones-Key replied: "*I agree with her don't think it will help. You need a break from full on ITU*."

3.46 At 21:55, Letby replied: "*Just feel I need to be in* [Nursery] *1 to get the image out of my head, Mel* [Taylor] *said the same and Nurse W let her go. Being in* [Nursery] *3 is eating me up, all I can see is* [Baby A] *in* [Nursery] *1 X.*"

3.47 At 21:56, Letby wrote: "*It probably sounds odd but it's how I feel X.*"

3.48 Ms Jones-Key replied: "*Well it's up to you but don't think it's going to help. It sounds very odd and I think I would be the complete opposite. Can understand Nurse W she is trying to look after you all x.*"

3.49 Ms Taylor was referred to these messages when giving evidence. She denied requesting to be back in Nursery 1. She commented: "[M]*y personal experience was I found it* [Baby A's death] *extremely traumatic and difficult. I found it difficult to go back into work. And I wouldn't have wanted to voluntarily go back into Nursery 1.*"[55]

3.50 Mother A and B said there were "*several text messages* [of Letby's] *that came out through the trial that were lies*".[56] She gave the example of Letby saying in a text that Father A and B had collapsed to the floor when Baby A was taken to post-mortem. This was a reference to the text message Letby sent to Ms Taylor on 9 June 2015, including the words: "*Dad was on the floor crying Saying please don't take our baby away when I took* [Baby A] *to the mortuary.*"[57] Mother A and B was clear that that was not true and did not happen. In her view, Letby's messages were "*attention seeking*" and a "*red flag*". I agree with her.

Baby C

Mother C: "[T]*o hold him was a really big thing for us. It was very emotional, and I -- you know, I hadn't had a baby before, and I didn't really anticipate all the feelings that I would have when I held him, and that immediate bond that you feel that, you know, I couldn't describe now but I certainly didn't anticipate. It was a really amazing feeling.*"[58]

3.51 Baby C was born by caesarean section at 30 weeks and 1 day's gestation. His growth in the womb had been slow and he weighed 800 grams at birth, a low weight for this gestation. Mother C said that she and her baby were:

> "*very closely monitored under the care of foetal medicine, that was predominantly Jim McCormack, and the foetal medicine midwife at the time was Jill Ellis* [an advanced midwife practitioner]. *They saw us very regularly and gave us really excellent support, we were very grateful for that, but the pregnancy was very precarious, really. The scans were to monitor growth but also to monitor blood flow to weight, up until the point where the situation was critical and the baby would need delivery.*"[59]

3.52 During the course of her pregnancy, Mother C asked Dr McCormack whether she needed to be transferred to somewhere like Liverpool Women's Hospital or a different unit. Dr McCormack reassured her that he did not feel that was necessary. He would continue to monitor things closely and, if that changed, he would change the plan.

3.53 Baby C, though very small, was born in good condition; no resuscitation was required. He was taken to Nursery 1 on the neonatal unit. Dr Sally Ogden, a paediatric registrar, told his mother in theatre that Baby C was "*doing really well, he was born in good condition*".[60] Dr Ogden also told her that Baby C was ventilated for a brief period and then began breathing by himself.

3.54 Like Mother A and B, Mother C was unable to see her baby for some time after birth – in her case because the midwife had told her that she had to be able to stand up unaided to go and see him. She had had an epidural injection and a caesarean section. Obviously, she could not stand up. It may be that the midwife thought she should rest, but she had not seen her baby; nothing would have been more important. She could and should have been taken down to the ward (which was on a different floor) in a wheelchair. After six or seven hours of not seeing her newborn baby and of receiving updates from her husband and the doctor, she forced herself to stand, "*because I needed to go and see him*".[61]

3.55 Mother C said that, in the days after Baby C's birth, she and her husband saw a lot of Dr Gibbs. He was very open and honest with them. He said that Baby C was:

> "*very small for his gestation and that that represented certain risks such as an increased risk of developing infection and an increased risk of a particular bowel complication called necrotising enterocolitis, but that he was born in very good condition, he was making good progress, and he was doing well. He expressed to us that although babies of … that size at that gestation -- were at risk of these complications that, his prognosis was good and that he was not expected to die.*"[62]

3.56 Nurse W was the team leader for the night shift of 13/14 June 2015 and it was her responsibility to allocate nurses to the babies. Ms Sophie Ellis, a neonatal nurse (band 5), was Baby C's designated nurse that night. Ms Taylor was also working in Nursery 1, caring for a different child and overseeing Ms Ellis, who was less experienced. Letby was working on the night shift but was caring for a different child in Nursery 3. Letby made it clear to Nurse W that she wanted to be in Nursery 1 rather than Nursery 3. This was consistent with her text messages and her later behaviour.

Collapse

3.57 When the alarm sounded for Baby C, Ms Sophie Ellis went from the nurse's station into Nursery 1. Letby was already there, standing next to Baby C's cot. A short time later, Baby C had a prolonged period of bradycardia and desaturation. The nurses started resuscitation and put out a crash call for the on-call doctors. Ms Ellis recalled Letby saying, "*He's going*."

3.58 Dr Davis, a registrar, had "*received a 'crash call'*" to attend to Baby C at about 11pm.[63] When she arrived, resuscitation was already under way. As the senior doctor, she took over leading the resuscitation attempts and asked for the on-call consultant, Dr Gibbs, to be alerted and to attend. She told the Inquiry:

> "[T]*here was no obvious explanation as to what may have caused Child C's unexpected collapse … The lack of explanation for the collapse was unusual but more unusual was the lack of response to resuscitation and the complete lack of a heart rate at the time of my arrival. I had managed a number of neonates in need of resuscitation by that point in my career, and they usually have a slow heart rate, rather than an absent*

> *one …* [T]*he total absence of a heart rate despite effective airway management, chest compressions and resuscitation medication* [was] *not something I had experienced before, or indeed since.*"[64]

3.59 Dr Gibbs arrived ten minutes into the resuscitation.[65] He described how Baby C failed to respond to resuscitation and was then given "*a limited form of resuscitation*" in order to await attendance of the chaplain to baptise Baby C. He and Dr Davis noted that, during this period, Baby C "*began to make occasional, abnormal gasping respiratory efforts and a slow heart rate was heard intermittently*". However, after discussion with his parents, it was agreed that no further full resuscitation would be offered. Baby C died several hours later at 05:58.

3.60 Dr Davis said:

> "[W]*e stopped chest compressions and ventilation breaths … Child C continued to show signs of life with some spontaneous breaths and a good heart rate. The fact that this happened following a prolonged period of chest compressions without the use of medication and without any response to earlier efforts when drugs were used was highly unusual. I was unable to think of any medical explanation why this had happened. I would have discussed this with Dr Gibbs.*"[66]

3.61 Mother C gave evidence that, at around 11pm on 13 June 2015, she was woken up by a panicked midwife "*telling me that I needed to come immediately because my son had become unwell really quickly*". She got herself to the room where Baby C was and "*was faced with … it was awful … There were medical personnel everywhere.*"[67] The only one she knew was Dr Gibbs. She recalled that when she arrived on the neonatal unit, staff were performing CPR on her baby. She sat down. A nurse asked her if she would like her to call a priest. Mother C recollected asking the nurse: "'*Do you think he's going to die?' And she said, 'Yes, I think so.' And at the time -- you know, as I say, I didn't know this nurse's name, I hadn't seen her before, but I believe this was Lucy Letby.*"[68]

3.62 Mother C confirmed that limited resuscitation continued until the priest arrived and baptised Baby C some 50 minutes later.* Afterwards, Parents C went to the family room with Baby C, where they held him for several hours until he died. Some other family members were with them, including Baby C's maternal grandmother. During the hours that Baby C was alive, his mother was sure that he was in pain. She insisted that he be given some pain relief, which was, in the end, administered, and he settled peacefully for his final hours.[69]

3.63 Mother C said that at this time two nurses were coming in and out of the family room while Baby C was with his family. One was Ms Taylor, to whom the care had been transferred, and the other was Letby.[70] Mother C explained that they were:

> "*creating things for a memory box. So taking Child C's hand and footprints, taking a bit of his hair, and checking on us. So my understanding at that time was that they were designated to do that, and it was only at the criminal trial that I realised that*

* When reviewing this death, Dr Gibbs advised a change so that, where a priest was not available, a member of staff should carry out a baptism; see **INQ0000108/27**.

that was not the case, that Lucy Letby was specifically designated not to do that, and she was supposed to be somewhere else and was repeatedly told to be looking after a different child."[71]

3.64 Nurse W explained in evidence that, having assisted with the resuscitation, Letby "*kept trying to help Melanie Taylor, who is more senior than her and more than capable*". Nurse W noted that on several occasions she had to insist that Letby return to care for her allocated child.[72] Nurse W described Letby as "*consumed with Baby C and wanting to be in the family room with Baby C and that family even though I distinctly asked her to not be in there*".[73]

3.65 Nurse W was concerned about Letby assisting Ms Taylor to take Baby C's hand and footprints following his death, rather than caring for her allocated child. In oral evidence, Nurse W stated: "[S]*he* [Letby] *didn't need to be there. Mel* [Taylor] *was more than competent to be there at that family support.*"[74] Ms Taylor, in her evidence to the Inquiry, said that Letby "*wanted to help rather than look after the baby she'd been allocated*".[75]

3.66 Nurse W discussed the incident with Ms Taylor during the night and with Ms Powell, her manager, the next morning. Nurse W reported Letby not following instructions to Ms Powell and informed her that babies' care in Nursery 3 was compromised as a result.[76] Nurse W said she would have expected Ms Powell to speak to Letby about her behaviour; however, she did not know if this happened. She could not recall receiving any feedback from Ms Powell about her concern.

3.67 In oral evidence, Ms Powell emphasised the importance of an allocated nurse staying with their child.[77] She acknowledged that Nurse W had informed her that Letby was not staying with her allocated child and was instead trying to be involved in Baby C's bereavement care. She said Letby's behaviour was a serious breach of protocol.[78] Despite this, Ms Powell had no recollection of speaking to Letby about the incident.[79] It is most unlikely that she did so. She did, however, recall that she "*asked Nurse W to do a Datix and have it documented*".[80] However, the Datix report that was completed was in relation to Letby's allocated child under the category of delayed treatment. Nothing was done about Letby repeatedly ignoring directions from the shift leader and leaving the other child to intervene with Baby C. This was a failure by Ms Powell for which she had no explanation. It is likely that her judgement was affected by her view that Letby was a very good nurse (she was later to describe her as the "*crème de la crème*") and that she was always available for extra shifts.[81]

Letby's final intervention with Baby C

3.68 Mother C said that, while Baby C was still alive, Letby prompted her to put him in a ventilated Moses basket, known as a cold cot. Mother C recalled: "*I remember the cold cot being plugged in … we were in this really difficult situation where, you know, our son was dying, and it was certainly jumping the gun to bring that in and plug it in.*"[82] Father C was rightly very curt with Letby, who swiftly 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.*"[83]

3.69 Ms Taylor was not in the family room when the incident with the cold cot happened. She first heard about it during the criminal trial. She stated that she was "*horrified*" to hear that Letby had said words to the effect of: 'It's time to say goodbye now and put him in this cot.'[84] In her view, it was an "*uncompassionate and cold*" comment. It was not aligned with the team's ethos of following grieving parents' wishes to spend time with their child or make memories.[85] Similarly, Nurse W was "*absolutely horrified*" and "*deeply upset*" to learn about the incident.[86]

Responses to Baby C's death

3.70 In oral evidence, Dr Gibbs confirmed that Baby C's death on 14 June 2015 was sudden, unexpected and unexplained.[87] He added that in his 21 years' experience, sudden and unexpected deaths were "*occasional, every few years*".[88]

3.71 Letby was convicted of the murder of Baby C.

3.72 Ms Sophie Ellis was stunned by the collapse and death of Baby C, recording in her police statement: "[W]*e don't know, even now what caused Child C's collapse and ultimate death.*"[89] Ms Ellis recalled that, following the death of Baby C, there was an informal debrief at the end of the shift.[90] A more formal debrief was then led by Dr Gibbs some weeks later on 2 July 2015.[91] An email was sent out by Ms Powell, Manager of the neonatal unit, to Letby and the other nurses on duty, inviting them to attend "*only if you want to*". The notes of this debrief are in Baby C's medical notes. It is recorded that Ms Powell, Ms Taylor, Dr Davis, Ms Ellis, Dr Gibbs and Letby attended. There was a discussion about the events leading up to Baby C's death and that he "*did not seem unwell*".

3.73 Dr Gibbs said in evidence that Baby C had been born in a good condition at 30 weeks and 1 day and was expected to survive. From a respiratory point of view, Baby C was improving in the days leading up to his collapse and would not have been expected to have any significant problem at that stage from his breathing. Dr Gibbs also noted that blood cultures did not show any sign of infection, something confirmed in the post-mortem.[92] Dr Gibbs pointed out that Baby C showed no response to resuscitation. In oral evidence, he explained this reaction would be expected in a child who had been poorly for a while and had no reserves left. However, this was not the case with Baby C. Dr Gibbs said: "[I]*t is unusual from a sudden collapse in the baby that was managing well beforehand not to get a response to resuscitation.*"[93]

3.74 Dr Gibbs referred Baby C's death to the coroner's office.[94] He explained that he did this because he "*didn't know why Child C had collapsed and died*".[95] A post-mortem examination was carried out at Alder Hey on 16 June 2015 by Dr George Kokai, a consultant paediatric pathologist. On 14 August 2015, Dr Gibbs spoke to Dr Kokai on the phone about his preliminary findings about Baby C. Dr Gibbs explained in evidence that Dr Kokai considered Baby C had died from myocardial ischaemia, and that the heart damage had predated and could have caused Baby C's collapse.[96] Dr Gibbs explained to the Inquiry that he:

> "*wasn't sure whether the damage to the heart that was noticed on this postmortem would have all happened at and after the resuscitation or whether it happened before. It was Dr Kokai's view that the damage to the heart had happened before the resuscitation and therefore caused the collapse but it didn't fully explain it because I then asked 'but why did the damage occur to the heart?'*"[97]

Dr Gibbs added that myocardial ischaemia "*didn't quite fit together*" with Baby C's history.[98]

3.75 A coronial investigation was commenced for Baby C on 14 June 2015. Dr Kokai's post-mortem report was received in November 2015; he had concluded there was a natural cause of death. As a result, the investigation was discontinued on 26 November 2015.[99]

3.76 Although he was not satisfied by Dr Kokai's explanation for Baby C's death, Dr Gibbs did not have any concerns about deliberate harm at the time. He explained: "[S]*adly it had been my experience even after postmortem it is not always possible to explain a death and that is occasional.*" However, he added: "[W]*hen that situation keeps arising, something very strange is happening.*"[100]

Other reports and reviews

3.77 Baby C's death was reported as a Datix incident by Ms Griffiths. The Datix description refers to the "*sudden deterioration of an infant following full resuscitation*".[101] In fact, Baby C deteriorated suddenly and then did not respond to full resuscitation. Nothing turns on this error.

3.78 The death of Baby C was also referred to an Executive Serious Incident Review to be held on 2 July 2015, at the same time as a review of the death of Baby A and the death of Baby D (who died eight days after Baby C).[102] See further in Chapter 4.

3.79 The death of Baby C was reported to the CDOP on 15 June 2015. There was a significant backlog of cases, so Baby C's death was not reviewed by the panel until 23 March 2016. The panel identified no issues, made no recommendations and identified no learning points or actions.

3.80 In her evidence, Mother C said: "[T]*hat night* [Baby C died] *and everything that has happened since have left an indelible mark*."[103]

3.81 She told the Inquiry: "[T]*hat there had been another death that week, I had no idea until the criminal trial. I had no idea that there were various text messages flying around about the death of our son and the other collapses.*"[104]

Baby D

Mother D: "*My pregnancy was smooth, apart from the odd pain that people get. There was no concern, no issues. I was towards the end of my pregnancy just over three weeks, so my daughter was a good size baby. She was pretty much -- I was almost full term so everything for me was in place. Everything was ready. The nursery was sorted. I crafted everything in the room. I painted, I decorated, I made everything. Only we knew the name, so we had like a little reveal ready. Everything was ready in the house. So we were just on the little cloud nine.*"[105]

3.82 Mother D and her husband had been looking forward to the birth of their baby. The pregnancy had been straightforward and was at 37 weeks and 1 day's gestation.

3.83 Mother D's waters broke at 03:30 on 18 June 2015. She went into the maternity unit at 11:30, was monitored and then advised to go home until her contractions started. She was told she would be booked in for the following morning. Mother D returned to the hospital on 19 June. She was concerned about infection because it was now 30 hours since her waters had broken. She was admitted and received treatment during the day. Contractions did not begin. Mother D was started on an intravenous induction on 20 June. Labour did not progress and Mother D became more and more anxious, repeatedly asking for a caesarean section as she was worried about her baby, she was exhausted and labour was not progressing. She told me that midwives dismissed her concerns and told her to be patient. She felt she was not listened to. A doctor tried to reassure her but then agreed to perform a caesarean section because labour was not progressing. Mother D said that it felt like a real emergency. 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. After a short while, Mother D was concerned about Baby D because she was grunting and appeared floppy. She was observed by nursing and medical staff over the next three hours, and at 19:00, Baby D was admitted to the neonatal unit on Nursery 1, antibiotics were administered and she was given light therapy for a period.

3.84 Ms Oakley was the designated nurse for Baby D on the night shift of 21/22 June 2015. Letby was caring for two different babies in Nursery 1. Ms Oakley said in her witness statement to the Inquiry: "*Dr Brunton reviewed Child D at the start of his shift, and he was happy with her status too*."[106] Dr Andrew Brunton, then a paediatric registrar, now a consultant neonatologist, confirmed that he had reviewed Baby D at 21:10 and was not concerned for her. Mother D said that Dr Brunton reassured her and her husband that "*everything'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 said: "[T]*hey said: if all carried on, continue expressing milk, and if all carries on, tomorrow morning you can breast feed her and you can have a cuddle and that's that. She's on her way to recovery … full recovery.*"[107] Mother D could see that her daughter looked better and went back to bed.

Collapse and skin changes

3.85 At 01:30, Baby D unexpectedly collapsed. Ms Oakley was called back to the nursery by Ms Percival-Calderbank, who had been covering her break.[108] Dr Brunton was paged to attend the neonatal unit to examine Baby D. Dr Brunton attended immediately: "*I noted that there were significant areas of light brown/dark brown and black lesions tracking across the trunk. Given that that the rash itself was unusual, in conjunction with the short episode of increased support for Child D's breathing, I contacted the Consultant on Call.*"[109] Dr Elizabeth Newby, a consultant paediatrician, was the consultant on call.

† The Apgar score is used to assess the condition of a baby at birth. It considers five factors, each scoring from 0 to 2: Appearance, Pulse, Grimace, Activity and Respiration. A score of 10 is not common. A score of 7 or above is reassuring.

3.86 Both Ms Oakley and Ms Percival-Calderbank referred to the unusual skin discolouration of Baby D, described by Ms Oakley as blotchy and appearing over the trunk and top of her legs. Ms Oakley's evidence was that "*around that time there was a cluster of similar rashes that had appeared on other babies on the unit*".[110]

3.87 Dr Emily Thomas, then a junior doctor (paediatric specialty trainee), who was also on the night shift, recalls being called from the children's ward by Dr Brunton because Baby D had a very unusual rash. Dr Brunton told her that he had never seen a rash like this before and asked if she had. In her statement to the Inquiry, Dr Thomas, now a consultant paediatrician, confirmed that she had not seen a rash like that before, but given that she was very junior, there were many things she had not previously seen. Importantly, however, she said that she had not "*seen such a rash since*".[111]

3.88 Mother D recalled staff being unsure about the cause of the rash on Baby D. She told the Inquiry: "[T]*he mottling on my daughter, -- they told me clearly they don't understand, they've never seen this, they don't know what's going on*."[112]

3.89 Dr Brunton requested abdominal X-rays and blood tests and discussed these with Dr Newby.[113] Baby D initially improved and was considered stable by Dr Brunton at 02:35. At 03:15, she deteriorated again and Dr Brunton was recalled. Again, she stabilised. However, at 03:45, Baby D collapsed for a third time and stopped breathing. Letby was present at the resuscitation of Baby D.[114] Dr Thomas was already on the unit and she assisted with the resuscitation. At 03:55, Dr Brunton was called back to the unit. He attended and asked for Dr Newby to be recalled. Dr Brunton had called her because, as well as the unusual rash and the need for increased breathing support for Baby D, he "*had concerns that this was an unusual pattern of behaviour for a baby who had been clinically stable previously*".[115] He went on to say: "*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 … Child D's episodes of deterioration and subsequent death were completely unexplained.*"[116] In her evidence to the Inquiry, Dr Newby referred to lesions on Baby D's abdomen and explained that she considered Baby D's death to be an unexpected event that she could not fully explain.[117]

3.90 Mother D was woken up by one of the nurses, who told her: "*You need to come now, your daughter is very poorly.*"[118] She arrived on the neonatal unit to the sight of Dr Brunton holding Baby D and trying to save her. Baby D did not recover, and at 04:25 on 22 June 2015 she died. Parents D were told that there would need to be a post-mortem. Mother D remembered: "[W]*e were told that's because they don't understand what happened, and why it happened. So they need to investigate.*"[119]

3.91 Ms Oakley described Baby D's death as "*unexpected*", saying: "*I remember feeling happy with her at the start of the shift … I remember thinking she looked well*."[120]

3.92 Letby was convicted of the murder of Baby D.

3.93 Dr Newby said in evidence that she had independent recall of the last 24 hours of Baby D's life because "*it'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*".[121] She described Baby D's death as "*very difficult and traumatic*" for staff working that night shift.[122]

3.94 Mother D said that she felt that Letby was observing them when they were with their daughter after her death. She described Letby as out of place and that her presence made Mother D feel uncomfortable.[123] Mother D said that later, at the criminal trial, she:

> "*found out that* [Letby] *looked us up, both my husband and I … she should have had no reason to go and look us up. And the conversations she had by text message with colleagues about my daughter and how she called this 'fate', and that 'sometimes things happen', this I found shocking, because after what she's done, this is disgusting.*"[124]

Report to the coroner

3.95 Dr Newby reported Baby D's death to the coroner's office on 22 June 2015. She could not recall the exact details of the conversation; however, she thought that she would have reported that "*it was an unexpected event that I couldn't fully explain*" and that she "*wanted a postmortem in order to for everybody, really, for myself and for the family to -- to help everybody to understand what had happened*".[125] Dr Newby stated that she would also have mentioned the lesions on Baby D's abdomen. Her account is confirmed by the coroner's authorisation form, which sets out the information reported by Dr Newby: "*Dr cannot offer COD* [cause of death] – *sudden and unexpected.*" Under the heading 'additional information', it is recorded: "[J]*ust before 4am, she went profoundly mottled and apnoeic, lost heart rate.*" Dr Newby also informed the coroner of the deaths of Baby A and Baby C and the collapse of Baby B. The form reads: "*Reported that this had been 3rd death in 12 days for neonatal. Also a further episode of apnoeic event and CPR for previous twin death; surviving twin had successful CPR.*"[126]

3.96 On 23 June 2015, Dr Jo McPartland, a consultant paediatric pathologist at Alder Hey, conducted a post-mortem of Baby D. The original report was dated 26 August 2015. Dr McPartland then produced a supplementary report on 17 September 2015. She concluded that Baby D's cause of death was pneumonia with acute lung injury.

3.97 Despite reading the information on the form about three deaths in 12 days and a further episode of apnoeic event and CPR, Dr McPartland did not think this was enough to raise suspicions. She stated: "*I wasn't informed that the same staff member was involved.*"[127] She considered that, in order for concerns of deliberate harm to be picked up at the coronial stage in the referral, it would require someone directly to say: "[T]*here is an increased number of worrying deaths and we are worried that the same staff member has been involved in all of them.*"[128] Dr McPartland told the Inquiry that she would need a "*strong clinical steer that it was a suspicious case to warrant insisting on police and forensic pathology involvement*".[129] As a result, she treated the fact that there had been three deaths and a non-fatal collapse in 12 days as irrelevant to the post-mortem. She did not seek to discover why this information had been provided when she did not consider it relevant. It is likely that had she asked, she may have been told: 'Three deaths is the equivalent of our usual annual number of deaths. They were all unexpected and we are worrying about them.' Nothing would have been said about an individual nurse because Dr Newby did not have those concerns at that time, nor did anyone else. She would have described Baby D's death as "*very unexpected*"[130] and, at the time, she thought she was "*working within a medical model, there was evidence of sepsis*".[131] It is unlikely therefore that Dr McPartland would have arranged a forensic post-mortem.

3.98 Dr Newby's letter to Parents D, dated 19 August 2015, summarises their meeting on 17 August 2015 and records that the post-mortem results were not yet available. Dr Newby wrote: "[W]*e felt as a department that the most likely diagnosis was one of sepsis, ie; overwhelming infection.*"[132] The letter also records that Dr Newby and Parents D "*discussed the aetiology of the rash which is documented to have appeared during Child D's first episodes of deterioration. This appeared to look like bruising under the skin and we discussed that this was likely a sign of the effect the infection was having upon Child D's circulation.*"[133]

3.99 Mother D said in evidence that she challenged Dr Newby about the sepsis diagnosis: "*I said, 'Well, you explain this to me because if an infection is that overwhelming that it will kill a baby but doesn't show on the reading, this does not make sense. She was getting better. Not getting worse. Again, explain.' She couldn't explain.*"[134] Dr Newby confirmed this discussion took place between her and Mother D and acknowledged that sepsis did not appear in the test results. She said: "[A]*lthough we felt that* [Baby D] *did have an infection and she was septic as she presented that way, the blood cultures hadn't proven that.*"[135]

Text messages from Letby

3.100 At 08:39 on 22 June 2015, a few hours after Baby D's death, Letby texted Nurse T: "*We lost Child D.*" Nurse T responded: "*What!!!! But she was improving. What happened.*" At 08:41, Letby told Nurse T via text that Baby D "*came out in this weird rash looking like overwhelming sepsis*".[136] Nurse T told the Inquiry that reading Letby's message did not make her think of the rash on Baby A and Baby B because, in her opinion, the rash on the twins did not look like a sepsis rash.[137]

3.101 At 08:48 on 22 June 2015, Nurse T messaged Letby, stating: "[Y]*ou've had it all recently.*"[138] In oral evidence, Nurse T explained what she meant by this message: "*I knew she was there for* [Baby] *A, I knew she was there for* [Baby] *B, because she was with me. I knew she was on duty when Child C died because she told me, and here we are, what, within a fortnight, and she's there for Child D as well.*"[139]

Dr Brearey and Ms Powell: Mortality review

3.102 On 22 June 2015, the day Baby D died, Dr Brearey met Ms Powell to conduct a mortality review into Baby D's death. Ms Powell said that she and Dr Brearey discussed whether one person was there for all the deaths because they were suspicious about three deaths happening so rapidly and unexpectedly. She thought that it was Dr Brearey who raised this first.[140] Dr Brearey thinks it was Ms Powell. It does not matter which of them it was. They were both thinking along the same lines at that point and Letby's presence was acknowledged at that time. The shift patterns were not written down until 23 October 2015, the day Baby I died.

3.103 At 19:41 on 22 June 2015, Dr Brearey sent an email to Dr Jayaram, copied to Ms Powell, explaining that he had reviewed Baby D's death with Ms Powell:

> "*Just to confirm that I have met with Eirian* [Powell] *and reviewed the case notes of Child D … who died in the early hours this morning. We have also discussed whether there are any other issues to address in view of the two other recent sudden deaths on NNU* [neonatal unit].
>
> …
>
> ***There does not seem to be any staff (medical or nursing) members present at all three episodes other than one nurse, who was not the nurse responsible for Child D on that shift*** [emphasis added]."[141]

3.104 The email then sets out details of Baby D's care and then this:

> "***I would be very surprised if Child D's death is linked in any way to the previous recent deaths of Child A and Child C.***
>
> ***We have agreed an action plan however*** [emphasis added]:
>
> *1. I will review Child A and Child C's case notes in detail this week.*
>
> *2. I will review Child A's preliminary PM report which I have not seen yet.*"[142]

3.105 It is clear, therefore, that by 22 June 2015, the day of the third death, Dr Brearey was aware of an unusual increase in deaths on the unit, even though he had not been involved in looking after any of the babies. He knew that a review was needed and that one nurse had been present at all three episodes, and he knew who she was, as did Ms Powell. It is equally clear that, at that stage, he did not think there was a link between the death of Baby D and those of Baby A and Baby C, but, as he said in evidence, he was aware of the association with the nurse "*and it was more of a growing nagging concern*".[143]

3.106 Dr Brearey was asked by Mr Richard Baker KC, Counsel for Family Groups 2 and 3, whether he should have included a review of Baby B's case notes in his action plan. At the time, Dr Brearey did not think that was necessary because he had seen Baby B clinically and had scanned Baby B's heart, so a review would not add information he did not already have. Whilst that was a reasonable approach to take at the time, hindsight reveals that it meant he did not know about the expert view (expressed in the notes of Baby B) that Mother A and B's blood disorder was unlikely to have contributed to the death of Baby A (see paragraph 3.16).

3.107 A Datix entry was made recording the death of Baby D.[144] This noted the mottled skin prior to death.

Junior doctors' concerns

3.108 Dr Lambie raised concerns about Baby A and Baby B with various consultants "*a number of times*". She stated: "[E]*ach time I had a very positive response and I was very much under the impression that they were listening, they shared our concerns and they were being dealt with*."[145] Dr Lambie recalled having an informal conversation in the coffee room with Dr Newby about the rash. She stated that Dr Newby approached her to find out more information about it.[146]

3.109 Dr Newby recalled speaking to Dr Lambie, Dr Brunton and Dr Harkness about the rash that was observed in Baby A, Baby B and Baby D; she stated: "*I knew that the trainees were very concerned about it and we were very concerned about it as well.*"[147]

3.110 On 23 June 2015, Dr Gibbs sent the following email to the consultant paediatricians:

> "*Rachel Lambie came to see me this morning (I think because I was the only person in the office when she came), to say that the Registrars are very concerned about the recent neonatal deaths and collapses (Child B) where all the infants showed a strange purpuric looking rash (that probably wasn't true purpura). However, I pointed out that Child C who also died did not have this rash – but it's true the Child A, Child B and the recent death (Child D), did show a similar strange colour change on 'collapsing'. Rachel also said that 'all' the neonatal nurses are very worried. They feel we 'ought to be doing something' and also asked what else different the Registrars can do.*
>
> *I explained that we were looking into this worrying spate of deaths (and Child B's collapse), but at the moment couldn't identify a unifying cause.*
>
> …
>
> *Do we need a meeting with the neonatal nurses (or are you arranging this anyway, Steve* [Dr Brearey]*). I think a meeting would be useful, even if we have no answers – just to let the nurses air their concerns and to show we are concerned also (since clearly the nurses are worried and talking about this with the Registrars and the perception seems to be that we're not doing anything active at present). So, even though we don't have answers, just meeting with the nurses (and also perhaps the Registrars), might be helpful.*"[148]

3.111 Dr Newby responded to Dr Gibbs' email later that same morning on 23 June 2015: "*I agree, I have just been grilled by Dave Harkness. This is causing a lot of concern/upset. Can we pull something together fairly soon? I think we need to meet with both-probably separately would be better.*"[149]

3.112 Dr Newby informed the Inquiry that Dr Harkness was "*very concerned about the three deaths and he also mentioned the link between the … rashes that were seen on each baby*".[150]

3.113 On 23 June 2015, Dr Newby sent another email to Dr Brearey and the consultant paediatricians suggesting that Baby A, Baby C and Baby D be reviewed together at the perinatal mortality and morbidity meeting the next day. Dr Brearey declined this suggestion and wrote that he wished to review only Baby A and discuss the other two afterwards.[151] Dr Brearey explained in evidence that there was limited time available to discuss more than Baby A because two other babies were already scheduled to be discussed in the meeting. Also, at the time he thought that the three deaths (of Baby A, Baby C and Baby D) had different causes.[152] This was consistent with his email to Dr Jayaram on 22 June 2015 (see paragraph 3.103). Dr Brearey accepted that, in retrospect, it might have been helpful to review all three deaths and Baby B's collapse with the registrars present.[153]

3.114 Counsel asked Mother A and B for her thoughts on how the rashes were investigated. She replied: "[F]*or everybody to be so shocked and never ever seen this before, why was something more not done about it? Because it wasn't just Child A and Child B.*"[154]

Senior clinicians' meeting

3.115 On 29 June 2015, there was a senior clinicians' meeting attended by the consultant paediatricians, Ms Anne Murphy and Ms Powell. It is recorded in the meeting notes that the registrars had been worried about the three recent neonatal deaths: "*There was also an issue raised around the fact that with the three recent neonatal deaths, the Registrars had been quite worried and feel that nothing is being done. Behind the scene reviews are going on but it was felt that formal debriefs should probably take place, rather than any specific meeting to discuss all three.*"[155] At this time, Dr Newby did not have concerns of deliberate harm; she said: "[W]*e were concerned that we had some bug on the unit, maybe contamination of some equipment, one of the ventilators, for example, so we were extremely concerned about it.*"[156] Dr Gibbs also stated that his main concern at this stage was that there was a bug on the neonatal unit or contamination of feeding fluid.

3.116 The doctors and nurses undertook various investigations to rule out whether any environmental factors explained the neonatal deaths. The following were excluded as causes of the deaths: (a) equipment on the neonatal unit; (b) infection; (c) pseudomonas; (d) respiratory syncytial virus (RSV) outbreak; and (e) staff competencies.

Nurses' concerns and messages with Letby

3.117 There was understandable concern amongst the nurses too about three sudden and unexpected deaths occurring so closely together. Nurse T expressed her concerns in a WhatsApp message to Letby on 30 June 2015. Nurse T wrote to Letby: "*There's something odd about that night and the other 3 that went so suddenly.*" Letby responded to this with the following: "*Odd that we lost 3 and in different circumstances?*" Nurse T responded: "*Were they that different? Ignore me. I'm speculating.*"[157]

3.118 In evidence to the Inquiry, Nurse T confirmed that by "*odd*" she meant Baby B's collapse and the deaths of Baby A, Baby C and Baby D were "*highly unusual*".[158] She stated: "[I]*n all my 15 years to then and 25 years to now, I have never seen three babies die so suddenly in such a short space of time.*"[159] Nurse T confirmed that these events did not cause her to have any suspicions.

3.119 Nurse T said that she did not share her thoughts with anyone other than Letby, noting: "*There was no formal debrief.*"[160] Similarly, Ms Powell could not remember any specific conversations about the deaths or the commonality of the rash at the time of the children's collapses.[161] However, she recalled staff speaking to her about "*how upsetting*" the deaths were and that they were "*unexpected*".[162] Ms Powell had also "*picked up that there's anxiety there about the unexplained deaths*".[163] She had never experienced three unexpected deaths and one collapse in such a short period in her career.[164]

3.120 Ms Griffiths gave oral evidence that, after Baby D's death, "*I think everyone was trying to look for, for reasons why we had so many close together and I think Nurse Oakley commented about the skin discolouration.*"[165] She described the staff thought process as follows: "*We didn't suspect at that time any harm, but is there something that we are unaware of?*"[166]

Dr Gibbs

3.121 In oral evidence, Dr Gibbs confirmed:

> "*There were informal discussions between Consultants around July 2015, several had been involved with the death on the NNU* [neonatal unit]*. It was recognised that Letby had been present on each occasion …* [I] *felt sympathy for Letby at that time because* [I] *felt she had been unlucky to have been involved in a number of incidents.*"[167]

3.122 Dr Gibbs knew that Letby worked more shifts than others and at that time he believed that she was unfortunate to have been involved in the cluster of deaths. He explained that he thought Letby was on a "*bad run*", which can sometimes happen, "*but then that stops happening if it is just an unfortunate coincidence*".[168]

3.123 On 2 July 2015, Dr Gibbs conducted a debrief and meeting in respect of Baby C. It was recorded on a pro forma document headed 'Sudden Unexpected Death in Infancy and Childhood (SUDIC) initial strategy meeting'. Dr Gibbs made it plain that this was not a SUDIC meeting. In his view, SUDIC did not apply to Baby C; the pro forma was a convenient way of recording information to be reported in due course to the CDOP.[169] I deal with SUDIC in Chapter 12.

Dr Brearey's review of Baby A, Baby C and Baby D, 1 July 2015

3.124 Dr Brearey, Ms Debbie Peacock (Risk and Patient Safety Lead for the Women and Children's Division) and Ms Powell carried out a case note review of the deaths of Baby A, Baby C and Baby D on 1 July 2015. Dr Brearey produced individual reviews for each child and a summary report dated 1 July 2015.[170] In the individual review of Baby A, and in the summary report, there is reference to Baby B having a respiratory arrest 24 hours later but responding to resuscitation: "[C]*ollapse of twin 1 24hrs later with successful resuscitation.*"[171] The section of the summary report relevant to Baby A was subsequently sent to the coroner. It did not suggest any cause of death, but stated: "*Awaiting full PM report. Preliminary report did not identify any macroscopic abnormalities. UVC in liver but no significant clots present and no perforation*." In respect of Baby C, the summary conclusion was: "*Awaiting PM but likely diagnosis of acute bowel obstruction and/or sepsis with background of extreme prematurity and IUGR* [intrauterine growth retardation]." The summary also set out learning, including points for discussion and improvement in practice. They were not likely to have influenced the outcome.[172]

3.125 Ms Powell confirmed that the rashes were not discussed in the review.[173] Dr Brearey told the Inquiry that he regretted not paying more attention to the rashes and skin abnormalities in Baby A, Baby B and Baby D when he conducted this review. He also acknowledged that a case note review has limitations because it does not involve speaking to clinicians involved in the care.[174] This limitation would be seen again in 2016, but on that occasion in respect of a review completed by an expert brought in by Mr Harvey.

3.126 Towards the end of the case note review, Dr Brearey set out the Countess's annual neonatal mortality data over the previous seven years.[175] The figures were:

- 2008 = 4
- 2009 = 1
- 2010 = 1
- 2011 = 3
- 2012 = 3
- 2013 = 2
- 2014 = 3.

3.127 He explained that he did this in anticipation of the Serious Incident Panel meeting scheduled for the next day, knowing that Ms Kelly and Ms Ruth Millward (Head of Risk and Patient Safety) would be there. He said in evidence to the Inquiry: "[K]*nowing what our annual mortality rate is historically obviously informs Alison Kelly, who's the Executive lead for patient safety, as to how significant three babies dying in that short period of time was.*"[176]

3.128 Dr Brearey emailed his summary report to Ms Peacock, copying in Ms Powell and Dr Jayaram, for use at the Serious Incident Panel meeting on 2 July 2015 (see Chapter 4).[177]

Equipment

3.129 Following the deaths of Baby A, Baby C and Baby D, Ms Powell checked the incubators, the thermometers and the antibiotics prescribed to the babies.[178] Ms Powell was satisfied that each baby was nursed in a different incubator, the thermometers were in good working order and the antibiotics were given as per the electronic Medication Administration Record (eMAR) system. No issues were found.[179]

3.130 In his Inquiry statement, Dr Brearey stated that, as part of the reviews into the three deaths, "*it was important to consider contaminated TPN* [total parenteral nutrition] *as a possible cause*". In oral evidence, Dr Brearey explained that "*only two of the babies had TPN and Baby D wasn't on TPN at the time so that was excluded*".[180]

3.131 The microbiology of each baby was also checked; the test results were negative.[181] In oral evidence, Dr Brearey told the Inquiry: "[T]*here wasn't any microbiology evidence that there was any -- any links* [between the three babies]."[182]

Endnotes

1 Mother A and B 16 September 2024 2/16-18
2 Mother A and B 16 September 2024 10/20-23
3 Melanie Taylor 10 October 2024 18/7-10 and 12-16
4 Nurse T 14 October 2024 28/25 to 29/2
5 Melanie Taylor 10 October 2024 18/25 to 19/5
6 Nurse T 14 October 2024 29/6-18
7 Nurse T 14 October 2024 29/11-15
8 Melanie Taylor 10 October 2024 21/1
9 Melanie Taylor 10 October 2024 19/16
10 Nurse T 14 October 2024 32/8-9
11 Nurse T 14 October 2024 34/6-8
12 Mother A and B 16 September 2024 9/7-9
13 Mother A and B 16 September 2024 9/11-12
14 Mother A and B 16 September 2024 3/5-6 and 4/1-2
15 Nurse T 14 October 2024 36/11-14
16 Witness statement of Dr David Harkness INQ0102350/3/para 13
17 Nurse T 14 October 2024 30/24 to 31/2
18 Witness statement of Dr David Harkness INQ0102350/3/para 14
19 Dr Rachel Lambie 2 October 2024 8/19 to 11/10
20 Dr Ravi Jayaram 13 November 2024 21/13-16
21 Dr Ravi Jayaram 13 November 2024 21/19-20
22 INQ0001986/6
23 Mother A and B 16 September 2024 34/25 to 35/6
24 INQ0002042/4
25 Mother A and B 16 September 2024 3/5-7
26 Nurse T 14 October 2024 37/3
27 Nurse T 14 October 2024 37/13-20
28 Nurse T 14 October 2024 38/12-15
29 Nurse T 14 October 2024 39/3-4
30 Dr Rachel Lambie 2 October 2024 11/20-22
31 INQ0000698/26-28
32 Dr Rachel Lambie 2 October 2024 39/11
33 Dr Rachel Lambie 2 October 2024 12/3

34 Dr Rachel Lambie 2 October 2024 12/5-8
35 Dr Rachel Lambie 2 October 2024 14/12-13
36 Dr V 7 October 2024 89/21-23
37 INQ0000698/28
38 INQ0000698/29
39 Dr V 7 October 2024 90/5-11
40 INQ0000698/25
41 Dr V 7 October 2024 91/17-19
42 Dr Rachel Lambie 2 October 2024 11/4-13
43 Dr John Gibbs 1 October 2024 126/22 to 127/3
44 Witness statement of Dr Katherine Lyddon INQ0017996/8/para 28
45 Mother A and B 16 September 2024 35/3-5
46 Mother A and B 16 September 2024 49/15-19
47 INQ0000008
48 Yvonne Griffiths 16 October 2024 107/5-7
49 Yvonne Griffiths 16 October 2024 107/11-16
50 Yvonne Griffiths 16 October 2024 108/24-25 and 109/2-3
51 INQ0000101/1-2
52 Ashleigh Hudson 10 October 2024 83/19-25
53 Ashleigh Hudson 10 October 2024 85/17-20
54 INQ0000101/6-7
55 Melanie Taylor 10 October 2024 20/25 to 21/1-3
56 Mother A and B 16 September 2024 42/20-21
57 INQ0000008
58 Mother C 16 September 2024 61/20 to 62/1
59 Mother C 16 September 2024 57/16-25
60 Mother C 16 September 2024 60/10-11
61 Mother C 16 September 2024 59/24-25
62 Mother C 16 September 2024 60/24 to 61/11
63 Witness statement of Dr Katherine Davis INQ0018001/2/para 7
64 Witness statement of Dr Katherine Davis INQ0018001/3/para 9 to 4/para 11
65 Dr John Gibbs 1 October 2024 43/23-24
66 Witness statement of Dr Katherine Davis INQ0018001/4/para 12
67 Mother C 16 September 2024 63/5 to 64/6
68 Mother C 16 September 2024 65/5-9

69 Mother C 16 September 2024 67/5-24

70 Mother C 16 September 2024 68/3-5

71 Mother C 16 September 2024 68/9-17

72 Nurse W 14 October 2024 93/21

73 Nurse W 14 October 2024 93/13-15

74 Nurse W 14 October 2024 145/1-2; Mother C 16 September 2024 68/10-20

75 Melanie Taylor 10 October 2024 59/24-25

76 Nurse W 14 October 2024 93/4-9 and 98/3-9; Melanie Taylor 10 October 2024 29/21 to 30/17 and 59/20 to 60/1

77 Eirian Powell 17 October 2024 78/5-12

78 Eirian Powell 17 October 2024 78/19-23

79 Eirian Powell 17 October 2024 80/17-19

80 Eirian Powell 17 October 2024 79/2-3

81 Eirian Powell 17 October 2024 72/14-18; INQ0003243/1

82 Mother C 16 September 2024 69/24 to 70/5

83 Mother C 16 September 2024 69/13-17

84 Melanie Taylor 10 October 2024 60/12

85 Melanie Taylor 10 October 2024 60/16-23

86 Nurse W 14 October 2024 96/23-24

87 Dr John Gibbs 1 October 2024 209/19-21

88 Dr John Gibbs 1 October 2024 209/5

89 Witness statement of Sophie Ellis INQ0017829/4/para 14

90 Witness statement of Sophie Ellis INQ0017829/3/paras 10-13

91 Dr John Gibbs 1 October 2024 58/7-15

92 Dr John Gibbs 1 October 2024 199/16 to 201/23

93 Dr John Gibbs 1 October 2024 43/12-14

94 INQ0002047/3

95 Dr John Gibbs 1 October 2024 44/8-9

96 Dr John Gibbs 1 October 2024 208/16-20

97 Dr John Gibbs 1 October 2024 65/24 to 66/6

98 Dr John Gibbs 1 October 2024 66/11-12

99 INQ0008979/2

100 Dr John Gibbs 1 October 2024 66/23 to 67/2

101 INQ0000111/1

102 Julie Fogarty 15 October 2024 97/22 to 100/7

103 Mother C 16 September 2024 118/11-12
104 Mother C 16 September 2024 116/16-19
105 Mother D 17 September 2024 9/1-11
106 Witness statement of Caroline Oakley INQ0101334/4/para 20
107 Mother D 17 September 2024 19/2-10
108 Witness statement of Kathryn Percival-Calderbank INQ0017999/6/para 38
109 Witness statement of Dr Andrew Brunton INQ0018067/4/para 16
110 Witness statement of Caroline Oakley INQ0101334/3/para 14
111 Witness statement of Dr Emily Thomas INQ0017995/6/para 27
112 Mother D 17 September 2024 50/7-10
113 Witness statement of Dr Andrew Brunton INQ0018067/4/para 17
114 Witness statement of Dr Emily Thomas INQ0017995/7/para 31
115 Witness statement of Dr Andrew Brunton INQ0018067/4/para 16
116 Witness statement of Dr Andrew Brunton INQ0018067/4-5/paras 17-18
117 Dr Elizabeth Newby 3 October 2024 18/3-23
118 Mother D 17 September 2024 20/12-13
119 Mother D 17 September 2024 23/13-15
120 Witness statement of Caroline Oakley INQ0101334/4/para 20
121 Dr Elizabeth Newby 3 October 2024 17/8-11
122 Dr Elizabeth Newby 3 October 2024 17/12-13
123 Mother D 17 September 2024 45/5 to 46/16
124 Mother D 17 September 2024 6/10-21
125 Dr Elizabeth Newby 3 October 2024 18/2-6
126 INQ0002045/8
127 Dr Jo McPartland 12 November 2024 111/7-8
128 Dr Jo McPartland 12 November 2024 111/12-14
129 Dr Jo McPartland 12 November 2024 156/21-23
130 Dr Elizabeth Newby 3 October 2024 45/5
131 Dr Elizabeth Newby 3 October 2024 16/9-11
132 INQ0008651/2
133 INQ0008651/3
134 Mother D 17 September 2024 30/16-20
135 Dr Elizabeth Newby 3 October 2024 27/22-25
136 Nurse T 14 October 2024 42/13 to 43/6
137 Nurse T 14 October 2024 43/10-16

138 Nurse T 14 October 2024 44/4-5
139 Nurse T 14 October 2024 44/6-10
140 Eirian Powell 17 October 2024 83/21 to 84/7 and 85/13-17
141 INQ0003110/4-5
142 INQ0003110/4-5
143 Dr Stephen Brearey 19 November 2024 59/21-22
144 INQ0000766/1
145 Dr Rachel Lambie 2 October 2024 17/4-8
146 Dr Rachel Lambie 2 October 2024 16/12-20
147 Dr Elizabeth Newby 3 October 2024 22/14-16
148 INQ0025743/2
149 INQ0025743/1
150 Dr Elizabeth Newby 3 October 2024 23/10-13
151 INQ0025743
152 Dr Stephen Brearey 19 November 2024 37/21 to 38/8
153 Dr Stephen Brearey 19 November 2024 42/5-8 and 43/2-5
154 Mother A and B 16 September 2024 41/5-8
155 INQ0036166/2
156 Dr Elizabeth Newby 3 October 2024 22/18-21
157 INQ0000101/22-23
158 Nurse T 14 October 2024 48/11
159 Nurse T 14 October 2024 48/8-10
160 Nurse T 14 October 2024 33/25 to 34/23
161 Eirian Powell 17 October 2024 74/21 to 76/2
162 Eirian Powell 17 October 2024 77/3 and 77/20
163 Eirian Powell 17 October 2024 87/12-13
164 Eirian Powell 17 October 2024 76/3-11
165 Yvonne Griffiths 16 October 2024 113/20-22
166 Yvonne Griffiths 16 October 2024 114/17-19
167 Dr John Gibbs 1 October 2024 54/7 to 55/8
168 Dr John Gibbs 1 October 2024 55/10-14
169 Dr John Gibbs 1 October 2024 56/6 to 57/6
170 INQ0003191/1-6
171 INQ0026017/3
172 INQ0003191/1-3

173 Eirian Powell 17 October 2024 91/21 to 92/5

174 Dr Stephen Brearey 19 November 2024 44/13 to 45/3

175 INQ0003191/3

176 Dr Stephen Brearey 19 November 2024 45/23 to 46/2

177 INQ0008302; INQ0003191/1-6

178 INQ0003110/7

179 INQ0003110/4

180 Dr Stephen Brearey 19 November 2024 49/4-6

181 INQ0003110/6

182 Dr Stephen Brearey 19 November 2024 48/22-24

Chapter 4. Risk and Patient Safety Department

4.1 The purpose of a department for risk and patient safety is to identify risks and take steps to enhance patient safety in response. The department at the Countess neither identified the risk nor took steps to protect patients until after the deaths of Baby O and Baby P. The department failed in its fundamental task to enhance patient safety.

4.2 In 2014, the Risk and Patient Safety Department comprised a small team of 10 to 12 people. By June 2016, this had risen to approximately 30 staff.[1] From March 2014, Ms Millward was Head of Risk and Patient Safety at the hospital. She reported to Ms Sian Williams, Deputy Director of Nursing.[2] Ms Millward was a nurse who had qualified in 1997.[3] She began the Risk role on a temporary basis in March 2014, being substantively appointed from 2015.[4] Between 2004 and 2011, Ms Millward had worked as the Quality Improvement Facilitator in the hospital's Risk and Patient Safety Department. Following this role, she worked as a matron, before returning to the Risk Team as the Head of Risk and Patient Safety.[5]

4.3 In her evidence to the Inquiry, Ms Millward was keen to emphasise that her job title was "*a little bit misleading as to the level of influence*".[6] She asserted that she did not have ultimate responsibility for risk, but that her responsibilities were focused on designing and delivering systems and processes for risk management, advising on whether matters needed to be escalated to the Executive Team via the Executive Risk Register[7] and attending QSPEC meetings.[8] The Risk and Patient Safety Department also took the lead on matters such as inspections by CQC. It was the evidence of Ms Millward that the CQC inspection of the hospital was her "*priority*" in February 2016.[9]

4.4 This was telling evidence. Ms Millward's role as Head of Risk and Patient Safety, and that of the department she led, was to enhance patient safety. She was keen to emphasise her responsibility for systems, processes and inspections. However, reporting systems, risk registers, committee structures and even submission to outside inspection do not in themselves protect patient safety. What is needed is that those in the key roles within risk and patient safety continually seek to expose what the risks to patient safety are and address the question of what actions need to be taken to reduce these risks.

4.5 Within the Risk and Patient Safety Department, there were identified Risk and Patient Safety Leads associated with the different divisions and services within the hospital. From December 2013 to February 2016, the Risk and Patient Safety Lead for Women and Children, to whom risks and patient safety incidents occurring on the neonatal unit were referred, was Ms Peacock.[10]

4.6 Ms Peacock, in her role as Risk and Patient Safety Lead for Women and Children, covered neonatology, midwifery, gynaecology and paediatrics. Ms Peacock had qualified as a registered general nurse and a sick children's nurse in 1985, and as a midwife in 1987. She had experience working as a nurse on a neonatal unit. Having subsequently qualified as a solicitor in 2010 and worked as a solicitor in clinical negligence, Ms Peacock then moved to a role as Clinical Risk Manager within a hospital. Her appointment at the Countess was her second post in a risk-related role within a hospital setting.[11] She was one of a small number of Risk and Patient Safety Leads at the hospital, who between them reviewed the risk and patient safety issues arising in the different divisions and specialties within the hospital.[12]

4.7 The purpose of Ms Peacock's role, as she accepted in her evidence, was to improve patient safety.[13] She did this by managing Datix incidents, identifying trends and attending incident review meetings.

4.8 Ms Peacock explained in her evidence that incidents were broadly investigated in the following ways:[14]

- 'No harm' incidents (where despite an error no harm was caused to the patient) were managed at local level and dealt with by the ward manager or lead consultant.
- Serious incidents, which involved some level of harm, had a Situational Background Assessment Recommendation (SBAR). In the neonatal unit, Dr Brearey's clinical assessment would usually form the basis of the SBAR.
- SBARs were escalated to the Serious Incident Panel and Ms Millward or Ms Peacock would usually make the recommendation to the Serious Incident Panel.
- The Serious Incident Panel would then meet and make decisions about further investigatory steps, such as reporting the matter to the Strategic Executive Information System (StEIS) and thus triggering a more in-depth investigation.

4.9 Ms Peacock was a member of the Women and Children's Care Governance Board,[15] the purpose of which was to bring together those working within obstetrics and gynaecology and representatives from the Paediatric Department, including the neonatal unit. Her role included preparing a quarterly report of incidents for the Board.[16] The minutes of the Women and Children's Care Governance Board meetings were sent to Ms Kelly.[17] A baby death by a natural cause would not be escalated to the meetings but would be received by the Board in a yearly report. A sudden and unexpected neonatal death would be discussed in a perinatal mortality meeting and later escalated to the Women and Children's Care Governance Board.[18] As I said earlier in this Report, the Women and Children's Care Governance Board was introduced because maternity and neonatal care were now in different divisions. This might fairly be described as a sticking plaster remedy for a structural problem. Ms Millward observed that this "*confused their process*".[19] It is not apparent that she sought to do anything about that. The meetings of the Women and Children's Care Governance Board were not, generally, well attended.

4.10 Ms Peacock also attended the Neonatal Incident Review Group. These meetings were usually attended by Ms Powell, Dr Brearey, Ms Hayley Cooper (Griffiths), the Countess's Royal College of Nursing Representative and a neonatal pharmacist. The group aimed to hold meetings fortnightly and would review Datix incidents and medical notes.[20]

4.11 When Ms Peacock left her employment at the hospital on 15 February 2016, Ms Janet McMahon, also a midwife, temporarily took over the role.[21] In May 2016, Ms Annemarie Lawrence was appointed as Risk Midwife, a permanent full-time replacement for the Risk and Patient Safety Lead role, covering maternity, obstetric, neonatal and paediatric services.[22]

4.12 Between Ms McMahon's time in the temporary role and Ms Lawrence's appointment, the name of the role of Risk and Patient Safety Lead for the Women and Children's Division (itself an outdated title) had been changed to Risk Midwife, although the role continued to cover neonatal and paediatric services as well as maternity and obstetrics. Ms Millward's view was that the role always had a predominant focus on maternity services, and the new title reflected this. She explained that the name change was prompted by national guidance on maternity safety released in 2015/16. Ms Millward accepted that the name Risk Midwife signalled externally that the maternity guidance was being taken seriously, and the occupant of the role would respond to the national guidance. Significantly, she sought to emphasise that "*at no point was this going to be a withdrawal of support for paediatrics, neonatology*". Ms Millward did however accept that the decision to change the name of the role to Risk Midwife was made without consulting paediatrics and neonatology.[23] In her view, the support provided to paediatrics and neonatal services would be the same.[24] It follows therefore that this was either a cosmetic change of title to give the impression externally that the new maternity guidance was being taken seriously, despite nothing changing, or it was a real change, signalling a shift in approach. In fact, the support provided to the neonatal unit was considered inadequate by Dr Brearey and he expressed that view very clearly in June 2016 (see Chapter 14).[25]

4.13 The Risk and Patient Safety Department had systems and processes for identifying and addressing risk within the hospital. Underpinning these was a Datix risk management system, intended to record all incidents where unnecessary harm had been caused to patients. The most significant incidents reported on the Datix risk management system were referred for consideration by a Serious Incident Panel. Incidents that were, after consideration by the panel, categorised as serious incidents requiring fuller investigation were then reported to StEIS.

4.14 The Datix risk management system was intended to be integrated with, and to inform, a system of risk registers, which recorded identified risks within a particular hospital division. Risks that were identified as relevant to the neonatal unit would be recorded on the Urgent Care Risk Register, as the neonatal unit fell within the hospital's Urgent Care Division. The most serious risks recorded on these divisional registers would be entered in the Executive Risk Register, which would be reviewed by the Corporate Directors Group.[26]

4.15 According to Ms Millward, daily, weekly and monthly meetings would be held to consider ongoing risks.[27] Ms Millward's role also involved attending the meetings of QSPEC, which sat just below Board level. In her evidence, Dr Susan Gilby (Medical Director and then Chief Executive of the Countess from 2018) described this as the most important subcommittee in most hospitals. It is usually called the Quality and Safety Committee. She said: "[T]*hey look at data, and they receive reports surrounding patient and staff, safety and experience.*"[28]

In evidence, Ms Millward described her role on QSPEC as "*providing oversight of our Serious Incident investigations*".[29]

4.16 Ms Millward's evidence was that the correct escalation route for matters of patient safety occurring within the neonatal unit was first to raise the issue at neonatal unit meetings and thereafter raise it with the Urgent Care Division. The most serious safety issues were referred to QSPEC or the Corporate Directors Group.[30]

4.17 Despite, or perhaps because of, all these reporting systems, risk registers and committees, the Risk and Patient Safety Department failed promptly to identify as a risk the increased mortality on the neonatal unit in 2015. Neither did they ask the key question: why were these deaths happening? Not only as a department did they fail to identify the problem, even when Dr Brearey started to raise concerns about the deaths from his clinical perspective, they failed to ensure that the issue of increased neonatal mortality and its cause was discussed by the relevant committees or appropriately raised with the Executive Team. Most significantly, the Risk and Patient Safety Department failed to take prompt and appropriate steps to protect patients.

4.18 A phrase that was used by many witnesses to the Inquiry was an inability or reluctance to 'think the unthinkable', referring to the possibility that a member of clinical staff could be deliberately harming patients. It was, above all, for the Risk and Patient Safety Department to consider such a possibility. Even when presented with a chart that highlighted Letby's presence on duty for seven of the eight deaths in 2015,* the department took no steps to ensure that this was investigated promptly and treated as a matter of patient safety; that is, risk to babies. In so far as the risk of deliberate harm by a member of staff was even acknowledged, it appears to have been considered as a matter for HR rather than an issue of patient safety.[31]

4.19 Dr Gilby took over as Chief Executive in 2018. In her assessment, the risk management framework and strategy fell "*significantly below*" what she would have expected.[32]

Datix risk management system

4.20 Central to the way in which the hospital sought to identify risks and address them to enhance patient safety was the Datix risk management system. It was the responsibility of the managers of wards or units to ensure that incidents were recorded on the Datix risk management system. Staff received mandatory training on Datix reporting every two years.[33]

4.21 The reporting of incidents on the Datix risk management system was determined by whether 'unnecessary harm' had been caused. The hospital's Policy for the Reporting of Incidents set out that "*an event or circumstance which could have resulted, or did result, in unnecessary damage, loss or harm to patients*" should be reported on the Datix risk management system.[34]

* Up to 23 October 2015.

4.22 The hospital's Policy for the Reporting of Incidents set out an "*incident grading system*" to be used on any Datix report.[35] This grading system was intended to record the actual degree of harm suffered by the patient as a direct result of the patient safety incident. The practical impact of this was that the harm grade for a neonatal death, where there was no identifiable error in the care at the time, would be graded as 'no harm'.

4.23 With the exception of Baby O and Baby P, whose deaths were reported on the Datix risk management system by Ms Powell with the most severe grading, "*Result*: *Actual Harm – Death (caused by the Incident)*", all the other babies on the indictment who died on the unit were graded contemporaneously at the minimum level: "*Result: No Harm – None (no harm caused)*".[36]

4.24 Datix entries were filled in by the person, usually a member of clinical staff, who acted to report the incident.

4.25 As Ms Peacock observed in her evidence, the effectiveness of the Datix risk management system was "*dependent on having a good reporting culture*".[37] If an incident was not recorded on the system, there was no deeper investigation into the incident.

4.26 Ms Peacock's successor in the role, Ms Lawrence, expressed the view that the Datix risk management system provided "*an open and transparent way of improving the safety and culture of a hospital*".[38] However, she stated that staff on the unit, including consultants, registrars and nurses, did not report incidents "*freely*" and instead sought to corroborate with one another whether there was a need to complete a Datix report.[39] Her perspective was that clinicians regarded the reporting of incidents as "*punitive*".[40] However, this was not terminology or sentiment that was reflected in the evidence of nurses or doctors.

4.27 All neonatal deaths were reported to Ms Peacock via the Datix risk management system. Ms Peacock explained that, sometimes, Ms Powell would also call her to report a death. Upon being informed of a death, Ms Peacock would visit the neonatal unit and review the medical records with Dr Brearey. This happened for every death.

4.28 Datix reports were completed in respect of the deaths of Baby A, Baby C, Baby D, Baby E, Baby I, Baby O and Baby P. Parents were not made aware of the Datix report in respect of their baby's death; nor were they made aware of any meeting about the death of their baby until the criminal trial or when they received disclosure from the Inquiry.

4.29 Mother A and B told the Inquiry in relation to Baby A's death: "*I wasn't even aware that a Datix form had been completed.*"[41] Mother C stated she had never seen the Datix report prior to being shown it in oral evidence.[42] Mother D told the Inquiry she was not aware Serious Incident meetings or any other meetings had taken place about Baby D.[43] Mother E and F was not aware that a Serious Incident Panel meeting regarding Baby E's death had taken place.[† 44]

4.30 Mother I said: "*I now understand that a report called a 'Datix' was created on 01/10/2015 about our baby's collapse on 30/09/2015. I was not told about this at the time and would not have known what a Datix report was. I had no idea there were any meetings or discussions about her collapse*."[45] She was also not aware of a Datix report created in

† It is worth noting that a Serious Incident Panel meeting is triggered by a Datix report. Thus, if the parents were not informed about the meeting, it is highly unlikely they were informed about the report.

relation to Baby I's collapse on 13 October 2015,‡[46] and told the Inquiry: "*I understand that a Datix report was created on 23/10/2015 about our baby's death. As with the other Datix reports, I wasn't told about this at the time*."[47]

4.31 Mother O, P and R told the Inquiry: "*As far as the Datix reports are concerned, I did not know they existed until we saw them in the criminal trial*."[48] Father O, P and R stated: "[W]*e had never seen the Datix reports before the trial. I didn't even know they existed until the trial. The trial was the first time we saw them*."[49]

4.32 As the trigger for a Datix report was a clinical event that could have (or had in fact) resulted in 'unnecessary damage', an unexplained collapse of a baby on the neonatal unit (unattributed at the time to any error in clinical treatment) would not normally lead to a report under the policy.

4.33 No Datix reports were completed in respect of the unexplained or unexpected non-fatal collapses pursued on the indictment. However, apart from Baby G, Baby K and Baby L, each of the surviving babies named on the indictment had a Datix report created about them in respect of some identifiable event in their care. The parents were not informed about these Datix reports.

4.34 Ms Peacock informed the Inquiry that "*generally speaking collapses weren't Datixed*".[50] A non-fatal collapse would be recorded if there was an identifiable issue with equipment or a staff member's competency, but not otherwise. She acknowledged that this was "*a flaw in the system*" but noted:

> "[I]*f they reported every collapse on Datix, it would be its own industry, I think. However, in this situation, I would have thought it was relevant for us to be notified of the collapses, which we weren't.*"[51]

Ms Peacock accepted that she never raised this with Ms Millward or Dr Brearey at the time.[52]

4.35 Ms Millward's evidence was that unexpected neonatal collapses should have been reported as clinical incidents, but that this did not occur in practice. She accepted in evidence that the requirement to record such incidents was not formally conveyed to staff.[53] However, Ms Millward said that the fact the collapses of Baby B and Baby F§ were not reported on the Datix risk management system meant that, in her view, "*the fuller scope and understanding of what was happening in the unit wasn't there*".[54]

4.36 Ms Millward asserted in her evidence to the Inquiry that the issues with incident reporting were twofold:[55]

- Not enough Datix reports were completed.
- The quality of the information on the Datix system was limited.

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‡ Please note that these Datix reports are not about Baby I's collapses in and of themselves. The reports concern incidents at the time of the collapses, such as an antibiotic administration error and delayed treatment of emergency blood.

§ On 9/10 June 2015, Baby B collapsed. On 5 August 2015, Baby F suffered from hypoglycaemia and collapsed.

4.37 The Datix risk management system had a pick list (drop-down menu) of incident categories, which included a sub-category titled 'expected and unexpected death'. Ms Millward's evidence was:

> "[T]*he use of the pick list and the category or subcategory as an unexpected death was not particularly helpful because it is not telling me what has contributed to the incident, what element of the patient's care or treatment you want us to look into, what element of the treatment you are concerned about.*"[56]

The practical effect of this was, she said, that it was not easy to understand what the concern or incident related to without seeking more information from the incident reporter.

4.38 Ms Millward asserted that "*the use of the pick lists meant that there was quite a narrow focus at the time so as I say you would tend to see the same sorts of incident types being reported*".[57]

4.39 Ms McMahon, who, as noted above, temporarily took over from Ms Peacock as Risk and Patient Safety Lead covering the neonatal unit, pointed out in her evidence two flaws that she perceived with the Datix risk management system:

- The grading of harm incidents was subjective because staff reporting incidents had the discretion to grade an incident 'no harm', 'moderate harm' or 'severe harm'. It was common for the Risk Team to investigate the incident and change it to more "*realistic categories*".[58]
- The Datix system was live and could be repeatedly updated. This made it difficult to identify when changes had been made: "*the only way to see when the change has been made is to get the audit trail so you can print out a copy that shows every date and time a change has been made*".[59]

4.40 Despite the perceived shortcomings of the system, all the deaths of the babies who were named on the indictment were promptly reported on the Datix risk management system. Whilst it may be that further detail should have been supplied in the Datix entries, the number of Datix reports of neonatal deaths should have been sufficient to alert the Risk and Patient Safety Department to the fact that there was an increase in mortality on the neonatal unit. This should have prompted a full and early investigation of potential causes of the increase in neonatal deaths.

4.41 Ms Millward's view was that the lack of Datix reporting of collapses meant that "*the fuller scope and understanding of what was happening in the unit*"[60] was not understood. However, this has to be seen in the context of the fact that, when presented with a list that identified eight neonatal deaths in 2015, indicating that Letby had been on duty for seven of the eight deaths, no proactive steps were taken by the Risk and Patient Safety Department to make further investigations. That there was not a "*fuller scope and understanding of what was happening in the unit*" was not due to a failure in the Datix risk management system – it was due to a failure to investigate.

Serious Incident Panel, 2 July 2015

4.42 By July 2015, whatever the flaws in the Datix risk management system, it was plain that there had been three neonatal deaths in very short succession during the month of June 2015.

4.43 On 26 June 2015, Ms Millward emailed the Serious Incident Panel members, including Ms Kelly and Mr Harvey, to invite them to a meeting of the panel on 2 July 2015 to discuss three neonatal deaths (of Baby A, Baby C and Baby D). She explained that "*child death is no longer included as a Serious Incident by definition [in the SI Framework or on StEIS], however it may be reported as a serious incident under another category e.g. medication error*".[61]

4.44 As set out in Chapter 3 (paragraph 3.124 onwards), Dr Brearey, Ms Peacock and Ms Powell had carried out a case note review of the deaths of Baby A, Baby C and Baby D. In addition, Dr Brearey had produced a report that included details of the annual neonatal mortality data for the Countess for the previous seven years (ranging from four deaths per year to one death per year). This report was referred for discussion to the Serious Incident Panel meeting on 2 July 2015.

4.45 In evidence, Mr Harvey confirmed that he was invited to the Serious Incident Panel meeting on 2 July 2015, but he "*was on leave and hadn't received -- or didn't receive the email in a timely fashion and wasn't at the meeting for the conversations* [on 2 July 2015]".[62]

4.46 The Panel meeting took place on 2 July 2015. Its purpose was to discuss the deaths of Baby A, Baby C and Baby D.[63] Ms Kelly was the only executive in attendance, although decisions were for the Executive Team. Ms Fogarty (Head of Midwifery) was at the meeting. She had been involved in the obstetric secondary review of the deaths of Baby A, Baby C and Baby D, and noted in respect of each baby that there were no maternity issues. Also at the meeting were Dr Brearey, Ms Millward, Ms Peacock and Ms Sian Williams.[64] Dr Brearey's recollection is that Ms Powell was also at this meeting.[65] I think he is wrong about that. She is not recorded as present and no one else refers to her as present either. She cannot remember whether she was there or not. Dr Brearey and Ms Powell had many conversations and it is likely that they spoke on a different occasion.

4.47 Ms Millward said that the aim of the meeting was to review the three cases with a view to reporting any of them to StEIS, thus triggering a more in-depth investigation. Serious incidents that are reported to StEIS lead to notification of the relevant commissioner in the NHS about the incident.[66]

4.48 Ms Millward explained that the Serious Incident Framework has three criteria for reporting to the local commissioning group:[67]

a. any act or omission that has led to serious harm or death

b. never events (a list of incidents that should never happen)

c. a broad category relating to system deficiencies in the delivery of care or service failures.

4.49 NHS England's *Serious Incident Framework policy*, dated March 2015, sets out that:

> "[S]*erious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.*"[68]

It also provides that serious incidents in the NHS include the unexpected or avoidable death of one or more people. This sentence has a footnote which specifies that the unexpected or avoidable death must have been caused or contributed to by weaknesses in care or service delivery.[69] Despite this, Professor Sir Stephen Powis, National Medical Director, NHS England, asserted in his evidence to the Inquiry: "[A]*t the time the definition did include … unexplained or unexpected death, that could not be explained by a particular omission or a particular act.*"[70]

4.50 No one at the meeting had been present at any of the deaths or collapses of Baby A, Baby C and Baby D. Although neither Dr Harkness nor Dr Jayaram had recorded the rash on Baby A at the time, others had done so but this issue did not feature in the meeting, nor in Dr Brearey's review. No questions were asked about which doctors and nurses were on duty with a view to asking the people involved whether they had any recollection and any concerns. Had that been done, the issue of the rashes/skin mottling may have been identified. It was only just over a week since the registrars had raised their worries about the rashes (and they had been referred to the senior clinicians' meeting on 29 June 2015). That should have prompted some questions. The fact that these collapses and deaths were all sudden and unexpected did not, at that stage, cause a more inquisitive approach. Nor did it prompt anyone at the meeting to consider the Pan-Cheshire Guidelines for the Management of Sudden Unexpected Death In Infants and Children (SUDIC) (the Pan-Cheshire Guidelines),[71] due to a widespread misunderstanding that the multi-agency referral that should have been triggered did not apply where a neonatal death occurred in a hospital setting (see Chapter 12). It is probable that the mistaken belief that the death of Baby A may be attributable to the medical condition of Mother A and B, and that the cause of death was bowel obstruction in respect of Baby C, led to an acceptance that no further investigation was needed. Ms Millward explained that, during the Serious Incident Panel meeting, Dr Brearey and Ms Fogarty asserted that for Baby A and Baby C's deaths "*it was likely that their clinical condition was more attributable to the death … it was progression of the clinical illness that the children had rather than an incident*".[72] I understood her to mean that there were clinical explanations for the deaths of Baby A and Baby C, and so there was no need for a StEIS report.

4.51 The belief at that time was that Baby D had died of sepsis. Concern had been expressed that there had been a delay on the maternity ward in starting the process of induction, there had been a delay by the paediatric senior house officer in identifying subtle signs of sepsis in the early stage of Baby D's life and so moving her to the neonatal unit, and there had been a delay in administering antibiotics. For those reasons, the death of Baby D was referred to StEIS.

4.52 Baby B's collapse was not discussed at the meeting. In evidence, Ms Fogarty said that in her view it should have been. She acknowledged that the commonality of the rashes seen in Baby A, Baby B and Baby D at the time of collapse was not mentioned. She went on to say that "*there was no clinical, no detailed clinical information given*" in the

meeting.[73] Ms Fogarty's view of the meeting was that "*with hindsight, really what should have happened is there should have been a total review of all three cases by someone external from the Trust*".[74]

4.53 I accept that hindsight may lead, reasonably, to that conclusion.

4.54 Ms Millward's evidence was that all the attendees contributed to the discussion. She confirmed that her role was to advise on the options, "*but the final decision whether or not a case would go for a Serious Incident investigation would sit with the Executive*".[75] This was Ms Kelly. Apart from referring Baby D to StEIS, it was decided that there would be no further investigation.[76] Ms Fogarty confirmed that "[t]*hat decision was made by the Director of Nursing*".[77]

4.55 Ms Millward conceded in evidence that "*the three deaths could have been considered as a Serious Incident*" as a "*collective review of the three deaths and more of a systems process review of the neonatal unit*" under the third broad category.[78] She said that, in 2015/16, the Trust's approach to the Serious Incident Framework "*was narrow, the largest focus was of course upon the acts or omission criteria. The third section, as I say, which talks around systems failures, that wasn't really something that was considered at that time.*"[79] She accepted she should have considered the third option.[80] Whilst the third option was systems failure and would have justified a report to StEIS on that basis, it was the view of Sir Stephen that three deaths of vulnerable children should have been reported to StEIS as a cluster.[81]

4.56 Dr Brearey said that during the meeting they discussed the fact that "*three deaths in a short period of time, this was unusual. This amounted to what would be our normal annual mortality rate.*"[82] Ms Kelly's reaction was that "*we'll have to keep an eye on it*".[83] In oral evidence, Dr Brearey said he understood that Ms Kelly was "*alluding to the fact that, you know, we would have to keep our eye on things going, going forwards in the future*".[84] Ms Kelly's evidence was to the same effect. They would be keeping an eye on the mortality rate; it was not a reference to Letby. I find that there was no discussion about Letby at this meeting.

4.57 Dr Brearey was asked whether he thought the cluster of Baby A, Baby C and Baby D's deaths should have been reported to StEIS as a Serious Incident. He acknowledged that he had not thought of it (he was not familiar with the process, and had received no training). He said that in retrospect it would have been reasonable to report the cluster.[85] He stated that "[i]*t would have led to greater scrutiny*" and resulted in family involvement, external reporting and increased objectivity.[86] This would have been particularly important because the families were not included in the local investigations at the hospital.

4.58 On 3 July 2015, Ms Peacock completed the StEIS report for Baby D and copied it, as required, to the regional commissioning group.[87] There was a full case review by the obstetric team and by the neonatal team. The two teams met separately and wrote their reports separately; the reports were then put together under the heading 'Case Review'. Ms Fogarty stated that "[w]*ith hindsight definitely, that, that should have been done*" for Baby A and Baby C.[88]

4.59 Once the post-mortem results in respect of Baby D had been received, a further meeting was held on 12 October 2015 of the obstetric and neonatal teams (Dr Joanne Davies, a consultant in obstetrics and gynaecology, Dr Newby, Ms Fogarty, Ms Powell and Ms Peacock). They reviewed the post-mortem results then reviewed the care of mother and baby in light of those results. They acknowledged, as in the main body of the review, the delays in beginning induction, in transfer to the neonatal unit and in the administering of antibiotics. They decided that antibiotics should be administered to women in labour after Preterm Prelabour Rupture of Membranes.¶ They noted that the (junior) paediatrician had not identified risk factors for sepsis and had delayed transfer to the neonatal unit, but that antibiotics had been commenced within the recommended time limit. They also set out other changes in practice, not directly relevant to the death of Baby D but directed to improving practice generally. See further details about Baby D in Chapter 3.

4.60 The case review for Baby D (also described as a root cause analysis) was sent by the Countess to Wirral Clinical Commissioning Group (CCG), who considered it at their meeting on 14 December 2015. The group concluded that no further investigation was required.

4.61 Following the Serious Incident Panel meeting, Ms Kelly emailed Dr Brearey to say she was happy to meet if he wanted to discuss anything. He did not take Ms Kelly up on this invitation. He reflected in oral evidence: "[I]*n retrospect, it was an opportunity where I could have come back to her with, you know, a suggestion of how we are going to keep an eye on it going forwards.*"[89] Whilst this may be the case, I have no reason to think such a discussion would have made any difference in light of what did happen later.

4.62 There is no evidence that Mr Harvey ever asked what had happened at the meeting or that he sought any follow-up.

4.63 Barely a month later, Baby E died. A Datix report was opened by Letby on 4 August 2015 and recorded an "[u]*nexpected death following GI* [gastrointestinal] *bleed. Full resus* [resuscitation] *unsuccessful.*"[90]

¶ This decision was taken although it was not yet National Institute for Health and Care Excellence (NICE) guidance.

Endnotes

1 Ruth Millward 4 November 2024 66/14-20
2 Ruth Millward 4 November 2024 66/11-12
3 Ruth Millward 4 November 2024 63/15-18
4 Ruth Millward 4 November 2024 66/5-8
5 Ruth Millward 4 November 2024 65/5-8
6 Ruth Millward 4 November 2024 102/8 to 103/13
7 INQ0014962/9
8 Ruth Millward 4 November 2024 68/24-25
9 Ruth Millward 4 November 2024 76/18-22
10 Ruth Millward 4 November 2024 67/6 to 68/6
11 Debbie Peacock 22 October 2024 2/8 to 6/2
12 Debbie Peacock 22 October 2024 10/3-10
13 Debbie Peacock 22 October 2024 16/8-10
14 Debbie Peacock 22 October 2024 13/1 to 16/17
15 INQ0015325/1
16 Debbie Peacock 22 October 2024 15/17-19
17 Debbie Peacock 22 October 2024 17/18-21
18 Debbie Peacock 22 October 2024 19/4-10
19 Ruth Millward 4 November 2024 95/10-14
20 Debbie Peacock 22 October 2024 55/21 to 56/18
21 Ruth Millward 4 November 2024 82/20 to 84/22
22 Annemarie Lawrence 22 October 2024 185/21 to 188/6
23 Ruth Millward 4 November 2024 88/12 to 89/3
24 Ruth Millward 4 November 2024 80/2 to 82/16
25 INQ0006769/1-2; Annemarie Lawrence 22 October 2024 252/5-23
26 INQ0049845/1
27 Ruth Millward 4 November 2024 68/14-19
28 Dr Susan Gilby 24 February 2025 46/1-6
29 Ruth Millward 4 November 2024 69/16-17
30 Ruth Millward 4 November 2024 95/14-18
31 Janet McMahon 22 October 2024 181/9-13
32 Dr Susan Gilby 24 February 2025 47/24-25
33 Ruth Millward 4 November 2024 139/17

34 INQ0006466/3

35 INQ0006466/5-6

36 INQ0000016/1; INQ0000111/1; INQ0000766/1; INQ0000194/1; INQ0040506/1; INQ0008615/1; INQ0008624/1; INQ0001457/1-2

37 Debbie Peacock 22 October 2024 45/6

38 Annemarie Lawrence 22 October 2024 200/19-21

39 Annemarie Lawrence 22 October 2024 198/2-7

40 Annemarie Lawrence 22 October 2024 222/15

41 Mother A and B 16 September 2024 13/10-11

42 Mother C 16 September 2024 127/2-5

43 Mother D 17 September 2024 55/25 to 56/2

44 Mother E and F 18 September 2024 64/25 to 65/8

45 Mother I 17 September 2024 97/16-21

46 Mother I 17 September 2024 106/23 to 107/1

47 Mother I 17 September 2024 121/12-14

48 Mother O, P and R 25 September 2024 24/18-20

49 Father O, P and R 25 September 2024 59/1-4

50 Debbie Peacock 22 October 2024 28/16

51 Debbie Peacock 22 October 2024 29/9-13

52 Debbie Peacock 22 October 2024 30/9-25

53 Ruth Millward 4 November 2024 138/12 to 139/16

54 Ruth Millward 4 November 2024 160/23-24

55 Ruth Millward 4 November 2024 141/4-6 and 143/19-24

56 Ruth Millward 4 November 2024 145/12-18

57 Ruth Millward 4 November 2024 143/22-25

58 Janet McMahon 22 October 2024 150/8

59 Janet McMahon 22 October 2024 158/19-21

60 Ruth Millward 4 November 2024 160/23-24

61 INQ0003144/3

62 Ian Harvey 28 November 2024 112/24 to 113/1

63 Julie Fogarty 15 October 2024 97/22 to 100/1; INQ0003530

64 INQ0003530

65 Dr Stephen Brearey 19 November 2024 201/2-6

66 INQ0009236/34

67 Ruth Millward 4 November 2024 150/8-18

68 INQ0009236/13

69 INQ0009236/14

70 Prof. Sir Stephen Powis 17 January 2025 105/22 to 106/1

71 INQ0014582

72 Ruth Millward 4 November 2024 150/23 to 151/5

73 Julie Fogarty 15 October 2024 102/24-25

74 Julie Fogarty 15 October 2024 101/17-19

75 Ruth Millward 4 November 2024 158/13-15

76 INQ0003299/2

77 Julie Fogarty 15 October 2024 103/1-6

78 Ruth Millward 4 November 2024 152/5-9

79 Ruth Millward 4 November 2024 158/19-23

80 Ruth Millward 4 November 2024 158/16-17 and 160/2-6

81 Prof. Sir Stephen Powis 17 January 2025 106/7-12 and 108/10-22

82 Dr Stephen Brearey 19 November 2024 48/5-7

83 INQ0103104/17/para 117

84 Dr Stephen Brearey 19 November 2024 52/13-15

85 Dr Stephen Brearey 19 November 2024 235/8-14

86 Dr Stephen Brearey 19 November 2024 54/10 to 55/15

87 INQ0108752; INQ0103104/17/para 118

88 Julie Fogarty 15 October 2024 105/12-13

89 Dr Stephen Brearey 19 November 2024 53/24 to 54/2

90 INQ0000194/1

Chapter 5. August to September 2015: Baby E, Baby F, Baby G and Baby H

Baby E and Baby F

Mother E and F: "*We found out we were having twins, which was – it was a miracle … we were ecstatic. It didn't feel real. We were very, very happy.*"[1]

5.1 Baby E and Baby F were identical twins born by caesarean section at 29 weeks and 5 days' gestation. Both twins were born in good condition, weighing 1.327 kilograms and 1.434 kilograms respectively. Mother E and F told the Inquiry: "*Everybody that we came into contact with said how well they were doing and they were doing way better than what, you know, they were meant to be doing for their gestation that they were born at. Child E was actually breathing for himself, he was on no support. Child F, he needed a little bit of extra support but that was explained to us.*"[2]

Baby E

5.2 On 3 August 2015, Parents E and F had spent all day with their newborn sons. Both parents had skin-to-skin contact with Baby E; Mother E and F described him as "*thriving*".[3] Mother E and F informed the Inquiry that, on the evening of 3 August 2015, she went to the neonatal unit to bring expressed milk to Baby E. When she entered the corridor, she "*could hear screaming and crying, and it was a shock*". She said: "*I'd never heard a baby cry like that. And then I walked into the room and I realised it was my baby. And I went to him, and he had blood around his mouth and I was just shocked.*"[4]

5.3 Mother E and F said Letby was in the nursery room between Baby E's incubator and the workstation, shuffling papers around.[5] She said:

> "*I asked Lucy Letby why there was blood around his mouth, why he was bleeding. She was quite dismissive and said, 'It'll be the feed tube rubbing the back of his throat, and that's where the blood will have come from. But I've contacted the registrar, and … he's on his way. Go back … you go back to the ward and if there's any problems I'll ring for you.'*"[6]

5.4 Mother E and F said, and I accept, that Letby's behaviour towards her during this incident was different from previous occasions. She told the Inquiry that previously Letby had been kind and looked her in the eye; however, on this occasion, "*she seemed really abrasive and didn't make eye contact with me*".[7]

5.5 Mother E and F followed Letby's instruction and went back upstairs to the post-natal ward. She told the midwife what she had seen. She also phoned her husband at 21:11 because she "*knew there was something not right*".[8]

5.6 Dr 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. In his written evidence to the Inquiry, Dr Harkness described being asked by Letby to review Baby E, as Baby E had suffered a vomit with blood. Approximately half an hour later, Baby E developed sudden, substantial bleeding. Dr Harkness, who is now a consultant paediatrician, said: "*I noted this to be unusual. This was then followed by a further episode of substantial bleeding which I commented to be 'out of nowhere' and something I had not seen before or since.*"[9] Dr Harkness described seeing a colour change over the abdomen with "*purple and pale patches*".[10] The only other time he had seen such patches was in the case of Baby A.

5.7 Dr ZA was called and arrived on the neonatal unit. Baby E suffered a sudden collapse. Dr ZA, Dr Harkness and the nurses began resuscitation.

5.8 The midwife to whom Mother E and F had spoken earlier came to her room and asked her to contact her husband and tell him to come to the hospital. Mother E and F went down to the neonatal unit and could see the team working on Baby E. A member of staff asked if she wanted Baby E to be christened.[11] Mother E and F said: "*I actually don't believe that I would have -- I don't think I would have been with Child E if it hadn't have been for the midwife, because I heard her talking to the staff, saying, 'It's not fair, it's not right. She's his mum. She should be there with him. This isn't right. She's sat in a corridor.'*"[12] Mother E and F remembered sitting outside for some time, and then a nurse came out and invited her to go in. She described holding her son's hand and said: "*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.*"[13] She said that Baby E was christened, and, when it became clear that they could not save him, Dr ZA asked to stop working on him. Baby E died at 01:40 on 4 August 2015. In August 2023, Letby was convicted of his murder.

5.9 On reflection, Mother E and F believed that she had witnessed "[a]*n interrupted attack*". She added: "*I think I caught her off guard. Something had happened to him for him to be bleeding. Stable babies don't bleed.*"[14]

5.10 Mother E and F subsequently saw Baby E's medical records and learnt from the criminal trial "*that the notes had been changed to suit a different narrative of when Child E's bleed started*". In Baby E's nursing notes, Letby wrote: "[A]*t 22:00 large vomit of fresh blood. 14ml fresh blood aspirate obtained from NG* [nasogastric feeding] *tube. Reg Harkness attended.*" There was no reference in the notes to the incident described by Mother E and F at about 9pm. Mother E and F obtained a copy of her own phone records, which demonstrated that her memory was accurate about the timing of her exchange with Letby, before she had telephoned her husband. I accept Mother E and F's evidence about her experiences that evening. I accept that Letby omitted from the notes Baby E's distress and the blood on his mouth at about 9pm. She also omitted Mother E and F's visit to the neonatal unit.

5.11 At the time of these events, Parents E and F both believed that Letby was doing what was best for Baby E. After he died, Letby bathed him and chose the clothes that he was to be buried in. Letby also made a memory box for Baby E. Mother E and F described it as "*painful*" to know that all the contents had either been created or touched by Letby.[15]

She told the Inquiry that Baby E's memory box was created without her consent or prior knowledge: "[T]*he memory boxes, they're really important, but we didn't know that that was happening. You know, we hadn't given any consent for that to be done*."[16]

5.12 At the time Baby E died, Dr ZA thought that he had died of necrotising enterocolitis (NEC), a serious condition of the intestines that mainly affects premature babies. She spoke to Baby E's parents about a post-mortem. Mother E and F said that Dr ZA had "*mentioned a post-mortem*". She said: "*I think it was my husband who asked what would that be able to tell us? And she* [Dr ZA] *said well, she didn't think that that would … because, you know, she believed he'd died from NEC.*"[17] Dr ZA did not remember the conversation as well as the parents did, but she accepted their account that she had said a post-mortem would not add anything. She said in evidence that an additional reason for Baby E not having a post-mortem was because she "*knew that Child E's parents were already devastated and didn't like the idea of a postmortem*". She said: "*I didn't want to do anything that made what was already an awful situation for them any harder. So it was the wrong decision but it was done with the best of intentions.*"[18] She spoke to the coroner's officer, who spoke to the assistant coroner, who accepted her diagnosis and decided against a post-mortem.[19]

5.13 Dr ZA stated she was "*surprised at how quickly he deteriorated*"; however, she did not link Baby E's death to the three June 2015 deaths because she "*felt that there was an appropriate medical explanation* [for Baby E's death] *at that time*".[20] Baby E had an abdominal X-ray in the early hours of 4 August 2015. In her evidence to the Inquiry, Dr ZA acknowledged that she had not realised the significance of the absence of signs of NEC on the abdominal X-ray. She explained that, when she had looked at Baby E's X-ray, it had looked relatively normal, but that does not exclude an NEC diagnosis. She went on to say: "*It was reviewing Child E's death in hindsight I thought that if the NEC was severe enough to cause him to die, then there should have been signs on the X-ray, but I didn't make that connection at the time.*"[21] Dr ZA acknowledged that she "*should have been more curious*" with regard to the X-ray and whether the images amounted to an NEC diagnosis.[22] Because Dr ZA did not carefully review the X-ray, she was satisfied, when she should not have been, that her diagnosis was correct and advised the parents and the coroner accordingly. Mr Harvey would later, reasonably, rely on the coroner's view in support of the view that this was a natural death.[23]

5.14 Parents E and F decided not to have a post-mortem. Mother E and F explained:

> "*I think trying to make an informed decision when you've got your child that's died in your arms on whether you want him to have a postmortem is -- it's an impossible decision to have to make and I couldn't -- I couldn't make an informed decision at that time. So I feel that it's unfair to ask a bereaved parent whether they want that to happen for their child, because of course you don't.*"[24]

Mother E and F 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?*"[25]

5.15 Dr Harkness accepted in his statement that, at the time, he too had thought that NEC was the cause of death. He added, however, that, with the knowledge and experience he has now, and in his current position as Named Doctor for Safeguarding, were he faced with a similar circumstance today, he would initiate a SUDIC procedure, which would

involve a post-mortem. However, he told the Inquiry: "*I do not think that decisions to undertake these procedures in inpatient deaths* [were] *common at the time, although in light of the events at the Hospital it has affected the practice in my health board and I am sure it has affected practice elsewhere.*"[26] His observation about the general view at that time is correct. I deal with the question of SUDIC in Chapter 12.

5.16 Baby E died on Dr Wood's last day at the hospital as a GP trainee. Dr Wood said: "[I]*n relation to Child E's death* 'it 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.*"[27] In his statement to the Inquiry, Dr Wood went on to say: "*I was worried about the number of deaths only because it was suggested that they were more numerous than normal and perhaps occurring in babies who seemed to be doing well.*"[28]

5.17 Mother E and F also spoke of how sudden and unexpected Baby E's death was. She shared in oral evidence that "*a couple of hours earlier we had two thriving little boys*". She added: "[I]*n the space of a couple of hours, it had all been taken. And our world had just* [spun] *upside down and nothing felt right.*"[29]

5.18 She told the Inquiry that, after Baby E's death, Parents E and F "*went into see Child F, and Child E was still in his incubator*". Mother E and F said: "[I]*t took my breath away in that moment. And it was actually Lucy Letby, and I said, 'He's still here' and she said, 'You haven't told us to take him', but then I didn't know that I was meant to -- I didn't know what was meant to happen.*"[30] Letby's remark to a bereaved mother was shockingly cold and unfeeling.

5.19 Nurse W had a recollection of Baby E from her shifts on 29 July 2015 and 3 August 2015. She gave evidence that, when she had left Baby E on 3 August 2015, he was clinically well. He died the next morning. Recalling coming in to work on 4 August 2015, she said: "*She* [Letby] *couldn't wait to tell me and it was not easy news to walk into first thing in the morning.*" Nurse W felt "*bombarded*" by Letby.[31] Ms Taylor similarly described Letby informing her of another child's death, saying that "*it was almost in a way where she was excited to tell me almost like a gossip -- in a gossipy manner*".[32]

5.20 Letby was convicted of Baby E's murder.

Baby F

5.21 Baby F was born in good condition and, at 1.434 kilograms, slightly heavier than his twin brother. When admitted to the neonatal unit shortly after his birth, he had a low blood glucose level of 1.9 millimoles per litre. The following day, his blood glucose rose to the very high level of 15.1 millimoles per litre. At 03:40 on 31 July 2015, manufactured insulin was administered; he responded well to the insulin and his blood glucose dropped within an hour to 8.7 millimoles per litre. Letby was found guilty of the attempted murder of Baby F. Professor Peter Hindmarsh, Professor of Paediatric Endocrinology at University College London Hospital, who gave evidence at the criminal trial about Baby F and Baby L, said that Baby F's blood test results demonstrated that exogenous insulin had been administered to Baby F over a 17-hour period. The jury found Letby had added insulin to two total parenteral nutrition (TPN) bags. The two bags were supplying liquids to Baby F overnight on 4/5 August 2015 and on 5 August 2015 respectively.

5.22 During the night of 4/5 August 2015, Dr Harkness was called to attend to Baby F. As Dr Harkness noted in his statement to the Inquiry, he was "*concerned about both Child F's increased heart rate and low blood sugars*" and he discussed this on the phone with Dr Gibbs, the consultant on call.[33] Dr Gibbs said that he had examined Baby F at around 8.30am on 5 August 2015 and noted he had low blood sugar levels and suspected that he had an infection. The low levels persisted, despite Baby F being given extra sugar.[34] Dr Gibbs described this as "*unusual*".[35] Thus, blood samples were taken at 17:56 on 5 August 2015, while Baby F's blood glucose was low, and sent to Liverpool Clinical Laboratories at Royal Liverpool University Hospital for analysis.[36] When the intravenous feeds were stopped and the TPN bag was taken down, the blood sugars started to increase.

5.23 Mother E and F recalled that she and her husband were in the accommodation on the neonatal unit waiting for news of a transfer to a hospital nearer to their home. She said: "*Nurse T come and knocked on the door, and said, 'I think you need to come in to Nursery 2, Child F is experiencing really rapid, fast heart rate', and in that moment I just thought: not again. This simply cannot be happening to us again.*"[37] Mother E and F said Dr Gibbs had come to review Baby F and "*told me that Child F had an infection in the long line of his leg, and moving the long line in his leg, and setting him on a course of antibiotics would rectify things*".[38] She said: "*I didn't even know he'd been tested for insulin. Insulin was never mentioned to us at the time.*"[39]

The laboratory tests

5.24 Liverpool Clinical Laboratories performed an insulin and C-peptide test. Analysis of Baby F's blood samples showed low C-peptide to insulin. This was very significant, but, by the time the results were received on 12 August 2015, Baby F was stable and his glucose levels were normal.[40]

5.25 The results of the test (low C-peptide to insulin) were recognised as important. Baby F had an insulin level of 4,657 picomoles per litre and insulin C-peptide levels of 169 picomoles per litre. Ms Heather Wilshaw-Jones, Senior Clinical Scientist at Liverpool Clinical Laboratories, telephoned the Trust to speak to the "*Countess of Chester Biochemist*".[41] Ms Wilshaw-Jones did not have any clinical details and did not know whether insulin had been prescribed for Baby F. The note made by Ms Wilshaw-Jones of her call reads: "*Low C-Peptide to insulin. ?Exogenous – suggest send sample to Guildford for exogenous insulin.*"[42] This was serious. Exogenous meant external. What the result showed was that the blood sample contained insulin that had been administered from an external source, rather than being manufactured by the body. In other words, the baby had been given insulin, which had not been prescribed to him.

5.26 It seems that the results were phoned through to the ward by someone in the laboratory at the Countess. There is no evidence that there was any urgency expressed or that there were any concerns. But the evidence is that the laboratory only telephones the ward if there is something significant in the result.[43] It is not known who received the phone call or passed on the information. There is a note of the blood results in the medical note written by Dr Lyddon on 13 August 2015. The annotation shows, by vertical arrows, that the insulin level was high and the C-peptide level was low. Dr Lyddon's entry in the medical notes recorded the result and her subsequent discussion with Dr ZA thus:

> "*Hypo screen results*
>
> *Cortisol 364*
>
> *Insulin 4657* ↑
>
> *Insulin C-Peptide <169* ↓
>
> *C-Peptide / Ins 0* ↓
>
> *D/W Doctor ZA – insulin high, c-peptide low – unusual for hypoglycaemia. As now well and sugars stable no further ix*".[44]

5.27 In oral evidence, Dr Anna Milan, Principal Clinical Scientist at Liverpool Clinical Laboratories, explained the science behind Baby F's results. She said:

> "[W]*hen insulin's formed in the body it's formed from a precursor, so it's a molecule that contains insulin … So once it's cleaved in the body you get one C-peptide and one insulin. So in health it's equimolarly produced, so equal portions, and insulin has a very short half-life, whereas C-peptide has a longer half-life, so it hangs around for longer … the normal ratio in health should be that C-peptide to insulin has a ratio of about 10 to 1, sometimes that can be 5 to 1, depending on metabolism. In this case it was the other way round. So insulin is extremely high with an undetectable C-peptide. So that points to the fact that this wasn't produced by the body and so the primary differential is exogenous insulin administration.*"[45]

5.28 Dr Milan explained that the insulin C-peptide was undetectable and was recorded as "*<169*" because this is the lowest quantifiable measurement.[46] She asserted that Baby F's results "*warranted a phone call to Chester … to expedite that information to the clinical team*".[47] Dr Milan stated that the results "*would be considered a safeguarding issue*".[48]

5.29 There have been some suggestions from different quarters outside the Inquiry that the testing carried out was in some way defective. The evidence to the Inquiry was to the contrary effect. Dr Milan explained first in writing and then clearly in oral evidence that the quality assurance process at the laboratory enabled her to be sure the test results were accurate. She stated: "*We wouldn't have even measured the sample if we weren't sure that the analyser was performing appropriately that day. And then with the results, we have to double-check that the -- it's a quality control procedure before we even release a result on to an electronic system to be communicated.*"[49] This is what is to be expected of a laboratory providing such an important service. There is no reason to think that the machines were not properly calibrated or that there was any error in the process. Immune assay tests of this type are widely used. They are relied upon in every hospital in the land. External criticism has been made that the test does not distinguish between exogenous and endogenous insulin, but that is to overlook the other part of the test – the use of the C-peptide – which gives a robust basis to say that the insulin is exogenous.[50] None of the Core Participants sought to explore, still less challenge, any of Dr Milan's evidence.

5.30 Dr ZA said in evidence that the results indicated that something unexpected was happening, as "*the blood results looked as if Child F had been given exogenous insulin, which is an insulin as a medication*".[51] She explained that, if insulin was produced naturally in the body, you would expect to see significantly more C-peptide than

insulin.[52] She recalls that she checked and established that no other child on the neonatal unit had been prescribed insulin, making accidental administration unlikely. She dismissed the idea of deliberate administration of insulin:

> "[T]*he idea that someone could be doing it deliberately just seemed so fantastical and unlikely that that couldn't possibly be what had happened. With neonatal blood samples, because they're so small and often difficult to obtain, we do get unusual results from time to time, and our normal practice if something is outside of what we would expect is to repeat them. We obviously couldn't repeat the bloods at this point because Child F was well with a normal glucose level, so we wouldn't be able to repeat them.*"[53]

5.31 Dr ZA did nothing to check whether she was right to dismiss the possibility of deliberate administration of insulin. She did not contact the laboratory at Chester, or the laboratory at Liverpool. Nor did she speak with any colleagues. Nor did she mention it to Dr Brearey, even though she knew by that stage that he had concerns about the increased mortality on the neonatal unit. As for a further test in Guildford, the baby was now stable and no further test was deemed necessary.

5.32 Dr ZA was completely candid: "*At the time, I just dismissed the idea of someone deliberately administering insulin because it just seemed so impossible.*"[54] She later said, when asked if she had considered whether there was something unnatural, "*It crossed my mind and I rejected it.*"[55] She recognised she had "*made the wrong decision*".[56] Dr ZA 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*."[57] Unlike many who have given evidence, Dr ZA, from the outset, acknowledged her own failings. Long before the Inquiry, she had written to Parents E and F apologising for her errors in respect of both children. The insulin administration ultimately came to light because, when the police were alerted in 2017, she remembered the insulin results in August 2015. She had understood them at the time. Dr ZA explained in oral evidence that this was troubling her when she was on leave in mid-2017. She said: "*I had something in the back of my mind nagging about Child F's results and the fact that at the time I'd dismissed the possibility of deliberate harm, but now, based on what we were thinking, that didn't seem so impossible any more.*"[58] On 6 June 2017, Dr ZA sent an email to Dr Brearey raising her concerns about insulin.[59] Dr Brearey was going through the medical notes of all babies in the relevant period. He found the insulin results in Baby F's notes and the police were informed.

5.33 Mr Harvey said in his written statement for this Inquiry, and then in his evidence, that he should have been told about this important result.[60] I agree with him. He said it would have affected the decision about whether to call the police. It should have led immediately to a call to the police.

5.34 Dr Gibbs noticed the result for the first time when he was asked to provide a statement to the police in the investigation into Letby. He checked the significance of the C-peptide results, which meant that it "*was likely to be insulin that had been injected into the baby*".[61] Dr Gibbs had missed the results when he reviewed Baby F's case during the Silver Command investigation in July 2016 (see Chapter 15), but his role there was to look at babies who were transferred out of the neonatal unit following an unexpected

collapse.[62] Dr Gibbs explained: "*But Child F was transferred out when he was entirely well because the Family lived outside West Cheshire and he was going back home. So as soon as we saw that, we stopped looking at him in the review.*"[63]

5.35 To the Inquiry, Dr Gibbs expressed the view that the failure to see and act upon the insulin results in Baby F's notes was a collective failure by all the consultants. Other consultants said that too. Whilst it is true, as all the consultants acknowledged in evidence, that the results were there and anyone could have read them, no consultant at the Countess other than Dr ZA had any reason to look at the notes of Baby F at that time. Baby F was transferred to a different hospital shortly after the results were entered into the notes. I do not accept that there was a collective failure here.

5.36 Mother E and F said: "*I realised in the criminal trial that the insulin reading was there and it was seen and nothing was done. That could have been an end to this whole horrendously sad turn of events, but it wasn't.*"[64]

5.37 She said that what had happened to her sons had changed the course of the family's life completely, stating: "[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.*"[65]

Serious Incident Panel, 13 August 2015

5.38 On the morning of 13 August 2015, Ms Millward emailed Mr Harvey, Ms Kelly and others to inform them that the death of Baby E was to be considered by the Serious Incident Panel later that day. She described Baby E's death as: "*Unexpected neonatal death of a twin aged* [redacted] *days (NNU).*"[66] It is surprising that Ms Millward did not alert the recipients of the email to the fact that this was now the fourth death on the neonatal unit in a short period, nor did she establish and share with Mr Harvey and Ms Kelly that this was an unusually high number of deaths compared with previous years. She should have done both. It is equally surprising that neither Ms Kelly nor Mr Harvey connected the meeting held on 2 July 2015, which had discussed Baby A, Baby C and Baby D and had been attended by Ms Kelly, and so failed to connect the deaths of the four children themselves.

5.39 The Serious Incident Panel meeting was held on the afternoon of 13 August 2015. Present were Mr Harvey, Ms Kelly and Ms Sarah Harper-Lea (Head of Legal Services) along with Ms Millward. There are no minutes of the meeting except for a very brief note on the Datix form.[67] In oral evidence, Ms Millward explained that Baby E's death was not reported as a Serious Incident because, at the time, "*the feedback that was received from the unit was again that there was clinical reasons that would have contributed to the death*".[68] Mr Harvey was satisfied that, although the death of Baby E was unexpected, there were no apparent concerns from the medical staff (Dr ZA having concluded that Baby E had NEC). He took comfort from the fact that the coroner was content. There was no effective review, and so Baby E's death was not reported to StEIS.[69]

5.40 This outcome demonstrates a flawed approach to review. It is clear that the approach of those at the meeting was to look only at the case in front of them, that of Baby E. They were all satisfied that there was a natural cause, so they saw no reason to look further. That having been said, it had been Ms Kelly's view at the meeting in July 2015 that an eye should be kept on neonatal unit mortality in light of the three deaths. She should, as

a minimum, have reminded the other people at the August 2015 meeting that this was the fourth death in just over two months, and that she was keeping an eye on neonatal mortality. Given the clear finding of a natural cause for the death of Baby E, a referral to StEIS was not considered. The fact that this was the fourth death was not even recorded at that meeting.

5.41 Ms Millward agreed that, if the death had been reported to StEIS, it would have prompted a comprehensive review of the neonatal unit's practices.[70] As noted by Dr Brearey and set out in Chapter 4, an additional benefit of a Serious Incident Investigation is that investigators meet the parents, who have an opportunity to say what they are concerned about.[71] Had investigators spoken to Mother E and F, the disparity between what she had seen and heard and what Letby had written would have been obvious. The truth about the earlier part of the evening would have been known, including what Mother E and F had seen of the condition of her child. All that having been said, the StEIS report in respect of Baby D (see Chapter 4) led to no external comprehensive review. Given Dr ZA's confidence in her view of the cause of Baby E's death, it is far from certain that a StEIS report would have made any difference.

5.42 In oral evidence, Mother E and F said she was not aware of the Serious Incident Panel meeting regarding Baby E's death. She pointed out that the date of the meeting, 13 August 2015, was the day of Baby E's funeral.[72]

5.43 It was noted on the Datix form that the death of Baby E would be discussed in a neonatal mortality review.[73] This did not happen, because, at the meeting at which Baby E was to be considered, there were three other babies to be reviewed and there was not enough time to consider Baby E. The dates for these meetings were fixed at the beginning of the year. The number of meetings scheduled was assessed by reference to the number of deaths in the previous year; there had been three deaths in 2014. By August 2015, there had already been four deaths on the neonatal unit. The pre-arranged meetings could not accommodate them all. As a result, some cases were not considered in that forum. No further meeting was organised. It is likely that, as with the meeting of the Serious Incident Panel, NEC having been the diagnosis, it was thought there was no need.

5.44 Dr Brearey completed his own review of the death of Baby E, dated October 2015. He recorded the likely cause of death as "*a perforated bowel secondary to NEC*".[74] He agreed in evidence that Mother E and F had important information to give about the death of Baby E. He said: "[I]*t would have been really helpful to have the parents there but it just wasn't the process at the time.*"[75] He recalled speaking to Dr ZA about Baby E and that she was satisfied that the cause of death was NEC.

5.45 The deep-rooted belief held by many that nurses do not harm babies manifested itself in Dr Brearey's thinking at the time. In August 2015, despite being concerned about the deaths and being aware of Letby's presence, Dr Brearey explained it was "*quite firmly in my mindset that these were natural and this is me just being paranoid*".[76] He was not alone in this. No one else thought Letby or anyone on the unit was responsible for the deaths.

Clinical Effectiveness Group meeting

5.46 Baby E's death was referred to and discussed at the Cheshire and Merseyside Neonatal Network Clinical Effectiveness Group meeting held on 12 November 2015, attended by Dr Brearey and Ms Powell.[77] It appears that the three June 2015 deaths of Baby A, Baby C and Baby D had also been noted for discussion at the earlier meeting on 16 September 2015.[78]

5.47 Dr Subhedar was the Clinical Lead for the Cheshire and Merseyside Neonatal Network (the Neonatal Network). In oral evidence to the Inquiry, he explained that the Neonatal Network was one of three locality networks in the overarching Operational Delivery Network across the NHS North West region. There were nine neonatal provider units, including the neonatal unit at the Countess.[79] Dr Subhedar chaired the Clinical Effectiveness Group, which met every two months.[80] He explained: "*The primary role of that group was sharing and learning, really. Learning from Incident Reviews and Mortality Reviews that were conducted by neonatal unit providers and sharing best practice.*"[81]

5.48 It was Dr Brearey's recollection that, after the meeting on 16 September 2015, he told Dr Subhedar "*that we had had some more deaths in addition to the three that were discussed in the meeting*" and that the Countess was "*having more* [deaths] *than expected*".[82] He did not tell him about the association with Letby.[83] He said that Dr Subhedar advised him to keep the Neonatal Network informed. Dr Subhedar recalled this conversation but said that it had taken place after the Clinical Effectiveness Group meeting on 21 January 2016.[84] Dr Subhedar also recalled that it was during this conversation that Dr Brearey asked him (as he undoubtedly did) to be involved in the Thematic Review of Neonatal Mortality.[85] The precise date of the conversation does not matter. What matters is that Dr Brearey told Dr Subhedar about the increased mortality rate and asked him to become involved in a review.

Referral to CDOP

5.49 Baby E's death, as well as being referred to the Neonatal Network, was also referred to the CDOP on 5 August 2015 by Dr ZA.[86] It appears that there was a meeting on 18 December 2015,[87] at which the cause of death was recorded as 'Prematurity, Necrotising Enterocolitis' and no recommendations were made.

5.50 Ms Sharon Dodd, Paediatric Liaison and CDOP Nurse Representative, Cheshire and Wirral Partnership NHS Foundation Trust, received the CDOP Form A notification forms (see also Chapter 12). She gave oral evidence that she had a good working relationship with Dr Rajiv Mittal, Designated Doctor for Safeguarding and Child Deaths, Integrated Care Board (ICB). Ms Sharon Dodd stated they would inform one another of child deaths at the Countess depending on who had received the Form A first. Ms Sharon Dodd thought that she and Dr Mittal may have discussed in around September 2015 that there had been three or four deaths on the unit and that it was tragic to have those deaths; however, the pair did not discuss any concerns or scrutinise the deaths.[88] Her evidence was that "*the information that I received didn't alert me to any concerns around those deaths*".[89] She would have expected Dr Mittal to have told her if he knew there were concerns at the time.[90]

5.51 Dr Mittal had a similar recollection to Ms Sharon Dodd of their conversation. He gave evidence that he "*knew that the number of deaths* [were] *more because of the notification forms*"[91] and that "*the number of deaths in* [the] *Countess were much more than what we would normally expect in a year*".[92] Despite this knowledge, and being based on the same corridor as the other consultant paediatricians, Dr Mittal did not approach the clinicians to ask about the increased number of deaths. He accepted that, "*in hindsight*", he "*should have explored these more*".[93] Given his role, he should have asked some questions about the increased number of deaths. I deal separately with the multitude of failures of safeguarding in Chapter 12.

5.52 Dr ZA gave evidence that, at some point after Baby E's death, the consultants had a discussion about the number of deaths. She said: '[T]*here was quite a high level of concern that we'd had four deaths at this stage, and very much a worry about what were we overlooking in terms of medical care, environment, why -- why had this happened.*"[94] Dr ZA could not recall any concerns of deliberate harm being raised at this stage.[95]

5.53 Ms Anne Murphy (Lead Nurse for Children's Services) told the Inquiry that, after Baby E's death, she had informed Ms Jane Evans (Head of Nursing, Urgent Care Division) about "*a series of infant deaths*". She had informed her it was "*slightly unusual for the neonatal unit to have a spate of deaths all at once*".[96] It was not slightly unusual; it had not happened before.

5.54 Ms Karen Rees (Moore), Head of Nursing, later Associate Director of Nursing, Urgent Care Division, had replaced Ms Evans in the role by September 2015. Ms Rees stated she became involved in discussions around mortality when the Brigham Review was received by QSPEC in December 2015.[97] Ms Rees characterised the communication of concerns as "*a little bit cloak and dagger*" and thought she should have been informed sooner.[98] She thought that she had been left out of things by the senior managers. Her predecessor had been informed of the deaths and I see no reason for the same information not to have been passed on to Ms Rees. If the information was not passed on, that was an error by Ms Anne Murphy and by Ms Powell, both of whom understood the position. Ms Powell was well aware, at the time when Ms Rees joined the division, that there had been an increase in neonatal deaths. Whether or not there had been a failure to pass on the information by Ms Powell or Ms Anne Murphy, Ms Rees was right to say this was something she should have been told about shortly after taking on her new role in September 2015.

Board meeting, September 2015

5.55 On 1 September 2015, there was a public meeting of the Board of Directors.[99] The minutes record that the Medical Director (Mr Harvey) presented the hospital's mortality report to the Board.[100] However, there is no reference in the minutes to the increase in mortality on the neonatal unit, which had now reached four deaths in a period of just over two months. The three June 2015 deaths had also not been mentioned at the Board meeting on 7 July 2015.

5.56 The minutes of the meeting record: "*Mr Harvey now personally reviews every death in the Trust and then refers cases for further review where appropriate.*"[101] That statement was important and duly minuted. The minutes were not challenged until 2024, and then by Mr Harvey only in the context of this Inquiry. He said in evidence that the minutes were

wrong and should have referred to every adult death. If the public were to understand that Mr Harvey was reviewing all deaths except those of children, that should have been said in clear terms.

5.57 Mr Harvey was confident, he said in evidence, that there was a process in place for reviewing child mortality[102] – for example, mortality reviews, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and the like – but they are nothing to the point. There is no evidence of any process which put the mortality data for children and babies before the Board of the hospital, and there is no evidence that anyone noticed. Ms Kelly accepted in evidence that, whereas adult mortality was reported to the Board, the same scrutiny was not applied to neonatal deaths.[103] It was a failing of the governance process that the Board did not routinely receive information about neonatal deaths in 2015/16.

5.58 I acknowledge elsewhere in this Report that paperwork in the NHS is unnecessarily onerous, but the Board of a hospital should know about the deaths of babies and children. The contrary is unarguable. The numbers are, as I was often reminded, very small. That is not a reason to ignore them and all the more reason to be aware of an unusual increase.

5.59 I note that, at the same meeting, the Board specifically discussed the mix of expertise on the neonatal unit in light of recommendations made by Dr Bill Kirkup CBE in his report on the University Hospitals of Morecambe Bay NHS Foundation Trust. This was obviously the moment to say in public, if it were the case, that 'all the deaths in the hospital' did not include those of babies and children.

5.60 Mr Harvey and Ms Kelly both knew there had been a marked increase in deaths on the neonatal unit, and neither brought it to the attention of the Board when discussing the unit. It was less than three weeks earlier that they had been reviewing the death of Baby E, and both knew about the deaths of Baby A, Baby C and Baby D in June. The Board should have been told. That they were not told is evidence, at least, of a lack of interest in infant mortality and/or of a desire to keep unwelcome news under wraps in the hope that an explanation would come to light which would reassure the Board that there was nothing to worry about.

5.61 At the Board meeting on 1 September 2015, the Board was told that the number of staff who had received safeguarding training was under expected levels.[104] Whilst this was presumably the case for the hospital as a whole, it was not the case in respect of children, in that all Group 3 staff (those who had regular contact with children and their families, such as nursing and medical staff on the neonatal unit) received training in safeguarding. Ms Paula Sindall (née Lewis), a specialist safeguarding children's nurse (band 7), explained that training was monitored by staff managers to achieve compliance targets of 80%, as set by the Clinical Commissioning Group. She set out in her evidence that Group 3 staff both attended annual face-to-face training and completed additional e-learning.[105] In the event, no questions emanated from the Board about safeguarding children.

Baby G and Baby H

5.62 Between 7 and 27 September 2015, two more babies, Baby G and Baby H, suffered a number of unexpected collapses while Letby was on duty.

Baby G

5.63 Baby G was born in Arrowe Park Hospital at 23 weeks and 6 days' gestation, weighing 535 grams. She spent approximately 11 weeks at Arrowe Park Hospital.

5.64 Mother G said in evidence:

> "*Our baby was taken to the intensive care part of the Neonatal Unit of Arrowe Park Hospital. She was ventilated and had several intravenous lines. She was absolutely tiny and her skin was almost see-through, but I felt so much love for her … Our daughter had many brain scans at Arrowe Park Hospital, and we were told they were looking good. I could see her growing and made sure I was present as much as possible so we could bond. She was our little miracle, a gift from God. We were so happy to see her improving.*"[106]

5.65 On 13 August 2015, she was transferred to the Countess in a stable condition.

5.66 Mother G explained:

> "*At first, our daughter continued to improve. She was doing so well. She was smiling, grabbing her dummy with her hand, drinking from her bottle, recognising and responding to our voices. She had a cheeky little smile which I loved. We were coming up to her 100th day since birth … and the nurses on the Unit had prepared balloons, cake and a banner to celebrate our daughter's 100th day, which was very exciting. We were told that she was doing well and that it wouldn't be long before we would be able to take her home.*"[107]

5.67 Dr Brearey reviewed Baby G on 6 September 2015 in Nursery 2 and confirmed she was stable and improving, and preparations for her discharge home continued.

Collapses

5.68 Nurse Z was the designated nurse for Baby G for the night shift of 6/7 September 2015. Ms Ailsa Simpson was the shift leader and Dr Alison Ventress was the registrar on duty. Letby was working on the night shift, allocated to a child in Nursery 1.

5.69 Baby G suffered repeated collapses in the early hours of 7 September 2015 after a large projectile vomit at around 2.15am. The vomit was substantial and said to have projected several feet across the room, away from her cot. During subsequent attempts to resuscitate Baby G, 100 millilitres of milk was aspirated from her stomach. The volume of milk taken from Baby G's stomach, combined with the volume that she had vomited, far exceeded the small volume of expressed breast milk that she had been fed.

5.70 Parents G were called in the early hours of 7 September 2015 and were told that their child had vomited and aspirated her vomit. They were told that her blood tests confirmed neonatal sepsis. They were not told that Baby G had collapsed.[108] Father G said:

> "*The doctors didn't tell us that on 7 September 2015 our baby daughter in fact had a projectile vomit, with the milk coming out of her tiny little body with so much force that it reached the chairs opposite her cot. They also didn't tell us that upon aspirating the*

> *contents of our daughter's stomach after her projectile vomit on 7 September 2015, they found she still had around 45 millilitres of milk in her stomach, which was an enormous amount of milk and more than her feed.*"[109]

He continued: "[I]*t was calculated that her projectile vomit of 7 September 2015 that had reached the chair in her room was a distance of 3–4 feet away from her cot, indicating the force of her vomit and the pain she must have felt with the pressure building up in her tiny little body.*"[110]

5.71 After initial resuscitation efforts, Baby G was treated for presumed sepsis with antibiotics. The initial sepsis diagnosis was recorded, even though Baby G's CRP (C-reactive protein) was (at that point) normal and she had no other signs or symptoms of infection. At 15:00 on 7 September 2015, Dr ZA recorded a blood test result in Baby G's medical records which noted a CRP of less than 1. Dr ZA gave evidence that this result within 12 hours of Baby G's collapse was not consistent with sepsis causing a collapse.[111] Dr Brearey accepted in his oral evidence that, whilst at the time it was felt that the blood tests were indicative of an infection, he now accepted a different cause of collapse.[112] 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*".[113]

5.72 Baby G was transferred to Arrowe Park Hospital on 8 September 2015, where her condition improved. While she was there, a brain scan was carried out. Baby G was transferred back to the Countess on 16 September 2015.

5.73 On the day shift of 21 September 2015, Baby G was being cared for in Nursery 4, with Letby as her designated nurse. Shortly after a feed at 09:00, Baby G had two large projectile vomits which caused her to stop breathing temporarily. Mother G recalled coming to see her daughter that morning. She was told by Letby to wait in the parents' room, as Letby had to do some tests on Baby G. After a while, Mother G heard Baby G screaming, so she ran back into the room to make sure that her child was okay. Mother G found "*Letby standing by our daughter's cot, looking sort of puzzled*". She continued: "*There was another nurse in the room as well. Our daughter was screaming and looked very red and I saw vomit on her.*"[114]

5.74 Baby G was moved to Nursery 1 mid-morning, and Nurse W took over her care. She collapsed again at 15:30. This episode was again put down to sepsis, although, as before, negative cultures were again reported and Baby G's slightly raised CRP was not considered to support such a diagnosis.

5.75 At the time, Dr Brearey was aware Baby G had had a large vomit yet still required an abnormally large amount of gas and fluid to be aspirated from her stomach. However, he did not appreciate the significance of this at the time, and did not tell Parents G about it. He should have done, as he accepted.[115] He accepted that the fact that, after large projectile vomits, there was still 100 millilitres of fluid in her stomach was certainly unusual. In 2017, he referred the case of Baby G to the police because it had reached the threshold at which it was appropriate to do so, but he did not have sufficient knowledge to say precisely what had happened.[116]

5.76 Dr Gibbs stated he did not have any concerns or suspicions about deliberate harm at the time of Baby G's collapses, because he had thought Baby G was an extremely premature child prone to collapse. With hindsight, he reflected: "*I feel I was misleading myself*."[117] He was. Baby G had been transferred to the Countess in a stable condition. She was now at the equivalent of 35 weeks' gestation. All the preparations were being made for her to go home. It was a time of celebration. The collapses came, apparently, from nowhere.

5.77 Letby was found guilty of attempting to murder Baby G on two occasions: during the night shift of 6/7 September 2015 and on the morning of 21 September 2015. She was found not guilty of a further charge of attempted murder on the afternoon of 21 September 2015.

5.78 Baby G suffered profound brain injury from her collapses with lifelong consequences. Mother G described the impact of Baby G's collapses on their family. She said: "*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.*"[118]

5.79 Mother G said:

> "*The Countess of Chester Hospital never once told us they had any concerns about Lucy Letby and we didn't find out until we were informed by the police in 2018 -- but even then, we knew no details of what precisely Lucy Letby was accused of having done to our daughter. We only found this out just before the criminal trial of Lucy Letby, which was harrowing. I feel that the Countess of Chester Hospital have covered up what happened to our daughter for years, telling us all this time that our daughter suffered neonatal sepsis, despite there not even being a marker for sepsis in her blood tests at the time.*"[119]

5.80 Dr Brearey has been the paediatrician for Baby G since 2015. He was reminded by Mr Baker KC of a time in one of their consultations when he showed Father G the observations for his daughter and told him that they were entirely normal up until the point of the collapse. He was asked whether he was trying to tell Father G something. He said that he could not remember that specifically. He said that, at that time, his focus was still on the deaths:

> "*I can't remember whether my suspicion with Baby G was -- was very high or I really can't remember where I was in my mind process about the concerns for her at the time. I certainly wouldn't have been in a position to or want to mislead any family in any way, certainly not -- not her family and -- and if I -- ever did, I am sincerely sorry for that really.*"[120]

He said that he had felt uncomfortable with other families but pointed out:

> "[O]*nce you share a concern like that with a parent, you are effectively putting your concerns into the public domain before a police investigation has even started which is -- is difficult to feel is -- is appropriate, you know, I had never been in this situation before. I have always tried to be as honest as I can with any set of parents and if I did mislead them and I was thinking of concerns at that time, I sincerely apologise for that. But that certainly wasn't anything malicious or intentional.*"[121]

Baby H

5.81 Baby H was born at 34 weeks and 4 days' gestation, weighing 2.33 kilograms. She suffered a series of collapses between 24 and 27 September 2015. Letby was charged with causing her sudden collapses during two consecutive night shifts, at 03:22 on 26 September 2015 and at 00:55 on 27 September 2015. Baby H was being cared for in Nursery 1, with Ms Tomlins as her designated nurse. Letby was also working in Nursery 1, caring for other babies.

5.82 During Baby H's time at the Countess, she had a recurring pneumothorax and three chest drain procedures. She was also placed on ventilation. The jury delivered a not guilty verdict in relation to the count of attempted murder in relation to the first collapse. The jury could not reach a verdict in relation to the second collapse. After the collapses, Baby H was transferred to Arrowe Park Hospital on 27 September 2015.

5.83 On 24 September 2015, Mother H was in a wheelchair and had been waiting for Father H to take her downstairs. Father H took Mother H down to the neonatal unit. She saw that Baby H had deteriorated since the previous evening and was now on ventilation. Mother H informed the Inquiry that no one had informed her or anyone else in the family about Baby H's decline. She stated:

> "*I asked the doctor what was going on and I was told that she had been put on a ventilator. I really couldn't understand why I'd not been informed of this earlier because we were told that she was okay. You know, I'd always check and would always ask how she was, and we were told that she was okay, you know, that she was okay. I was only upstairs. I knew they were busy but if it was something that significant to me, a ventilator sounds like a really scary and a really big change and there was no indication that that was going to happen that we were told of.*"[122]

Mother H recalled asking: "[W]*hat had happened? Why did she all of a sudden … obviously she had deteriorated and I don't remember anyone giving me a clear explanation as to why she had deteriorated.*"[123]

5.84 Mother H made a complaint to the Patient Advice and Liaison Service (PALS) about why no explanation was forthcoming about Baby H's deterioration. Later that day, Dr Gibbs apologised and stated there would be more timely communication in the future.[124] Ms Powell's reaction to the complaint was to criticise Mother H and express empathy for a nurse involved in the events. In an email response to the PALS complaint, Ms Powell wrote:

> "*My question as an addendum is why had it taken mum so long to come to the unit when she was aware how poorly her baby is. (just a thought) especially as she is an inpatient or even ask the midwife to ring/use her mobile for an update. I have spoken to Belinda and Nurse W as you can imagine Nurse W is upset that she has tried her best – only to receive this complaint.*"[125]

5.85 In oral evidence, Ms Powell confirmed she had made that remark without first speaking to Mother H and that she did not know that Mother H was having difficulty getting the midwives to take her down to the neonatal unit.[126] She also agreed that a mother finding

her child ventilated was a scary experience and that "*I'm sorry*" was the appropriate response.[127] Ms Powell's loyalty was first to the nurse. It led her to unjustified criticism of a mother who had proper cause for complaint.

5.86 Mother H was invited to comment on Ms Powell's email. She described feeling "*very, very upset*", and said:

> "*I am shocked that that is even part of a conversation between the nurse and the doctor, because she hasn't got the full story there at all. And, you know, I am deeply offended by that. You know, like how dare she make a comment on that at such a difficult time? Because in actual fact I was an inpatient on the ward, I had asked many a times for the people up there to phone, to phone down. I had used my mobile to ring to check that she was okay, and I was told that she was stable, and I was trying my best to get down there. I wasn't allowed to just go down on my own, so I couldn't get down there easily. And I wasn't aware of how poorly she was because I wasn't told how poorly she was.*"[128]

5.87 Dr Jayaram was called into the hospital in the early hours of the morning of 25 September 2015 because Baby H had increasing ventilator requirements. Dr Jayaram stated: "[A]*s I walked in it struck me it's -- it's Letby. And my thinking at the time is, you know, she's very unlucky that she seems to be associated with all of these.*"[129]

5.88 Dr Jayaram found the valve on Baby H's chest drain was in a closed position and reopened it. At the time, he thought this may have happened accidentally, as a result of many hands being in the incubator during Baby H's procedures.[130] He did not think anything untoward was happening at the time. He said: "*I had noticed that association with Letby being present but not with any, any thought of anything untoward.*"[131] However, he stated: "[I] *mentioned to Dr Brearey the next morning that it was -- it was -- it was Lucy Letby again, simply because I was thinking, well, she's -- she's very unlucky.*"[132]

5.89 Dr Brearey could not recall Dr Jayaram mentioning Letby, but he did remember him raising questions about Baby H. He said it was not until 2016 or 2017 that he became more aware of the unusual nature of Baby H's care, when the consultants discussed unusual morbidity cases that had occurred in relation to Letby.[133] Eighteen months later, on 15 March 2017, Dr Jayaram disclosed the incident with Baby H's chest drain to Ms Sue Hodkinson, Director of HR.[134]

5.90 Dr Gibbs stated both he and Dr Jayaram had noticed that Letby had been caring for Baby H. Dr Gibbs said that, around that time, "*we were trying to make sense of the number of collapses and deaths that were happening and then realising that Letby was around for many*".[135]

5.91 Baby H had a further collapse in the early hours of 26 September 2015 and she was resuscitated. Mother H described Baby H as "*very, very pale*", with "*sort of blue-purple marks, like a mottling, all over her body*". She said: "[W]*e didn't know, I suppose, that that was anything different, because we'd never seen anybody being resuscitated on the brink, you know, of death, really, before. And it is something, though, that stuck in our minds.*"[136]

5.92 Mother H said: "*I remember speaking with Dr Gibbs as to why it had happened, and we asked why she needed to be resuscitated, because, you know, that's a major thing. And I just remember him saying to us he didn't know. And, you know, why weren't we told that this could potentially happen? And he said he didn't know, and they didn't anticipate it to happen.*"[137]

5.93 Dr Matthew Neame was a paediatric registrar at the Countess in September 2015. He cared for Baby H. He told the Inquiry that, prior to, or at the very beginning, of his placement at the Countess in September 2015, he had a "*sense of being aware that episodes may have happened*" in relation to babies who had unexpectedly died or unexpectedly required an escalation of care.[138] He had a vague recollection of being informed of this by another registrar who had been working at the Countess prior to him starting there. He was not aware of any specific information related to these episodes. Dr Neame did not recall any speculation of deliberate harm when he had started at the Countess in September 2015. He had thought the episodes were down to "*bad luck*" or a "*bad run*".[139]

5.94 In his written evidence to the Inquiry, Dr Neame described Baby H as having "*challenging and unexpected episodes of deterioration*".[140] In oral evidence, Dr Neame said he had considered that Baby H's second collapse "*needed some further assessment and further investigations in order to try to identify the cause*".[141]

5.95 Baby H required adrenaline to be administered in the resuscitation that followed her collapse on 27 September 2015. Dr Neame stated it was "*relatively unusual*" to be required to use adrenaline when resuscitating a neonate.[142] He gave evidence that he had not associated the unexpected collapse of Baby H with what he had heard about the unexpected collapses prior to arriving at the Countess. Dr Neame could not recall attending a debrief into Baby H's collapses.[143]

5.96 Dr Saladi was involved in Baby H's resuscitation on 27 September 2015. In his written evidence to the Inquiry, he stated: "[I]*t was not clear why Child H had deteriorated hence why I sought help from the tertiary unit as documented in the notes. Any unexplained deterioration in a child is worrying.*"[144] In evidence, Dr Saladi said he had not linked Baby H's unexpected collapse to Baby B's collapse. He acknowledged that the consultants did not link the events.[145]

5.97 Baby H was transferred to Arrowe Park Hospital later on the morning of 27 September 2015. Mother H told the Inquiry that Letby had given her a memory box of sorts for Baby H. 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.*"[146] 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*."[147]

5.98 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.*"[148]

Further deaths on the unit

5.99 There were two further deaths in September 2015, neither of which led to charges against Letby. On 28 September 2015, Dr Gibbs sent Dr Mittal an email which stated: "*We've had another neonatal death.*"[149] Dr Gibbs said he had sent Dr Mittal the email as part of the CDOP process.[150] It is not apparent that Dr Mittal did anything about this information.

5.100 Dr Lambie told the Inquiry that in September 2015 staff were "*starting to think the unthinkable*".[151] When asked to define what she meant by the phrase, Dr Lambie explained "*that there might be a person who's deliberately causing harm*".[152]

5.101 Dr Lambie described that at handovers "*it was a regular topic of conversation*" and that, on more than one occasion, she had a "*heartsink feeling of oh, gosh, what's going to happen today*".[153]

5.102 She recalled seeing, at some point in September 2015, a "*huddle of nurses in the corner over the computer and I asked what they were doing and one of the nurses replied that they were going through the rota just to make sure that there wasn't somebody that was on for each one* [of the deaths]".[154] None of the nurses who gave oral evidence to the Inquiry recollected this huddle taking place. I am satisfied that it took place.

5.103 Ms Marshall told the Inquiry: "*Lucy was the one common factor who had been on shift.*"[155] She added: "[I]*t was my impression that she was always in -- yes she was always involved with what was going on when there was a major collapse.*"[156]

5.104 Dr Lambie gave evidence that she was so concerned by the increase in the number of deaths and collapses, and the unusual nature of them, that she discussed it with a medical colleague external to the Countess. She stated that they discussed the "*hypothetical possibility that, yes, at some point we might be needing to get the police involved*".[157]

5.105 Dr Davis said:

> "*During my 6-month rotation in COCH* [the Countess] *in 2015 it became clear that we were experiencing an above average rate of death and collapses. As a group of trainees, we discussed if we felt we were missing something. Due to the small number of middle grades and close working of the team it was, and still is, common practice to debrief informally with colleagues following a stressful event. As a result, we all knew that other babies had collapsed unexpectedly and in atypical ways. When we attended regional teaching or local paediatric courses, colleagues would ask if we were doing okay, as they had heard that we were having a particularly bad run in CoCH.*"[158]

5.106 Ms Kathryn Percival-Calderbank was a senior neonatal practitioner (band 6). She was not aware of, and was not involved in, the huddle of nurses that Dr Lambie observed checking the rota to see which staff were on shift for the deaths. However, she recalled that it was common to ask who was on shift for the deaths. When she was told that Letby was present, she can remember saying to a colleague, "*If somebody's not careful, they're going to think there's something untoward happening here.*" She said that she began to "*start worrying*". She thought: "[W]*hat are we missing? What's -- what are we not seeing here?*"[159]

5.107 The phrase 'what are we missing?' was used over and over again in this Inquiry, as nurses, doctors, managers gave evidence about their discussions at the time. It is a reasonable question when unexplained deaths are occurring. By the latter part of 2015, people were beginning to ask themselves whether there was a link between Letby and the deaths. They were not missing that – it was in front of them. What was much more difficult was to acknowledge what that might mean.

5.108 Ms Percival-Calderbank explained she had been working on the neonatal unit for ten years in 2015. She said: "[I]*n the period of the time before this – these – these four deaths* [Baby A, Baby C, Baby D and Baby E] *I'd never known to have that many deaths in such a short period of time … I'd not dealt with as many deaths before that.*"[160]

Ms Powell's instruction to shift leaders about Letby

5.109 A time came when Ms Powell had given the instruction to shift leaders that Letby was not to be scheduled to look after intensive care babies. When Ms Percival-Calderbank implemented those instructions, she met serious resistance from Letby. Ms Percival-Calderbank said:

> "*I think it must have been probably in the early stages* [… Ms Powell] *asked me to try and not let nurse Letby work in intensive care for her … mental health and well being after dealing with a death. So … she'd asked me as shift leader not to put her into the intensive care nursery, to put her into the outside nurseries for her … own mental health and well being which I had … put down … for the shift. … Lucy Letby then shouted at me for doing so because she felt she didn't want to be in* [an] *outside nursery she wanted to be in the intensive care setting because she felt that it was boring looking after the special care babies.*"[161]

5.110 Ms Percival-Calderbank said she had found Letby in intensive care several times during a shift when she had been allocated to an outside nursery. She had reported this to Ms Powell, who said: "[W]*e'll just have to try and stop her -- stop it again when you can.*"[162] This was an inadequate response, repeating the failure to deal with Letby's conduct with Baby C.

5.111 Ms Powell agreed that Letby really wanted to be in intensive care, and she had discussed this with other nurses, including Ms Percival-Calderbank.[163] She did not speak to Letby about this. There are two possible explanations for that: either she did not think this conduct was serious, or she did not want to confront Letby. The first is out of the question, since the instructions to put Letby on an outside nursery had come from her. The second is possible, since Letby was prepared to take on extra shifts, so it may have been that Ms Powell did not want to upset her. Whatever her reasons, Ms Powell was allowing Letby to break the rules. Letby was not a senior nurse – she had only been qualified for three years. Ms Powell had a duty to manage her effectively. She failed to do so over the morphine incident (see Chapter 2). She failed to do so when she interfered with the care of Baby C (see Chapter 3). She failed to do so here. As a result, Letby knew she could ignore instructions from a shift leader, she could shout and she could move between nurseries to find excitement. There were no adverse consequences for her arising from any of those behaviours. This was a management failure by Ms Powell.

Endnotes

1 Mother E and F 18 September 2024 58/16-21
2 Mother E and F 18 September 2024 8/19-25
3 Mother E and F 18 September 2024 9/15-19
4 Mother E and F 18 September 2024 10/5-10
5 Mother E and F 18 September 2024 61/5-8
6 Mother E and F 18 September 2024 10/18-25
7 Mother E and F 18 September 2024 61/20-21
8 Mother E and F 18 September 2024 11/2-3
9 Witness statement of Dr David Harkness INQ0102350/4/para 17
10 Witness statement of Dr David Harkness INQ0102350/4/para 18
11 Mother E and F 18 September 2024 12/23 to 13/1
12 Mother E and F 18 September 2024 13/4-9
13 Mother E and F 18 September 2024 14/1-3
14 Mother E and F 18 September 2024 63/2-4
15 Mother E and F 18 September 2024 2/17 to 3/25
16 Mother E and F 18 September 2024 53/14-17
17 Mother E and F 18 September 2024 14/21-22 and 15/3-8
18 Dr ZA 7 October 2024 26/8-13
19 Nicholas Rheinberg 6 December 2024 31/2 to 32/3
20 Dr ZA 7 October 2024 23/1-3
21 Dr ZA 7 October 2024 24/19-22
22 Dr ZA 7 October 2024 25/14-15
23 Ian Harvey 28 November 2024 115/19-25
24 Mother E and F 18 September 2024 15/23 to 16/5
25 Mother E and F 18 September 2024 42/10-13
26 Witness statement of Dr David Harkness INQ0102350/5/para 22
27 Witness statement of Dr Christopher Wood INQ0098316/6/para 19
28 Witness statement of Dr Christopher Wood INQ0098316/8/para 29
29 Mother E and F 18 September 2024 17/20-24
30 Mother E and F 18 September 2024 53/22 to 54/3
31 Nurse W 14 October 2024 110/1-3 and 110/12
32 Melanie Taylor 10 October 2024 39/3-5
33 Witness statement of Dr David Harkness INQ0102350/6/para 29

34 Dr John Gibbs 1 October 2024 60/19 to 61/2

35 Dr John Gibbs 1 October 2024 61/4

36 INQ0000861; Dr Anna Milan 9 October 2024 6/23 to 7/1

37 Mother E and F 18 September 2024 21/3-7

38 Mother E and F 18 September 2024 21/17-20

39 Mother E and F 18 September 2024 22/2-8

40 Witness statement of Dr Stephen Brearey INQ101304/24/para 149f; Dr ZA 7 October 2024 32/3 to 41/1

41 Witness statement of Heather Wilshaw-Jones INQ0101363/2/para 8

42 INQ0000862

43 Dr Anna Milan 9 October 2024 14/21 to 15/24 and 22/2-14

44 INQ0000859/39

45 Dr Anna Milan 9 October 2024 11/3-19

46 Dr Anna Milan 9 October 2024 8/7-14

47 Dr Anna Milan 9 October 2024 14/22-23

48 Dr Anna Milan 9 October 2024 27/7-14

49 Dr Anna Milan 9 October 2024 20/25 to 21/9

50 Dr Anna Milan 9 October 2024 19/17-23

51 Dr ZA 7 October 2024 36/5-7

52 Dr ZA 7 October 2024 32/23 to 36/7

53 Dr ZA 7 October 2024 36/8-20

54 Dr ZA 7 October 2024 36/21-23

55 Dr ZA 7 October 2024 40/9

56 Dr ZA 7 October 2024 40/17

57 Dr ZA 7 October 2024 36/23 to 37/1

58 Dr ZA 7 October 2024 46/4-8

59 INQ0005890

60 Ian Harvey 29 November 2024 159/18-22 and Ian Harvey 28 November 2024 196/17-24

61 Dr John Gibbs 1 October 2024 64/15-16

62 Dr John Gibbs 1 October 2024 144/11 to 145/5

63 Dr John Gibbs 1 October 2024 146 /17-20

64 Mother E and F 18 September 2024 42/23 to 43/2

65 Mother E and F 18 September 2024 2/2-10

66 INQ0005592

67 INQ0000194/6

68 Ruth Millward 4 November 2024 160/14-17
69 INQ0000194/6
70 Ruth Millward 4 November 2024 161/24 to 162/9
71 Dr Stephen Brearey 19 November 2024 54/10 to 55/15
72 Mother E and F 18 September 2024 64/15 to 65/3
73 INQ0000194/6
74 INQ0003296/3
75 Dr Stephen Brearey 19 November 2024 57/1-3
76 Dr Stephen Brearey 19 November 2024 62/11-13
77 INQ0009762/6
78 INQ0005531/5
79 Dr Nim Subhedar 20 November 2024 4/16-23
80 Dr Nim Subhedar 20 November 2024 3/11 and 4/6-12
81 Dr Nim Subhedar 20 November 2024 3/24 to 4/2
82 Dr Stephen Brearey 19 November 2024 103/2-3 and 103/8-9
83 Dr Stephen Brearey 19 November 2024 103/7-8
84 Dr Nim Subhedar 20 November 2024 17/3-10
85 Dr Nim Subhedar 20 November 2024 18/6-15
86 INQ0012016/1
87 INQ0012189/2
88 Sharon Dodd 18 November 2024 25/3-10 and 60/10 to 61/7
89 Sharon Dodd 18 November 2024 25/10-12
90 Sharon Dodd 18 November 2024 25/13-15
91 Dr Rajiv Mittal 20 November 2024 105/11-13
92 Dr Rajiv Mittal 20 November 2024 102/16-18
93 Dr Rajiv Mittal 20 November 2024 105/16-17
94 Dr ZA 7 October 2024 28/8-11
95 Dr ZA 7 October 2024 28/13-16
96 Anne Murphy 21 October 2024 6/10-11 and 7/1-2
97 Karen Rees 21 October 2024 192/5-23
98 Karen Rees 21 October 2024 109/22
99 INQ0014813/4
100 INQ0014813/10
101 INQ0014813/10
102 Ian Harvey 28 November 2024 107/16 to 108/4

103 Alison Kelly 25 November 2024 268/23 to 269/1
104 INQ0014813/7
105 Paula Sindall 18 November 2024 142/23 to 144/10
106 Mother G 18 September 2024 73/10-24
107 Mother G 18 September 2024 74/18-75/3
108 Mother G 18 September 2024 75/13 to 76/19
109 Father G 18 September 2024 98/23 to 99/6
110 Father G 18 September 2024 106/19-24
111 Dr ZA 7 October 2024 76/11-25
112 Dr Stephen Brearey 19 November 2024 222/3-16
113 Mother G 18 September 2024 76/19-22
114 Mother G 18 September 2024 77/21-24
115 Dr Stephen Brearey 19 November 2024 68/5-9
116 Dr Stephen Brearey 19 November 2024 221/2 to 224/3
117 Dr John Gibbs 1 October 2024 69/11-12
118 Mother G 18 September 2024 71/16-19
119 Mother G 18 September 2024 84/9-20
120 Dr Stephen Brearey 19 November 2024 224/4 to 225/19
121 Dr Stephen Brearey 19 November 2024 225/23 to 226/7
122 Mother H 19 September 2024 12/16 to 13/2
123 Mother H 19 September 2024 15/2-8
124 Mother H 19 September 2024 16/22 to 17/7
125 INQ0030106/2
126 Eirian Powell 17 October 2024 8/18 to 9/9
127 Eirian Powell 17 October 2024 10/5-18
128 Mother H 19 September 2024 61/9-22
129 Dr Ravi Jayaram 13 November 2024 33/1-4
130 Dr Ravi Jayaram 13 November 2024 33/5-9
131 Dr Ravi Jayaram 13 November 2024 33/21-23
132 Dr Ravi Jayaram 13 November 2024 33/9-12
133 Dr Stephen Brearey 19 November 2024 68/11-22
134 INQ0003219/4
135 Dr John Gibbs 1 October 2024 70/24 to 71/2
136 Mother H 19 September 2024 63/17-23
137 Mother H 19 September 2024 28/20 to 29/1

138 Dr Matthew Neame 2 October 2024 71/16-17
139 Dr Matthew Neame 2 October 2024 73/1-2
140 Dr Matthew Neame 2 October 2024 77/16-18
141 Dr Matthew Neame 2 October 2024 75/20-22
142 Dr Matthew Neame 2 October 2024 76/16-18
143 Dr Matthew Neame 2 October 2024 80/17-20
144 Dr Murthy Saladi 3 October 2024 69/7-10
145 Dr Murthy Saladi 3 October 2024 70/15-16
146 Mother H 19 September 2024 35/24 to 36/5
147 Mother H 19 September 2024 36/6-11
148 Mother H 19 September 2024 54/5 to 55/1
149 INQ0103110/1
150 Dr John Gibbs 1 October 2024 72/3-15
151 Dr Rachel Lambie 2 October 2024 28/24-25
152 Dr Rachel Lambie 2 October 2024 29/8-10
153 Dr Rachel Lambie 2 October 2024 34/7-12
154 Dr Rachel Lambie 2 October 2024 27/18-22
155 Elizabeth Marshall 10 October 2024 204/5-6
156 Elizabeth Marshall 10 October 2024 202/14-17
157 Dr Rachel Lambie 2 October 2024 36/9-11
158 Witness statement of Dr Katherine Davis INQ0018001/5/para 17
159 Kathryn Percival-Calderbank 10 October 2024 151/5-11
160 Kathryn Percival-Calderbank 10 October 2024 151/17 to 152/2
161 Kathryn Percival-Calderbank 10 October 2024 138/11 to 139/1
162 Kathryn Percival-Calderbank 10 October 2024 141/18-19
163 Eirian Powell 17 October 2024 73/9-22

Chapter 6. August 2015 to February 2016: Baby I and Baby J; concerns increase; reviews

Baby I

Mother I: "*I didn't have any antenatal appointments as I breezed through my last pregnancies and there were no areas of concern … As I'd had other children already, my plan was to 'go in, give birth and go home'. I'd never needed to stay overnight with my other children.*"[1]

6.1 Baby I was born at Liverpool Women's Hospital at 27 weeks' gestation. She weighed 970 grams. She was transferred to the Countess on 18 August 2015. Following a deterioration in her condition, Baby I returned to Liverpool Women's Hospital (in the Level 3 neonatal unit) and stayed there from 6 to 13 September 2015, before returning to the Countess.

6.2 Mother I gave evidence that when Baby I first arrived at the Countess she was in Nursery 1, the intensive care room. She told the Inquiry: "[A]*t first, I had reservations about her care. I felt they didn't have time for our baby at Chester. Berni* [a senior nurse] *was looking after her, but they were so busy, I remember on one occasion we asked if we could get her out of her incubator but Berni told us 'No' as she just didn't have the time to do it.*"[2]

6.3 Mother I told the Inquiry that she "*felt that the Countess of Chester Hospital and the Liverpool Women's Hospital had different methods*" in regard to caring for her child.[3] She explained that, on 6 September 2015, the doctors at the Countess told them that Baby I had NEC because her stomach had swelled and veins were visible. However, later that day, when Baby I was transferred to Liverpool Women's Hospital, Parents I were told 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)*".[4]

6.4 Baby I stayed at Liverpool Women's Hospital for a week and recovered in that period. Mother I explained:

> "[O]*n our return to the Countess of Chester Hospital, our baby was placed in Room 3. This meant that, in 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.*"[5]

Mother I stated: "[M]*y emotions had gone from rock bottom to now being positive again*."[6] Baby I would go on to suffer further collapses at the Countess and be transferred to another hospital where she recovered, only to deteriorate again at the Countess.

6.5 Mother I reflected on this pattern in her evidence. She said: "[L]*ooking back now, it always seemed as soon as our baby left the Countess of Chester Hospital, her condition would improve … it was always very strange that she improved straight away once at Arrowe Park Hospital or at Liverpool Women's Hospital*."[7]

6.6 Mother I noted that a nurse on the neonatal unit at the Countess would cough and sneeze around her child.[8] She also encountered a distressed mother who had expressed breast milk only for it to be given to another child.[9]

6.7 On 30 September 2015, Letby told Mother I that her child's stomach looked swollen and that she would keep an eye on her. Mother I agreed that Baby I's stomach was swollen; however, she commented that Baby I had been doing really well. Mother I left the neonatal unit about 3pm. At 16:30 she received a call to return. When she came back, Baby I had collapsed, suffering a desaturation (a drop in blood oxygen levels below normal) and a fall in her heart rate. Mother I saw her baby receiving chest compressions. She said: "[O]*ur baby's stomach was swollen, she had been sick, and she looked really unwell*." She 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*."[10] After the collapse, Baby I was moved to Nursery 2 and soon recovered.

6.8 Mother I gave evidence that she "*was never led to believe that these collapses were anything to be concerned about or abnormal, or that they were worried about anything out of the ordinary*".[11] However, as mid-October 2015 approached, she "*felt the atmosphere within the hospital had changed. I had gone from feeling that our baby would be coming home to uncertainty*."[12]

6.9 On 13 October 2015, Parents I were called to the hospital in the night. Baby I was very poorly, "*the worst she'd ever been. The staff had to resuscitate her at least seven to eight times. She just kept flatlining*."[13]

6.10 The next night, 14 October 2015, Parents I were sleeping at the hospital. Mother I said: "*Every time we left and started to fall asleep, we'd be woken up with banging on the door telling us to come quickly. This wasn't once, this happened several times … Our baby also seemed to deteriorate when we left her alone and it was predominantly at night*."[14]

6.11 Dr Neame was on duty in the early hours of 13 October 2015, when Baby I collapsed. He considered this to be "*unusual*".[15] He was also on duty on 14 October 2015, when Baby I collapsed again. He described a "*difficult challenging week and in many ways … far more challenging than a typical week on a neonatal unit*".[16]

6.12 Dr Rachel Chang, a paediatric specialty trainee, was on day shifts at this time and frequently took handovers from Dr Neame. She commented:

> "*Child I had had almost regular events where she would be really sick and then 'bounce back'. Matt Neame had been resuscitating poor Child I every nightshift, then every morning at handover I'd be like, 'Oh, my God, Poor Child I and poor you', and then we'd have a day shift of where we would say 'Oh, she's not been too bad' as she had seemingly recovered quite quickly*."[17]

Concerns increase

6.13 On 14 October 2015, a message exchange took place between Nurse T and Letby. Nurse T was a shift leader who was responsible for allocating nurses to babies and/or nurseries. The context of the text message discussion is Baby I's care:

- At 17:49, Nurse T messaged Letby: "*I've had to reallocate. Sorry*"
- At 17:55, Letby messaged Nurse T: "*Ok no problem*"
- At 18:12, Letby messaged Nurse T: "*Has something happened?*"
- At 18:31, Nurse T messaged Letby: "*No. Was just asked to reallocate so no one has her for more than 1 night at a time*"
- At 18:31, Letby messaged Nurse T: "*Fair enough*"
- At 18:31, Nurse T messaged Letby: "*Or 1 shift. Not just night*"

6.14 Nurse T informed the Inquiry that she had originally allocated Baby I to Letby on consecutive nights for continuity of care. However, Ms Griffiths had asked her to reallocate Baby I because she was having recurring episodes of being unwell and it may be overwhelming for one nurse to care continuously for her. Nurse T took this request at face value.[18]

6.15 Ms Griffiths gave inconsistent evidence regarding the reason that Letby was moved from Baby I's care. Her initial detailed account to the police was that, during 14 October 2015, Dr Brearey had commented to her not to give Baby I to Letby for a third night, although she could not remember any specific conversation. She then speculated as to what the reason might be. In her Inquiry statement in 2024, she said that Dr Brearey had spoken to her about his concern that Letby seemed to be the common denominator in all the incidents, which all seemed to happen on night shifts. She listened to his concerns and decided to reallocate care for "*Letby's protection* … [and] *to appease Dr Brearey*" and to "*stop finger pointing*".[19]

6.16 It was her evidence that she then learnt that Dr Brearey had no memory of that conversation and he thought they had spoken in June 2016. She produced a further statement the day before she came to give evidence (on 15 October 2024):

a. She had now re-read her police statement and original Inquiry statement.

b. She was now aware of Dr Brearey's account.

c. She had reconsidered the neonatal mortality table dated 23 October 2015 produced by Ms Powell and realised she could not have seen it before her decision to change Letby's shift on 14 October 2015.

6.17 Although she had previously said that she had moved Letby because of concerns expressed by the medical staff, that was not correct, she said.[20] Rather a lot of time was spent trying to establish precisely what had happened. There is no need to repeat it all. WhatsApp messages show that Ms Griffiths had three band 6 nurses available that evening and did not require Letby, who was less experienced. It was nothing to do with Dr Brearey or any of the doctors. Whatever conversation she had with Dr Brearey on

the topic of Letby on shift, it took place after the death of Baby O. She recognised and I accept that her original assertion that Dr Brearey had asked her to remove Letby from shift after the death of Baby I was inaccurate.

6.18 Baby I was transferred to Arrowe Park Hospital on 15 October 2015, remained there until 17 October 2015, and then returned to the Countess.

6.19 On the night shift of 22/23 October 2015, Ms Hudson was Baby I's designated nurse. Letby was also on duty and caring for other babies. Parents I had left the neonatal unit at approximately 10.30pm. When Baby I collapsed just prior to midnight, Ms Hudson called for help and Letby came to assist. A crash call was made, Dr Chang attended and Dr Gibbs was called. Baby I was ventilated and stabilised. At about 12.30am, Mother I woke up at home and realised she had missed a call from the hospital. She called the neonatal unit and was told that Baby I had collapsed. Parents I travelled to the hospital, and Mother I telephoned the hospital before arriving. She was told that Baby I had collapsed again. Ms Hudson had gone into the nursery, where Letby was with Baby I. Baby I collapsed shortly after 1am, soon after Ms Hudson's arrival. Ms Taylor, Mr Booth and Dr Chang all assisted with resuscitation. When Parents I arrived, they saw the efforts at resuscitating their daughter. Tragically, after at least 20 minutes of resuscitative attempts, Baby I was pronounced dead in the early hours of 23 October 2015. She was handed to Mother I. Mother I told the Inquiry: "[A] *part of us died with her*."[21]

6.20 As the designated nurse, Ms Hudson was involved in Baby I's aftercare. She told the Inquiry that she was worried about doing it so she asked her colleagues if someone could help her. Letby volunteered. At the time, Ms Hudson stated she knew Letby had "*lost a patient before, more than one, and I knew that she -- I knew that she delivered that* [aftercare] *because generally whoever is responsible for the care of that baby then delivers the aftercare*".[22] At the time, she thought that Letby was being helpful.

6.21 Mother I shared her account of the aftercare provided by Ms Hudson and Letby. She recalled:

> "*Ashleigh* [Hudson] *and Lucy would come in and out. 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. Eventually, I think she realised and stopped. It wasn't something we wanted to hear right then so I put it down to saying the wrong thing at the wrong time. However, I still thought her behaviour was strange*."[23]

Doctors' discussions

6.22 Dr Jayaram was not involved in Baby I's care at the time she died. He was away on professional leave and learnt of her death in November 2015 on his return to the neonatal unit. It was at this point that he became concerned that Letby could be causing inadvertent or deliberate harm.[24] He said in evidence that corridor conversations began between him, Dr Brearey, Dr Gibbs and Dr Newby: "[A]*ll of us had begun to consider*

whether her presence was of significance rather than just coincidental and bad luck. I -- I don't know whether all of us had genuinely begun to consider could she potentially be causing deliberate harm."[25]

6.23 Dr Gibbs said that it was around this time that Dr Brearey began to have concerns about deliberate harm; however, he did not agree with him. Dr Gibbs told the Inquiry:

> "[A]*fter Baby I died I didn't feel then that harm was being done to these babies but I was feeling very uneasy that it was strange that we had had -- I had been involved with two babies with such unusual deaths* [Baby C and Baby I] *that I felt, and then after that and maybe late 2015 or early 2016, began to worry that harm may have been happening on the unit*."[26]

6.24 Dr Newby cared for Baby I on 23 October 2015. By that stage she was worried about the deaths but was not suspicious that they were unnatural. However, some days after Baby I died, she had a conversation with Dr Gibbs, Dr Brearey and Dr Jayaram about their concerns:

> "*I can't remember precisely who started the conversation. I was asked if Letby had been there on the night that I was called in to that resuscitation and I replied that I had seen her. The conversation was then around the fact that she was always on duty when these events had happened and then also some counter arguments that we were in fact a very small unit with a very small pool of nursing staff, so it was not inconceivable that the same poor person might be on duty for a, for a number of events*."[27]

6.25 Dr Newby stated deliberate harm was not discussed out loud in that conversation but was implied. She explained that, at the time, she found the idea that someone was deliberately harming babies difficult.[28]

6.26 Dr ZA told the Inquiry that, after Baby I's death, "*I was aware that there was a definite sense of unease about what had happened with several of my colleagues who'd been involved with more of the babies*."[29]

6.27 Baby I's death was reported to the coroner. Mother I recollected Dr Gibbs explaining to her why it was necessary for Baby I to have a post-mortem. She stated:

> "*Dr Gibbs said that* [our] *baby was basically a full-term baby and that these collapses shouldn't have kept happening. He mentioned about our baby having a* [post-mortem] *examination. I said I didn't want her to have one, as I just wanted her leaving alone, but he informed me that I didn't have a say and that she needed to have one as her death had been unexpected and the results would be needed to 'clear the hospital'*."[30]

6.28 Letby was convicted of Baby I's murder.

6.29 Mother I said: "*Our baby would have turned nine this year. 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*."[31]

Ms Powell's table and association with Letby

6.30 Baby I's death was the fifth death on the neonatal unit that featured on the indictment in under five months. By the end of October 2015, there had also been two deaths on the unit that were not on the indictment and two babies who were born at the Countess had died at a different hospital post-transfer.[32]

6.31 Dr Brearey contacted Ms Powell on the day Baby I died (23 October 2015) and raised the association with Letby.[33] Ms Powell responded to Dr Brearey by email the same day, copying in Ms Peacock, the Risk and Patient Safety Lead, Ms Anne Murphy, the Lead Nurse for Children's Services, and Ms Griffiths. The email subject was "*mortality 2015*".[34]

6.32 Ms Powell responded to Dr Brearey as follows:

> "*Just to say that I have discussed the above with Anne Murphy and on reflection it was decided to leave this until Monday. Alison Kelly was not in the hospital and Sian* [Williams, Deputy Director of Nursing] *had just left as was not well.*
>
> *I have devised a document to reflect the information clearly and it is unfortunate that she* [Letby] *was on – however each cause of death was different, some were poorly prior to their arrival on the unit and the others were ?NEC or gastric bleeding/ congenital abnormalities. I have attached the document for your perusal.*
>
> *See you Monday – I will discuss further with Debbie* [Peacock] *on Monday*."[35]

6.33 A table attached to the email showed that there had been eight deaths of babies admitted to the neonatal unit that year to 23 October 2015.[36] The first death recorded was that of a baby whose death did not feature on the indictment and who was born at term and admitted to the neonatal unit because of severe hypoxic ischaemic encephalopathy. The baby was transferred to a different hospital and died some days later. All seven of the other babies had died on the neonatal unit.

6.34 The table included a list of all the nursing staff on duty during the shifts when the babies died and who the allocated nurse was. Letby's name was in red and the table showed her on duty at the time of death, or on the shift before, in all seven of the deaths on the unit. Baby A, Baby C, Baby D, Baby E and Baby I were listed on the table, along with two further babies who died in September 2015 from severe congenital abnormalities and whose deaths did not feature on the indictment. I note the question mark next to the word 'NEC' under 'Cause of death' for Baby E. The cause of death for Baby A was recorded as "*?Maternal syndrome*".[37] This must have been written by someone who was unaware that this had been ruled out. Letby was the allocated nurse for Baby A and Baby E at the time they died and was on shift for all the other deaths, according to the table. This included the deaths of the babies with congenital abnormalities about which no concerns had been raised.

6.35 Ms Powell said that she felt a degree of uncertainty when tasked with compiling the table and investigating the deaths. She asked herself questions such as "*am I doing, you know, am I looking at the right thing?*"[38] She conceded, "*in hindsight, yes*", the police were better placed to do the investigation she was tasked with doing and should have been contacted.[39]

6.36 Ms Powell said that, as she repeatedly added Letby's name to the list, she thought she "*was there more often by working full time and overtime*" and that there was no evidence linking her to the deaths.[40] This was a repeated theme from Ms Powell and I have no doubt that was her view. It was not an unreasonable view, but she did not seem even to consider that the fact Letby had been on duty for each of the unexpected deaths meant she could not reasonably exclude the possibility that she had the opportunity to cause harm.

6.37 Ms Anne Murphy, who was copied in to Ms Powell's email, stated she did not have concerns at this stage. She questioned whether the association was a "*coincidence*".[41] Ms Anne Murphy was asked whether, as Lead Nurse for Children's Services, she had a responsibility to try to gather more information about the deaths and concerns. She responded:

> "*I accept that it -- it was a serious matter and obviously on reflection even worse than we, we would have considered. But I was being informed by the unit manager that, you know, this -- this was literally just that she, she was actually present. What could she have done to those babies, especially those babies that she wasn't caring for, I -- you know. So -- so we could never find any evidence to support any wrongdoing and -- and therefore her literally being on the unit at that particular time, I don't think we felt as nurses that we could accuse her of doing some harm without actual evidence.*"[42]

Whilst I understand her reticence, the reality was that Ms Anne Murphy, like many others, was thinking only of the nurse and not whether there may be a need to protect babies.

6.38 Ms Griffiths stated in oral evidence to the Inquiry this was the first time she had seen all the deaths collated in a chart. She said she was "*reassured that the cause of death was actually entered on the chart*".[43] She understood the consultants and Ms Powell were looking at all possibilities regarding the higher mortality rate and stated she "*didn't think it was deliberate harm*[,] *I thought perhaps it was lack of knowledge or experience*".[44] If it was either of those things, babies needed to be protected.

6.39 Dr Brearey told the Inquiry, in written evidence, that upon receiving Ms Powell's email and table, "*I was keen to talk about LL with Eirian Powell because I felt we both needed to acknowledge the association between LL's presence on the NNU* [neonatal unit] *when these deaths occurred*."[45] He continued:

> "*Eirian Powell had mentioned discussion with Alison Kelly in her email, so I was quite confident Executives were aware of all the deaths, although I received no communication from them at this time. It was around this time and after a discussion with Dr Jo* [Joanne] *Davies, Consultant Obstetrician, that I started to consider a further review of all the deaths with some external expert support*."[46]

In oral evidence, Dr Brearey said that Baby I's death, which happened on 23 October 2015, the same day as Ms Powell's email and table, "*increased my level of concern at the time and triggered things afterwards, particularly in terms of the Thematic Review* [of Neonatal Mortality, discussed further below]".[47]

6.40 On Tuesday 27 October 2015, Ms Powell sent a further email to Dr Brearey (copied to Ms Griffiths and Ms Peacock) in which she reported that she had spoken to Ms Peacock "*at length … in relation to the Mortality rate for this year*" and that they had decided to

create a modified table that also included doctors as well as nurses. She ended the email as follows: "*Debbie was of the same opinion that we did not think there was a connection – however we would be highlighting the issues once the report has been completed*."[48] Safeguarding was not considered.

6.41 Ms Millward was not copied in to these emails. She could not recall Ms Peacock telling her about her conversation with Ms Powell nor about the neonatal mortality table. Her evidence was that she "*would have expected Debbie to bring it to my attention*".[49]

6.42 Ms Millward's evidence was that, if she had been told that Letby was associated with seven out of eight neonatal deaths, "*I am confident I would have* [taken] *action and that would have been* [to] *re-direct that through the Serious Incident Panel*", where it would have been discussed with the Executive Team.[50]

6.43 This evidence needs to be viewed against the fact that when Ms Millward was sent the Thematic Review in March 2016 (containing an appendix that identified Letby's presence on duty at the deaths of babies during 2015), she did not read the appendix. In late May 2016, when Ms Lawrence, who had taken over from Ms Peacock, alerted her to a highlighted version of the appendix, she dismissed Ms Lawrence's concerns and took no action (see paragraph 14.45, Chapter 14).

6.44 In oral evidence, Ms Peacock acknowledged Letby's association was a patient safety concern; however, she was not suspicious of Letby because she was not the allocated nurse for every child who died.[51] She conceded that she had not checked whether Letby had been involved in the care of the children she was not allocated to. She acknowledged that in those circumstances she was not in a position to state that there was no connection.[52] What is more striking is that, having acknowledged that Letby's association was a patient safety concern, she took no steps to protect patients.

6.45 Ms Peacock accepted in evidence that she understood that Dr Brearey had concerns about Letby being on shift for the deaths, but she emphasised that Dr Brearey never discussed concerns with her: "*Dr Brearey never discussed any concerns with me. He certainly never discussed any suspicions about any member of staff*."[53] As the Risk Lead for neonatology, whilst Ms Peacock would clearly work closely with Dr Brearey, it was for her to exercise her own judgement as to whether there was a potential issue of patient safety that required investigation.

6.46 Ms Peacock did not raise the matter at the Women and Children's Care Governance Board. Ms Millward's opinion was that Ms Peacock and Ms Powell should have raised this matter with the Women and Children's Care Governance Board when it first arose,[54] albeit Ms Millward accepted that she subsequently failed promptly to refer Dr Brearey's review to QSPEC.

6.47 Ms Griffiths gave evidence that she did not engage on these matters because she was only copied in to the emails in case Ms Powell was away and she had to deputise. When asked whether she had a responsibility to take a more active approach, she replied: "[Y]*ou've got two senior people, Eirian* [Powell] *and you've got Steve* [Brearey]*, both highlighting that there is a potential issue so I just presumed that they would both be taking that forward rather than myself as the deputy*."[55] As to whether, knowing of the concerns, she should have taken steps to change the rota, she said, "[N]*o, that didn't occur to me … unless somebody said she wasn't able to work on the shopfloor I would still*

utilise her within the nursing numbers because she is a Band 5 that's skilled."[56] She said she would have removed Letby from the rota for an identified competency concern but not for an unidentified concern. Whilst I can well understand she felt the concerns had been raised and would be dealt with at a higher level, her lack of initiative is striking. She did not raise the question of safeguarding either.

6.48 Dr Brearey produced a review of Baby I's case on 31 October 2015.[57] Baby I's case was discussed at a quarterly neonatal mortality review meeting held on 26 November 2015. It does not appear that the possibility that a member of staff might be linked to the death of Baby I was raised. The meeting notes state: "*SB* [Dr Brearey] *to take case to neonatal network and surgical case review*." There seems to have been no wider discussion about Baby I or about the fact that this was the fifth unexpected death in under five months. Nor was there any discussion of safeguarding.[58]

6.49 A Datix form was created regarding Baby I's death. There were also Datix forms created regarding the events surrounding Baby I's collapses (such as delayed treatment of emergency blood or errors in medicine administration), but not for the unexpected collapses in and of themselves. Mother I informed the Inquiry: "*I understand that a Datix report was created on 23/10/2015 about our baby's death. As with the other Datix reports, I wasn't told about this at the time*."[59]

6.50 There was a Cheshire and Merseyside Neonatal Network Clinical Effectiveness Group meeting on 12 November 2015 chaired by Dr Subhedar and attended by Ms Powell and Dr Brearey.[60] The minutes record discussions of three deaths at the Countess, one in detail. In the other two cases, the results of post-mortem examination were awaited. Baby I's death was discussed at the group's meeting that was chaired by Dr Subhedar on 21 January 2016.[61]

6.51 The Countess QSPEC met on 16 November 2015. Amongst those present were Mr Higgins, Ms Kelly, Mr Harvey, Sir Duncan Nichol, Ms Fogarty, Ms Hodkinson and Ms Millward. There was no discussion of Baby I, the raised mortality rate on the neonatal unit or unexpected deaths.

Baby J

Mother J: "*It was a difficult pregnancy but we were well informed and when things were changing in the pregnancy. The team -- the people around us acted quickly and communicated really well with us, so we understood the decisions that we had to take and we felt informed and we were making them based on their experience and scope.*"[62]

6.52 Baby J was born by caesarean section at the Countess at 32 weeks and 2 days' gestation. She weighed 1.709 kilograms. She was taken to Alder Hey for an operation on a perforated bowel, returning to the Countess on 10 November 2015. Baby J progressed well, eventually moving into Nursery 4.

6.53 Parents J contrasted their experience at Alder Hey with that at the Countess. Mother J told the Inquiry that at Alder Hey, a Level 3 centre, Parents J were included in meetings with the consultant and nurses about Baby J's care, there would be collective agreement on the next steps and they felt part of the journey. In contrast, Mother J described "*reactive communication as opposed to proactive communication*" at the Countess and it was "*by chance*" whether they were included in meetings.[63] The reality was that

if parents were on the ward at the time of a ward round, they would be involved in the discussion. Otherwise they were not. At that time there was no assumption at the Countess that parents should be involved in a ward round whenever possible. This was an old-fashioned approach. Mother J said:

> "[W]*e would like to be included because we needed to know what was happening and how our daughter was progressing, so that may not be perceived by the hospital as an important thing to have the parents involved because the care is in their hands, but actually for us to be present and so heavily involved I think it would have helped if everybody, the nurses and doctors, were there at the time*."[64]

Mother J was obviously right about that. Procedures at the Countess have changed markedly to make sure that parents are involved in the care of their children. As set out elsewhere, the facilities are hugely improved too.

6.54 Baby J had a stoma and a Broviac line, which needed to be kept clean.* Parents J had been advised that if the Broviac line became contaminated it might cause Baby J to develop an infection, which they understood could have serious consequences for her. On 15 November 2015, Mother J recalled going into Nursery 2 and finding Baby J in a cot with just a small towel over her and her stoma bag detached. She was covered in faeces. Mother J described her response as follows: "*I 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*".[65] Mother J said she asked the nurses why Baby J had been left like that; however, they did not really engage in discussion. Letby was Baby J's designated nurse during that shift. Parents J made a complaint, which resulted in a meeting with Dr Saladi and a nurse. Mother J said the reaction of Dr Saladi and the nurse was to tell them that they were tired and to go home and get some rest. Mother J said the meeting "*didn't really address what had happened so that's quite frustrating really that it got turned that it was us that were the challenge*".[66]

6.55 In oral evidence, Dr Saladi stated he could not remember the meeting. However, he accepted that it was reasonable for the family to be concerned by the state in which they found Baby J, that their complaint should have been accepted and they should not have been given the advice to go home and rest. Dr Saladi also agreed that the circumstances warranted a Datix form being completed but this was not done.[67]

6.56 The plan was for Baby J to go home at the end of November 2015. She collapsed during a night shift on 26/27 November 2015. Baby J had a number of sudden and unexpected desaturations which required resuscitation and were associated with seizures. Letby was on night duty caring for two babies in Nursery 2. Ms Nicola Dennison, neonatal nursery nurse (band 4), with then almost 30 years' experience, was Baby J's designated nurse in Nursery 4. Both Letby and Ms Mary Griffith, neonatal nurse (band 5), assisted with the collapses. Dr George Verghese, junior doctor on duty, consulted the registrar, Dr Rhiannon Austin. Dr Gibbs was called and Baby J was moved to Nursery 2.

6.57 Father J said that, prior to Baby J's collapse, "[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*".[68] Father J expanded:

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* A Broviac line is a long, thin rubber tube inserted into the chest when intravenous treatment is required. It is also called a central line.

> "[W]*e wanted to be out of the Countess and it's hard to describe the stress of any parent on a neonatal unit when they've got a sick child and when things aren't quite happening in the way you expect them to happen and then you have an unexplained collapse, that stress is almost incomprehensible. We sensed things weren't right. We felt the culture was a difficult one*."[69]

6.58 Some time after Baby J's collapse, Parents J had a conversation with Dr Gibbs. Father J explained:

> "[I]*t wasn't a formal debrief as such.* [Dr Gibbs] *told us what had happened. I understand there were some other things happening on the unit as well at the same time which was causing quite a bit of stress for the staff which had happened after our daughter's collapse … he 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*."[70]

6.59 The jury were unable to reach a verdict in relation to the charge of attempted murder of Baby J.

6.60 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*."[71]

6.61 In addition to the unexpected collapse of Baby J, there were two further deaths on the unit in December 2015 and January 2016. The deaths were not of babies named on the indictment. These further deaths prompted Dr Brearey to ask Ms Powell to produce an updated staff analysis.[72]

6.62 Nurse T gave oral evidence that, in November 2015, she saw a version of the neonatal mortality review table on Ms Powell's desk. She explained it had lists of names from different staff groups that worked on the neonatal unit and the names were listed in "*descending order, so at the top of the list was who had been at more of the incidents*".[73] Nurse T asked Ms Powell about the document. She said, "[W]*e're having to do a thematic review because the doctors feel our death rate has increased, it's all nonsense*."[74] I accept this evidence. It reflects Ms Powell's views at that time. Nurse T did not suspect deliberate harm; she assumed it was a member of staff's lack of competency or poor communication that was contributing to the deaths.[75]

6.63 Nurse T told the Inquiry that Ms Powell was "*very supportive*" of Letby.[76] She said that Ms Powell had told her "*on several occasions*" that, although there had been more deaths, "*if you took out the babies that had sadly been born with congenital abnormalities … the numbers weren't significantly higher than in previous years … and that Lucy was unfortunate that she did extra shifts so she happened to have been there for more of them*".[77]

6.64 It is helpful to review the list of all the neonatal deaths linked to the Countess in 2015 and 2016.[78] This is a document agreed by all Core Participants in the Inquiry. It shows that, in 2015, there were eight neonatal deaths on the neonatal unit. Of these eight

deaths, three were of babies whose deaths were not on the indictment. Of those three, two died in September 2015 and post-mortems showed that both had severe congenital abnormalities. There was no post-mortem for the baby who died in December 2015. There is no reference to congenital abnormality in the recorded cause of death, which is given as 'prematurity with sepsis'. In saying that the numbers of deaths were not significantly higher than in previous years if those with congenital abnormalities were removed from the numbers, Ms Powell was mistaken. Had she performed the opposite exercise and removed the babies whose deaths were unexpected (five), the number of deaths would have been three, which is consistent with the numbers in 2011, 2012 and 2014.

Reviews

The Brigham Review, 2015

6.65 In November 2015, Dr Sara Brigham, a consultant obstetrician and gynaecologist, produced 'Review of neonatal deaths and stillbirths at Countess of Chester Hospital – January 2015 to November 2015'.[79] The review had been carried out by a multidisciplinary team, including obstetricians, and reviewed by an external obstetrician. Ms Fogarty explained the decision to conduct the obstetric review was made by Dr Brigham and Dr McCormack due to a "*perceived increase in our stillbirth and neonatal deaths and so we wanted to be assured that we didn't have a problem with our practice*".[80] Ms Fogarty explained, although the word 'perceived' was used in the Brigham Review, the team "*knew from our data that there was an increase*".[81] That was the reason for the review. The team reviewed 18 deaths, including stillbirths, a termination of pregnancy and six neonatal deaths. It included Baby A, Baby C, Baby D and Baby E. It did not include Baby I, who was not born at the Countess. Dr McCormack confirmed that "*the report doesn't address any issues relating to the cause of death with the neonates*" and was solely focused on whether anything within midwifery, antenatal or obstetric care contributed to, or caused, the neonatal deaths.[82]

6.66 At the request of Ms Kelly, the Brigham Review was presented by Ms Fogarty to QSPEC on 14 December 2015.[83] The substantive report was two pages long and included detailed appendices in respect of the maternity/obstetric care of Baby A, Baby C, Baby D and Baby E as well as of two babies whose deaths were not on the indictment, together with a large number of stillbirths. Ms Fogarty was part of the panel that produced the review. She agreed the title could be misleading to others and opined: "*I think it should be explicit that it was purely the midwifery and obstetric care that was reviewed*."[84] She was confident, however, that she had made the position clear during the meeting.

6.67 The minutes record Ms Kelly thanking Ms Fogarty and the team for the review and the assurance it had provided to the committee.[85] Whilst I can understand that the obstetricians had given assurance that maternity care had not contributed to the increase in mortality, the increase was still there. This important committee had in its name 'safety'. It is baffling that no one asked what else was being or might be done to scrutinise the increase in neonatal deaths. QSPEC was ineffective in this regard. Sir Duncan was satisfied with the report and did not think it necessary to investigate further. He gave evidence that "*the concentration of that review was on the obstetric service and did not raise concerns … it was an obstetric report*".[86] This narrow view meant he did not think about whether neonatal care should be considered.

6.68 Ms Townsend was the Divisional Director, Urgent Care. She had a meeting with Dr Jayaram once every two months and met Ms Powell and visited the neonatal unit every four to six weeks. Despite those meetings, it was her evidence that she first became aware of the increased mortality when the Urgent Care Divisional Board received the minutes of the Women and Children's Care Governance Board dated 18 December 2015.[87] The minutes show 8 people in attendance out of a membership of 19. Only Dr Jayaram had sent a substitute, Dr Brearey.[88] The minutes referred to the Brigham Review of stillbirths and neonatal deaths, which Ms Townsend did not ask to see.[89] She did not raise the question of increased neonatal deaths with the Divisional Board. She did not ask Dr Jayaram, Dr Brearey or Ms Powell about it in her meetings with them. She acknowledged, "*I think that was a gap and a failing on my point*"; however, she caveated this admission with "*but neither was that point raised with me*".[90] I agree it was a failing. There was no point in receiving the minutes if they were not to be reviewed and acted upon where necessary. The fact that the point was not raised with her is well made, but it is not an excuse for her own failure even to look at the Brigham Review. Had the increase in deaths been raised with her at that point, I doubt she would have escalated it. I say that in light of her actions in late June 2016 (see Chapter 11). In any event, Ms Kelly received the minutes of the Women and Children's Care Governance Board as a matter of course and she saw the Brigham Review at QSPEC. Assuming she read it, she should have appreciated that the assurance she could take from the review was limited.

Meeting of the Board of Directors

6.69 There was a meeting of the Countess's Board of Directors on 2 February 2016. The minutes record that the Board received and noted the minutes of the QSPEC meetings of 16 November 2015 and 14 December 2015.[91] Given Sir Duncan's previously expressed view, it is perhaps not surprising that he was reassured.[92] He did not ask any questions about the Brigham Review or ask for an update on the issue of increased neonatal deaths. The fact that he understood that the matter had been investigated and assurance given missed the point about the reason for the review.

6.70 It follows that QSPEC, the Women and Children's Care Governance Board and the Divisional Board having all failed to recognise that the job was only half done, sending the minutes to the Board of Directors for noting was not an effective mechanism for remedying their failures. That there was no communication between maternity and paediatrics at this stage is a further example of the folly of separating the two. Dr Brearey was not aware of the Brigham Review until December 2015 when he asked for and received a copy. By this stage he was concerned about events on the neonatal unit and was beginning his own formal investigation.

Thematic Review of Neonatal Mortality, 2015 to January 2016

6.71 On 19 January 2016, Ms Powell updated her table of neonatal deaths and sent it to Dr Brearey, stating that she had conducted a further staff analysis which confirmed that Letby was present (but not necessarily the allocated nurse) for all the deaths since October 2015.[93] Dr Subhedar received the updated table a few days before the Thematic Review meeting. It was one of a number of documents that he read before the meeting. He said in evidence that he did not pay much attention to the columns with the staff names because he was more focused on the embedded documents which contained

clinical summaries of the cases. He accepted: "*With the benefit of hindsight it does seem a bit strange that there were names of individual staff members included in that table.*"[94] It seems strange to me that this was not of interest at the time, but the difference may simply reflect our respective professional backgrounds.

6.72 On 22 January 2016, an email chain linking Dr Brearey, Ms Peacock, Dr Jayaram, Ms Anne Murphy, Ms Griffiths and Dr Davies circulated Ms Powell's table showing Letby's shifts and the deaths of babies, under the title "*NNU MORTALITY 2015-16*".[95] The email chain sought to arrange an initial half-day meeting to discuss and review the cases of the deceased babies where the diagnosis was uncertain, with an external reviewer attending. The external reviewer was to be Dr Subhedar.[96]

6.73 Dr Brearey explained that he invited Dr Subhedar because "*I had an increasing level of concern about the mortality, about the association with Letby and the -- I felt there was a need for some external objectivity from somebody outside the hospital to sense-check, if you like, where we were at that time*".[97] To seek an objective external review from a senior neonatologist was good practice.

6.74 Ms Kelly said she became aware of the Thematic Review at a Serious Incident Review meeting in January 2016.[98] The evidence about this is somewhat inconsistent. I am prepared to accept her account on this point.

6.75 Dr V was invited to the Thematic Review meeting. She gave evidence that, prior to February 2016, she heard Dr Jayaram and Dr Newby comment "*once or twice and saying, 'Oh she's on today'*" in reference to Letby.[99] Dr V did not consider any of the deaths were unnatural and did not go into the Thematic Review with Letby's name in her mind. She explained to the Inquiry: "*I didn't think those comments were made to the extent to implicate that -- so somebody being there doesn't mean that they're doing something*."[100]

6.76 The Thematic Review meeting was held on 8 February 2016.[101] Present were Dr Brearey, Ms Powell, Dr Subhedar, Ms Peacock, Ms Anne Murphy, Dr V and Ms Eagles. Apologies were sent from Dr Christopher Green, Director of Pharmacy and Medicines Management.

6.77 Nine babies were reviewed (the first baby on Ms Powell's list had died in another hospital). Dr Brearey said that the meeting reviewed the care of all the babies who died in 2015 and January 2016, including Baby A, Baby C, Baby D, Baby E and Baby I. They considered all the previous reviews that had been undertaken, and looked for any common themes.

6.78 Dr Brearey's oral evidence was that most of the meeting was spent reviewing the care of each child who died at the Countess.[102] He did not raise the association with Letby with Dr Subhedar until the end of the meeting because he did not want to affect his judgement. Dr Subhedar recalled that the discussion about a member of staff was after the meeting, when Dr Brearey told him "*informally*".[103] He said it was some time "*between the end of that Thematic Review and by the time that Steve Brearey had emailed me with the draft report*" later that same day.[104]

6.79 Dr Subhedar understood Dr Brearey was concerned a staff member was responsible for the deaths. Despite this, he did not ask Dr Brearey to clarify whether he thought Letby had negligently or intentionally harmed babies. He accepted this was an important distinction to know. When asked why he did not ask the question, he answered: "[I]*t*

didn't occur to me that anyone would want to wilfully harm babies."[105] This was a sentiment, expressed by others as an inability to 'think the unthinkable', that was repeated frequently during the hearings. I have no doubt that many witnesses were in that position, genuinely and honestly, particularly the doctors and nurses who worked on the neonatal unit. It is absolutely plain that no one was seeking to blame Letby for their own shortcomings or for problems on the unit. There was bewilderment at the deaths, but no one was thinking that someone was deliberately harming babies. This is important, given the unfounded criticisms that have been directed at those working on the unit.

6.80 After the meeting, Dr Brearey produced a document headed 'Thematic Review of Neonatal Mortality 2015 – Jan 2016'.[106] It was dated 8 February 2016. There is no reference to Letby by name in the body of the report, nor does it refer to any consideration of whether the deaths could have been caused by deliberate harm. In this version of the report, the fourth theme was "*Timing of arrests: 6 babies had arrests between 0000 – 0400*". There was an action point: "*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*."[107]

6.81 In the evening of 8 February 2016, Dr Brearey sent Dr Subhedar a draft of the Thematic Review. On 10 February 2016, Dr Subhedar responded:

> "*One additional comment that you might consider adding somewhere that relates to the 'theme' of some of the cases involving babies that suddenly and unexpectedly deteriorated and in whom there was no clear cause for the deterioration/death identified at PM* [post-mortem]."[108]

6.82 Dr Subhedar said he suggested this addition to explain that some sudden and unexpected deteriorations/deaths had no clear cause because:

> "[T]*he purpose of me being there and for us to be having that Thematic Review was to confirm the suspicion in Chester, when they had done their reviews that there were still some cases where there was no clear explanation for a baby's collapse -- and/or death. I think what we decided at Thematic Review was that was correct that there were certain cases that were -- 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*."[109]

Dr Subhedar was right: the fact that the deaths were unexplained was striking. It required further investigation. Dr Brearey had, consciously or otherwise, not spelt it out. This was a recurring feature of his approach.

6.83 Mr Harvey had been aware of the cluster of neonatal deaths in June 2015 and of the death of Baby E in August 2015. On 15 February 2016, when the CQC inspection was imminent, he emailed Dr Brearey as follows: "*Am I correct in thinking that you commissioned an external review of recent neonatal deaths? If so, is there any early feedback ahead of this week's* [CQC] *visit?*"[110] Dr Brearey replied the same day, informing Mr Harvey that it was not an external review but confirming that "*we did have a review of all the cases from 2015 to identify any themes or common learning … I have attached the draft minutes and actions from the meeting … Once I have feedback from everyone,*

I'll circulate it more widely and make sure all actions are completed."[111] He attached a copy of the draft record of the Thematic Review of Neonatal Mortality meeting. It included the schedule of staff in place at the time of the deaths.[112]

6.84 Dr Brearey recalls emailing Mr Harvey with his review and seeking an urgent meeting. He believes this was on the day he sent the email.[113] Mr Harvey said in evidence that he did not remember such a request.[114] Extensive searches of Dr Brearey's emails have not found an email to that effect. Dr Brearey could not find it.[115] The Employment Tribunal, in a case brought against the Trust by Dr Gilby (successor to Mr Harvey as Medical Director and, later, to Mr Chambers) and heard in 2024, held that there was good evidence of the destruction of emails by the hospital in respect of her claim.[116] However, I have seen no evidence that this occurred in respect of emails between Mr Harvey and Dr Brearey. I accept that Dr Brearey wanted an urgent meeting and, by mid-March 2016, Ms Kelly was telling Ms Powell that a meeting was to be held about the Thematic Review with Mr Harvey, Dr Brearey and others.[117] It seems likely, therefore, that whenever, precisely, it was sought, by mid-March 2016 Mr Harvey knew about Dr Brearey's request for a meeting about the Thematic Review.

6.85 Mr Harvey forwarded the email of 15 February 2016 to Ms Kelly on the same day,[118] writing: "*FYI – in the light of Sarah's earlier graph … made things look far worse than they are*".[119] In fact, the number of deaths was significantly higher than in previous years. This was worrying.

6.86 Attached to the report sent to Mr Harvey and then to Ms Kelly was Appendix 1, which listed the nursing staff allocated and/or on duty at the time of the deaths. It identified Letby in respect of all nine of the babies who died at the Countess, including the five children whose deaths featured on the indictment.

6.87 In his written evidence to the Inquiry, Mr Harvey said of this email and report:

> "*Having reviewed this appendix in detail since, Letby was the allocated nurse for 3 of the 10 deaths and on duty (but not the allocated nurse) for a further 6. However, this is a dense report and in the absence of anyone specifically drawing this to my attention, I do not think I would have noticed this … The tone and content of Dr Brearey's email attaching the thematic review did not cause me any concern*."[120]

6.88 The purpose of the email was to send the Thematic Review, which Mr Harvey had asked for. It is not apparent that Mr Harvey read it carefully or at all. No part of the report or the appendix can fairly be described as dense. The effort to read and understand it is not great for an experienced clinician, albeit not a paediatrician. Had Mr Harvey read the Thematic Review when it was sent to him, he would have appreciated that in respect of Baby A there was a sudden, unexpected arrest and that the cause of the collapse and death was not clear. The collapse of Baby B was noted. In respect of Baby C, a post-mortem report had been requested "*but no cause for deterioration identified*".[121] The cause of Baby D's deterioration was uncertain. For Baby E, notwithstanding a cause of death given as 'necrotising enterocolitis', "*AXR* [abdominal X-ray] *some time before arrest showed no obvious evidence for NEC*".[122] For Baby I, the preliminary report showed no evidence of NEC, multiple transfers, and a joint meeting with surgeons was to take place.[123] There was plenty in the body of the report, before themes were identified, to suggest uncertainty about why those children had died.

6.89 Ms Rees said that Ms Powell sent her an email in February 2016 outlining the findings from the Thematic Review.[124] Ms Rees's response to the document was rather different from Mr Harvey's. She said: "*I think we all had concerns when we -- when we read that. I certainly did*."[125] Ms Rees stated she discussed the review with Ms Powell. She informed the Inquiry that she received "*assurance*" from Ms Powell that several of the babies had congenital abnormalities or known natural causes of death.[126]

6.90 In addition to requesting the draft version of the Thematic Review in advance of the CQC visit, Mr Harvey emailed Dr Davies on 25 January 2016. Mr Harvey wanted to know if there were any significant concerns, outliers or actions outstanding following the most recent MBRRACE-UK audit report. MBRRACE-UK collects infant mortality data across the UK and provides reports to hospitals.[127] The purpose of this request was not to inform the Board but to check that there was nothing to worry about in the context of the CQC visit.

6.91 In the body of her response, Dr Davies stated: "*We have had an increase in stillbirth and neonatal death for 2015*." She went on to explain that an additional review had been undertaken as a result and she provided a copy of the Brigham Review.[128]

6.92 Mr Harvey forwarded Dr Davies's email to Ms Kelly on 12 February 2016.[129] Both Mr Harvey and Ms Kelly knew that the number of deaths on the neonatal unit had increased in 2015. Further, they had both been provided, along with the Thematic Review, an appendix setting out Letby's association in advance of the CQC visit. Mr Harvey did not bring any part of its contents to the attention of CQC. This was his responsibility. He failed to discharge it. The CQC inspection is dealt with in Chapter 7.

Thematic Review of Neonatal Mortality (version 2), March 2016

6.93 On 2 March 2016, Dr Brearey circulated his final version of the Thematic Review with Appendix 1, the neonatal mortality table covering deaths from January 2015 to January 2016 and the Summary Action Plan. He sent this to the consultant paediatricians, Ms Powell, Ms Farmer, Ms Anne Murphy, Dr Subhedar, Dr Green, Ms McMahon, Dr Davies and Ms Millward.[130]

6.94 Dr Brearey sent an email to Ms Powell, copying in Dr Jayaram, saying: "*I think we still need to talk about Lucy – maybe when you are back and free the three of us can meet to talk about it?*"[131] The meeting never took place.[132]

6.95 The relevant parts of this version of the report (emphasis in original) are these:

> "***Themes identified during discussion of all cases***
>
> *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.*

> ***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.***"† [133]

6.96 As set out earlier, it was clear from the appendix that Letby was on shift at the time, or on the shift before, for all nine of the deaths reviewed.

6.97 The body of the report did not refer to Letby's presence at the sudden and unexpected deaths or deteriorations. Dr Brearey said: "*I wish I had put the association with Letby in at this stage*." He explained: "*I think at the time my thinking was that I'm not sure Eirian Powell would have been particularly keen to put it in*."[134] Dr Brearey added he "*didn't think the nursing staff would be happy*" and he had a "*feeling of appeasing*" others so that the report could be finalised and it could then be raised with the executives.[135] Dr Brearey's fear of upsetting Ms Powell and other nurses caused him to pull back from including as a theme the association between Letby and the collapses.

6.98 In oral evidence, Dr Subhedar considered the absence from the Thematic Review of a staff member's association with the deaths. He reflected: "[S]*hould we have made it clearer … I think you are probably right, it should have been*."[136] Dr Gibbs stated he was not aware of the themes in the Thematic Review at the time of the collapses but became aware after reading the document. He said sudden and unexpected deaths were "*occasional*" prior to June 2015 and occurred "*every few years*".[137]

Ms Millward

6.99 Ms Millward could not recall when she first read the March 2016 version of the Thematic Review; however, she remembered she had clicked on the attachment of the report sent to her by email. On being questioned, Ms Millward said she did not recall seeing it in any significant detail and did not think she had scrolled all the way down to Appendix 1.[138]

6.100 Ms Millward was defensive in her evidence to the Inquiry and denied having an obligation to ensure that she and/or Ms McMahon (the interim Risk and Patient Safety Lead) had read the Thematic Review carefully. She pointed out that she received more than 100 emails a day (not unusual or unmanageable for a professional) and asserted that "*if Dr Brearey felt that he needed me to do something, he should have stipulated that very clearly in the email*" rather than just copy her in.[139] Ms Millward's evidence was that at some point the Thematic Review was received by the Serious Incident Panel and she would have read it in detail then.

6.101 This response is unacceptable. Ms Millward was the Head of Risk and Patient Safety. The Clinical Lead had sent her a report about a rise in deaths on the unit. It was a report that should have been read immediately and with the utmost care. She did not read it at that point at all. Nor did she ensure that the Thematic Review or at least a summary of it

† The other themes were cord clamping, the use of ranitidine and the placement of UVC catheters.

was sent to QSPEC immediately, as she accepted.[140] In evidence, she said: "*I fully accept … I should have done something around that. I didn't and I can't explain why I didn't other than I suspect it's because things happened very quickly*."[141]

6.102 On 17 March 2016, Ms Powell emailed Ms Kelly with the subject line 'Thematic Review'. She requested a meeting to discuss how to move forward with the findings of the Thematic Review. Ms Powell summarised the findings as follows:

> "*1. High mortality – 8 as opposed to our normal 2 to 3 per year*
>
> *2. A commonality was that a particular nurse was on duty either leading up to or during (this particular nurse commenced working on the unit in January 2012 without incident).*
>
> *3. A doctor was also identified as a common theme however not as many as the nurse.*
>
> *Despite reviewing these cases there was nothing obvious that we were able to identify – therefore your input would be valued.*
>
> *I have been informed that Ian Harvey is aware that we have had an external thematic review*."[142]

6.103 Ms Kelly replied on 21 March 2016 and asked for a copy of the Thematic Review, which Ms Powell sent less than an hour later, copying in Mr Harvey.[143] This suggested some urgency on Ms Powell's part in respect of her request for Ms Kelly's input. This version of the Thematic Review[144] contained the additional information (inserted at Dr Subhedar's suggestion on 8 February 2016) that the deaths were unexpected. It also included as an attachment the table of nurses prepared by Ms Powell in which Letby's name featured repeatedly.

6.104 Ms Kelly did not remember opening the attachment and she did not recall looking at Appendix 1 (Ms Powell's neonatal mortality table), which showed Letby was on shift for the nine deaths at the Countess.[145] She said she received a lot of emails and would not be able to open every attachment for every email that she would have received. Whilst that may be true, the issue in this email was a Thematic Review of deaths on a neonatal unit, sent to her with a request for help by the Manager of the neonatal unit. Nothing could have been more important. She rejected the suggestion that the fact she did not open the attachment reflected that she was not taking the concerns seriously enough. Ms Kelly stated the reason she did not open it was because Ms Powell's language in her email was "*passive*". She also sought to point out that Ms Powell had made a qualifying statement (that there was nothing obvious that they had identified) and that Ms Powell had not asked for an urgent meeting. Ms Kelly stated this was "*reassuring*".[146] For these reasons, Ms Kelly told the Inquiry, the email "*didn't raise significant concerns with me*".[147] It should have done. Ms Powell was appropriately clear and direct. She was asking for help. Ms Kelly ignored her request.

6.105 By 21 March 2016, therefore, both Ms Kelly and Mr Harvey had received a copy of the final version of the Thematic Review. As at that date, Mr Harvey and Ms Kelly had been sent it twice, having received the draft version almost exactly a month earlier from Dr Brearey. Neither of them did anything with it for some time. Mr Harvey was asked in detail about his reaction to this version of the Thematic Review. He said: "*I probably wasn't as worried as I should have been in retrospect*."[148] Had he read the document carefully at the time, he should have been worried.

6.106 Mr Harvey and Ms Kelly were later to say in evidence that the Thematic Review had identified wider concerns about the quality of care in the neonatal unit. They did not mention this at the time. This is probably 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.

Endnotes

1 Mother I 17 September 2024 74/22-24 and 75/1-4
2 Mother I 17 September 2024 86/14-20
3 Mother I 17 September 2024 87/15-16
4 Mother I 17 September 2024 91/16-20
5 Mother I 17 September 2024 92/19-25
6 Mother I 17 September 2024 93/2-3
7 Mother I 17 September 2024 108/20 to 109/6
8 Mother I 17 September 2024 88/18-20
9 Mother I 17 September 2024 93/17-24
10 Mother I 17 September 2024 97/3-15
11 Mother I 17 September 2024 100/11-14
12 Mother I 17 September 2024 101/4-6
13 Mother I 17 September 2024 103/8-10
14 Mother I 17 September 2024 104/2-10
15 Dr Matthew Neame 2 October 2024 82/20-22
16 Dr Matthew Neame 2 October 2024 65/3-5
17 Witness statement of Dr Rachel Chang INQ0000536/7
18 Nurse T 14 October 2024 55/11 to 56/8
19 Yvonne Griffiths 16 October 2024 119/1 to 132/15
20 Yvonne Griffiths 16 October 2024 131/23 to 132/15
21 Mother I 17 September 2024 112/10
22 Ashleigh Hudson 10 October 2024 93/19-22
23 Mother I 17 September 2024 113/13 to 114/3
24 Dr Ravi Jayaram 13 November 2024 34/22 to 35/1
25 Dr Ravi Jayaram 13 November 2024 35/18-23
26 Dr John Gibbs 1 October 2024 124/11-17
27 Dr Elizabeth Newby 3 October 2024 32/25 to 33/9
28 Dr Elizabeth Newby 3 October 2024 33/10-17
29 Dr ZA 7 October 2024 44/8-11
30 Mother I 17 September 2024 114/13-20
31 Mother I 17 September 2024 142/13-17
32 INQ0108782/1
33 Witness statement of Dr Stephen Brearey INQ0103104/28/para 169

34 INQ0005609
35 INQ0005609
36 INQ0003189
37 INQ0003189
38 Eirian Powell 17 October 2024 102/6-7
39 Eirian Powell 17 October 2024 102/15
40 Eirian Powell 17 October 2024 103/15
41 Anne Murphy 21 October 2024 37/10-23
42 Anne Murphy 21 October 2024 38/19 to 39/5
43 Yvonne Griffiths 16 October 2024 134/22-23
44 Yvonne Griffiths 16 October 2024 136/10-12
45 Witness statement of Dr Stephen Brearey INQ0103104/28/para 170
46 Witness statement of Dr Stephen Brearey INQ0103104/28/para 173
47 Dr Stephen Brearey 19 November 2024 239/16-18
48 INQ0003107
49 Ruth Millward 4 November 2024 164/21-22
50 Ruth Millward 4 November 2024 165/18-22
51 Debbie Peacock 22 October 2024 72/10-14
52 Debbie Peacock 22 October 2024 76/18 to 77/22
53 Debbie Peacock 22 October 2024 73/8-10
54 Ruth Millward 4 November 2024 166/2-11
55 Yvonne Griffiths 16 October 2024 142/8-11
56 Yvonne Griffiths 16 October 2024 143/5-12
57 INQ0003286/3-4
58 INQ0003288/1
59 Mother I 17 September 2024 121/12-14
60 INQ0009762/1-2
61 INQ0005559/8
62 Mother J 23 September 2024 3/22 to 4/3
63 Mother J 23 September 2024 71/4-5 and 8
64 Mother J 23 September 2024 71/9-17
65 Mother J 23 September 2024 45/3-8
66 Mother J 23 September 2024 46/18-20
67 Dr Murthy Saladi 3 October 2024 125/5 to 126/7
68 Father J 23 September 2024 39/16-19

69 Father J 23 September 2024 48/19 to 49/1
70 Father J 23 September 2024 32/25 to 35/18
71 Mother J 23 September 2024 61/17 to 62/11
72 INQ0103104/33/para 197; INQ0003190
73 Nurse T 14 October 2024 57/5-7
74 Nurse T 14 October 2024 22/23-25
75 Nurse T 14 October 2024 23/19-22
76 Nurse T 14 October 2024 22/3
77 Nurse T 14 October 2024 22/5-11
78 INQ0108782
79 INQ0003589
80 Julie Fogarty 15 October 2024 111/19-21
81 Julie Fogarty 15 October 2024 111/24-25
82 Dr Jim McCormack 8 October 2024 25/23-25
83 INQ0003204/5
84 Julie Fogarty 15 October 2024 112/19-25
85 INQ0003204/5-6
86 Sir Duncan Nichol CBE 2 December 2024 35/12-18
87 Karen Townsend 4 November 2024 13/14-23
88 INQ0004371/1
89 Karen Townsend 4 November 2024 14/21 to 15/18 and 17/8-13
90 Karen Townsend 4 November 2024 20/5-7
91 INQ0014816/12
92 Sir Duncan Nichol CBE 2 December 2024 35/22-23
93 INQ0003190
94 Dr Nim Subhedar 20 November 2024 23/25 to 24/2
95 INQ0005643; INQ0003190
96 INQ0005643
97 Dr Stephen Brearey 19 November 2024 108/13-17
98 Alison Kelly 25 November 2024 217/18 to 218/6
99 Dr V 7 October 2024 126/16-18
100 Dr V 7 October 2024 127/3-6
101 INQ0003251/1
102 Dr Stephen Brearey 19 November 2024 111/4 to 113/20
103 Dr Nim Subhedar 20 November 2024 39/12-14

104 Dr Nim Subhedar 20 November 2024 25/21-23
105 Dr Nim Subhedar 20 November 2024 72/20-21
106 INQ0003217/1
107 INQ0003217/7
108 INQ0103111/1
109 Dr Nim Subhedar 20 November 2024 33/12-21
110 INQ0003140/2
111 INQ0003140/1
112 INQ0003217/9-13
113 Dr Stephen Brearey 19 November 2024 104/3-8 and 204/21 to 205/4
114 Ian Harvey 28 November 2024 121/14-24
115 Dr Stephen Brearey 19 November 2024 205/15-20
116 Dr Susan Gilby 24 February 2025 18/9-25; INQ0108901/3
117 INQ0003558/1; INQ0003558/2
118 Alison Kelly 25 November 2024 71/25 to 72/2 and 75/14-22; INQ0003140/1
119 INQ0003140/1
120 Witness statement of Ian Harvey INQ0107653/25/paras 109-111
121 INQ0003217/3
122 INQ0003217/4
123 INQ0003217/5
124 Karen Rees 21 October 2024 113/16-21
125 Karen Rees 21 October 2024 115/4-5
126 Karen Rees 21 October 2024 116/11-14
127 INQ0003575/1-2
128 INQ0003575/1-2; INQ0042323
129 INQ0003575/1
130 INQ0003251; INQ0003114
131 INQ0003114
132 Dr Ravi Jayaram 13 November 2024 97/19-20
133 INQ0003251/7
134 Dr Stephen Brearey 19 November 2024 113/17-20
135 Dr Stephen Brearey 19 November 2024 253/14-15 and 253/25 to 254/5
136 Dr Nim Subhedar 20 November 2024 40/11-13
137 Dr John Gibbs 1 October 2024 208/25 to 209/5
138 Ruth Millward 4 November 2024 176/12-13 and 178/1-2 and 252/12-15

139 Ruth Millward 4 November 2024 181/5-7

140 Ruth Millward 4 November 2024 206/9-14

141 Ruth Millward 4 November 2024 206/15-18

142 INQ0003089/2

143 INQ0003089/1-2

144 INQ0003251

145 Alison Kelly 25 November 2024 99/17-19

146 Alison Kelly 25 November 2024 228/6-13

147 Alison Kelly 25 November 2024 228/16

148 Ian Harvey 28 November 2024 129/16-17

Chapter 7. Care Quality Commission inspection, February 2016

7.1 CQC is the independent regulator of healthcare in England. It was established on 1 April 2009 by the Health and Social Care Act 2008. It is an executive non-departmental public body sponsored by the Department of Health and Social Care and is accountable to Parliament through the Secretary of State for Health and Social Care.[1] It is responsible for the registration, monitoring, inspection and regulation of NHS Trusts.[2] Its purpose is to make sure services provided are safe, effective, compassionate and high quality.[3]

7.2 Regulation principally consists of monitoring and inspection. Monitoring involves keeping the performance of a Trust under review through observing data, attending engagement meetings where CQC inspectors meet with representatives from the Trust, and internal CQC management review meetings where decisions are made as to any issues for investigation.[4] The purpose of engagement meetings is "*to enable CQC to monitor and act on patient safety concerns, monitor risk, and performance, and to seek assurance about any actions the Trust is taking to ensure safe care and treatment*".[5]

7.3 At inspection, services provided by a Trust are assessed through five questions: are they safe?; are they effective?; are they caring?; are they responsive?; are they well led? Each of those questions is broken down into key lines of enquiry, containing questions and prompts, to be used by inspectors at inspection.[6] An inspection report is prepared in which the services inspected are given one of four ratings: outstanding, good, requires improvement or inadequate.[7]

7.4 Regulation by CQC is in accordance with the 'fundamental standards' below which care must never fall. This includes Regulation 12, which provides for safe care and treatment, and Regulation 13, which provides for safeguarding service users from abuse and improper treatment.[8]

7.5 Mr Chris Dzikiti took on the role of Interim Chief Inspector of Healthcare at CQC in May 2024. He gave oral evidence to the Inquiry. His understanding was that Regulation 13 would extend to protecting patients from deliberate harm and, where a provider became aware of an allegation of deliberate harm, it was required to take appropriate action without delay. This "*must include investigation and may also include referral to an appropriate body*".[9]

7.6 CQC has power to undertake civil enforcement action, through which a registration can be cancelled, suspended or made subject to conditions.[10] It can take criminal enforcement action in response to breaches of certain regulations.[11] In 2016, it could issue requirement notices (now named Action Plan Requests) for regulatory breaches that did not place people at immediate risk of harm.[12]

Retention of documents

7.7 CQC disclosed a very large number of documents to the Inquiry, including the full inspection notes for the neonatal unit and the wider Children's and Young People's services. However, there were specific contemporaneous documents that CQC was unable to locate. These included notes from:[13]

a. a pre-inspection engagement meeting with the Countess in February 2016

b. a meeting between CQC and the Countess in February 2016

c. a listening event on 9 February 2016

d. a Quality Summit meeting on 29 February 2016

e. a Quality Surveillance Group meeting on 28 July 2016

f. the hospital-wide consultants' focus group meeting at the 2016 inspection[14]

g. the core interviews at the 2016 inspection with:[15]

i. Sir Duncan Nichol

ii. Ms Millward

iii. Ms Kelly

iv. Ms Burnett

v. Mr Harvey

vi. the staff-side representative

vii. the Safeguarding Lead

viii. the Non-Executive Director for Quality and Safety

ix. the Complaints Lead.

7.8 The CQC witnesses said there was no reason to think the documents that had not been found would contain information relating directly to the neonatal unit. CQC accepted that some may have included information relevant to the broader culture of the hospital, such as notes from the focus group meeting with hospital consultants on 17 February 2016.[16] Given the content of the note of that meeting that does survive, I am satisfied that it would have included relevant information about the culture generally and, possibly, something about the neonatal unit in particular. The inability to trace such material is a significant and regrettable disadvantage to the Inquiry.

7.9 CQC did not make efforts to gather the relevant material it held on the Countess until receipt of the Department of Health and Social Care letter of 13 September 2023 informing it of the need to gather material in readiness for this Inquiry. Both Ms Ann Ford, Head of Hospitals Inspections, CQC (North West) and Mr Dzikiti, on behalf of CQC,

accepted that steps should have been taken to ensure documents were retained long before they received the letter. They accepted that there were several points at which CQC should have ensured the documents were properly secured. These were:

- in July 2015, from the point of the publication of the Independent Inquiry into Child Sexual Abuse guidance[17]
- in May 2017, when CQC was told that a police investigation had commenced[18]
- in June 2018, when there was discussion of the police investigation at an incident coordination meeting chaired by NHS England[19]
- in July 2018, when Letby was arrested; November 2020, when she was charged; and during the criminal trial from October 2022.[20]

7.10 CQC's record keeping was poor. Its failure to locate and retain such documents was reprehensible. CQC accepted that such failures in managing documentation may impair the families' ability to learn what happened. It apologised to the Inquiry and to the families for this.[21] I am satisfied that it has impaired my ability to establish what happened. The Inquiry was told that CQC has now completed a detailed review of its information and records management practices to evaluate its level of compliance with information governance and to make recommendations for improvement. I was told in March 2025 that the report of the review had gone to CQC's executives.[22]

Disclosure

7.11 The first request from the Inquiry to CQC for information was made on 6 November 2023. That resulted in two statements from CQC's then Chief Executive, Mr Ian Trenholm, dated 12 February 2024 and 4 April 2024. A further request for documents was made on 17 May 2024. This led to CQC realising that the Inquiry required a much broader scope of information than had previously been provided.[23]

7.12 The failure to locate and retain relevant material at these earlier opportunities, and to recognise the extent of the material that might be required, led inevitably to the loss of many documents and to the very late identification of approximately 4,000 documents relevant to the Inquiry. These were sent to the Inquiry in July 2024, less than two months before the start of the public hearings.

7.13 CQC conceded it initially interpreted the Inquiry's disclosure request too narrowly. Ms Ford accepted there had been a very significant underestimation and that the delay in providing material was unacceptable. I agree that CQC's disclosure was neither timely nor complete, for which she apologised.[24]

Inspection of the Countess

7.14 CQC carried out a routine inspection of the Countess between 16 February 2016 and 19 February 2016, with further unannounced visits on 26 February 2016 and 4 March 2016. Eight different services were inspected, one of which was Children's and Young People's services. Another was Maternity and Gynaecology. Neonatal services at the hospital were inspected as part of the inspection of Children's and Young People's services.

7.15 As is usual with a routine inspection, CQC gave more than six months' notice to the hospital of its arrival. It will be recalled that Ms Millward devoted the six months to preparing for the inspection, to the detriment of her risk role. In due course witnesses involved in the inspection of the neonatal unit said that they paid no attention to the self-assessment; its value was simply to inform CQC of how the Trust saw itself. That is something that could be elicited during interviews. It does not, in my view, justify requiring a Trust to spend months assessing itself.

7.16 The inspection was chaired by Ms Elizabeth Childs, a specialist adviser (not employed by CQC). Ms Ford and Ms Julie Hughes, a CQC inspector, were also part of the inspection team. The inspectors responsible for inspecting Children's and Young People's services were led by Ms Cain, who drafted the relevant section of the inspection report, and the specialist advisers (not employed by CQC), Dr Benjamin Odeka and Ms Mary Potter. The advisers were involved only during the inspection, not in the drafting of the report.

7.17 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.

7.18 The report did not identify or discuss the increase in neonatal mortality at the hospital. It did not identify or discuss the recent incidents of unexpected or unexplained deaths, or any concerns of deliberate harm. There are two reasons for that. First, no one at the hospital alerted CQC to the recent incidents of unexpected or unexplained deaths. Second, although CQC had data provided by the hospital that was relevant to the question of neonatal deaths, the inspectors did not see it, nor were they aware of its existence. As a result, they did not ask questions that may have led to CQC learning about concerns about the rise in the number of deaths on the neonatal unit. Nor did they ask unprompted questions about infant mortality to gain assurance that the unit was safe. The failures were significant on all sides.

Notifiable incidents

7.19 Trusts were required to notify CQC (via NHS England) of incidents that affected the health, safety and welfare of patients. Notifiable incidents included certain types of injury and abuse or allegations of abuse. There was also a requirement for CQC to be notified of the death of patients.[25] NHS Trusts satisfied this obligation when submitting such information to NHS England's National Reporting and Learning System (NRLS*).[26] Such notifications to NHS England via NRLS were shared with CQC pursuant to a data-sharing agreement.[27] CQC was also able to access and track notifications to StEIS,[28] which records serious incidents and deaths reported by healthcare providers. Data from NRLS and StEIS was extracted by CQC and uploaded to its own system on a weekly basis.[29]

7.20 CQC did not investigate every notifiable safety incident, nor even a selection of them. Its role was to ensure that a hospital was discharging its responsibility and carrying out all aspects of the duty of candour. It could investigate a specific incident where there

* The NRLS is now the Learn from patient safety events service.

were concerns about the hospital's processes and would sample-check processes at inspection.[30] CQC used the notifications from StEIS and NRLS to inform its decisions regarding regulatory activity, including inspections. Inspectors could also request further data from a Trust before, during or after an inspection to enable a more detailed analysis of notified incidents.[31]

7.21 Ms Lyn Andrews (CQC Analyst Team Leader for the inspection of the Countess) provided a statement to the Inquiry on 20 December 2024, after all the evidence had been heard from the witnesses involved in the inspection. CQC's then Chief Executive, Mr Trenholm, provided statements dated 12 February 2024 and 4 April 2024.

7.22 In her statement, she described for the first time a number of limitations to CQC's access to NRLS and StEIS data.[32] The purpose of informing the Inquiry of this was, presumably, to show how difficult it was for CQC to monitor an NHS Trust in line with its statutory obligations. The way in which CQC went about its task was a matter for CQC. To the extent that what follows are real difficulties, responsibility for them lies squarely with CQC. Ms Andrews said, for example, that it could take a few days for the information from the electronic files received from the NHS to be transferred to CQC's internal system. The system also depended on timely reporting and proper allocation of the severity of harm to incidents by those making a report. Incidents were recorded as 'no harm', 'low harm', 'moderate', 'severe' or 'death'. Ms Andrews made clear that data analysts were not clinically trained; nor is it apparent that they knew the meaning of (say) 'low harm' when an incident had ended in death. They relied on the words used by those completing the forms and assumed they had correctly assessed the severity of harm. It is not clear that any analysis was taking place or if the information was just taken at face value.

7.23 When considering NRLS incident reports, especially where datasets were large (the Countess reported more than 8,000 incidents to NRLS between February 2015 and January 2016, which was the period for analysis of NRLS reports for the inspection), it was common practice for data analysts to filter out entries marked 'no harm' or 'low harm' on the spreadsheets because it was not "*viable*" for them to read descriptions of every report.[33] The analysts took account only of entries marked 'moderate', 'severe' or 'death'. It is not clear that they discussed this with anyone at the hospital, nor within CQC. To a layperson (including an analyst) it appears reasonable to exclude incidents with those descriptions but, since that step was not communicated, no one knew about it. It was one of the reasons that no questions were asked about the categorisation of events. Ms Andrews said that, had there been concerns about the incident-reporting culture, analysts could have conducted an analysis of other incidents, but they did not dip sample (say) 'no harm' or 'low harm' incidents to check that they had been properly categorised.

7.24 In evidence, Mr Dzikiti recognised that an alternative way of processing large amounts of information, rather than filtering out a large number of entries, would be to have more analysts analysing the data.[34] Mr Dzikiti also accepted that part of CQC's regulatory function was to consider whether patient safety incidents were being properly categorised, and that it was difficult to do that where entire categories of incidents were filtered out of the analysis.[35] This was a significant shortcoming of CQC's analytical processes.

Data analysis for the inspection

7.25 CQC analysts analysed data obtained by CQC and created data packs for each of the eight core services to be inspected. These were provided to all CQC inspectors and the Trust on 2 February 2016 (draft packs were provided to the Trust on 21 January 2016 to check for accuracy).[36]

7.26 Ms Andrews explained that basic 'shell' packs were created for all inspections covering the 12-month period prior to inspection. The shell packs use a standard template that a software program populates with relevant data from the CQC system, including NRLS and StEIS data. The shell packs for the Countess were created on 22 December 2015 and included data for incidents reported between October 2014 and September 2015.[37]

7.27 Ms Andrews also noted: "[A]*ny risks due to time lag were mitigated by the fuller analysis completed nearer the inspection to highlight key findings in the Intelligence Presentation …, which for this inspection included incidents reported up to 7 January 2016.*" This "*also would be further mitigated by up-to-date NRLS and STEIS information forming part of the additional data requests made on site by each core service lead during the inspection*".[38]

7.28 The analysts additionally prepared an up-to-date intelligence presentation, which was delivered to inspectors and specialist advisers on 16 February 2016.[39]

Omission of serious incidents and the deaths of Baby A, Baby C, Baby D, Baby E and Baby I

7.29 The pre-inspection packs and the intelligence presentation from the CQC analysts did not clearly identify the StEIS report in relation to Baby D. Nor did they identify at all the reports to the NRLS in respect of Baby A, Baby C, Baby D, Baby E and Baby I.

7.30 The result was that the data pack for Children's and Young People's services stated: "*No Never Events or Serious Incidents have been reported by the trust between November 14 and October 15.*"[40] That assertion was incorrect given the report to StEIS in respect of Baby D on 3 July 2015. CQC accepted this.[41]

7.31 Ms Ford also accepted that the inspectors and specialist advisers for Children's and Young People's services had been unintentionally misled, because they did not know that there had been a serious incident.[42] Mr Dzikiti agreed that the inspectors should have seen the StEIS and NRLS reports.[43]

7.32 The intelligence presentation similarly, and incorrectly, stated in respect of Children's and Young People's services that there were no never events or serious incidents reported up to January 2016.[44]

7.33 Ms Andrews said: "*It was standard practice for neonatal care to be dealt with in the maternity and gynaecology data pack* … [and she] *would expect inspectors and SPAs* [specialist advisers] *to be aware of this.*" She added:

> "[I]*nspectors and SPAs would be provided with data packs for all core services and would be expected to have reviewed all of these* … [they] *would have access to all the packs (both in hard copy while on site and electronically throughout the inspection and reporting period). This means that the CYP* [Children and Young People] *inspection team would also have had access to the maternity and gynaecology data pack.*"[45]

She explained that the reason for the data being reported in the maternity pack was "*due to neonatology being considered under the maternity core service for the purposes of data collection and analysis*".[46]

7.34 Whatever the 'standard practice' of those collecting and analysing data, it was not the approach of the inspection team. Maternity and Gynaecology was a different service from Children's and Young People's services, with a separate inspection team. There was no reason for the Children's and Young People's services team to interrogate the data from Maternity and Gynaecology, and I find that they did not do so. There was a serious gap between the understanding of the analyst team and that of the inspectors.

7.35 In fact, the data pack for Maternity and Gynaecology recorded that there had been one never event (which was a maternity/obstetric event) and seven other StEIS events, all of which appeared to be maternity/obstetric rather than neonatal. The presentation for Maternity and Gynaecology noted one never event; seven serious incidents within the reporting period; and another seven reported between February 2015 and January 2016.[47] The latter information does not feature in the Maternity and Gynaecology data pack and there is no indication of which incidents are referred to here.

7.36 The NRLS entries in respect of Baby A, Baby C, Baby D, Baby E and Baby I were not included in the data presented by the data analysts at all, presumably because they had not analysed them. Those entries would have been filtered out by the analysts because of their 'low harm' categorisation.

7.37 That the right information was not in front of the right people was the result of a flawed system within CQC. CQC accepted that the current system, in which neonatal services are inspected as a standalone service, not as part of Children's and Young People's services, is a better one. I accept that. It is highly regrettable that the need for change was not identified earlier. I can identify no good reason why neonatal data was not included in the data pack for Children's and Young People's services, which covered neonates. Mr Dzikiti quite properly acknowledged that neonatology data should have been addressed in the data analysis for Children's and Young People's services.[48]

7.38 The evidence of the inspectors was that they were unaware of the report to StEIS in respect of Baby D.[49] Ms Cain, the Lead Inspector for Children and Young People, gave evidence that she did not remember being made aware of the reports, and accepted that the data packs did not identify the StEIS report relating to Baby D or the NRLS incident reports relating to Baby A, Baby C, Baby D, Baby E and Baby I.[50]

7.39 The failure to ensure that the inspectors and specialist advisers were aware of the NRLS entries (particularly in respect of neonatal deaths) and the StEIS report for Baby D was a significant shortcoming in CQC's analytical process. It misled the inspectors in respect of safety incidents on the neonatal unit. It limited their ability to undertake a properly informed assessment of the 'safe' and 'effective' categories of inspection. The inspection framework requires, in the 'safe' category, investigation of serious incidents involving children and young people, as well as reports to NRLS categorised as 'moderate' or above.[51] In the 'effective' category, it requires investigation of serious incidents and all NRLS incidents. (There is no express limitation to those that are 'moderate' or above and, I would add, no good reason to impose such a limit, particularly without explaining that it has been done and why.)[52]

7.40 Mr Dzikiti accepted in evidence that members of the team inspecting Children's and Young People's services should have been made aware of the StEIS and NRLS incidents.[53] Ms Cain's evidence was that, if she had been provided with that information, it would have changed her preparation for the inspection: "[I]*t would have been more of a focus of the inspection. There would have been more direct questions asked about mortality and morbidity.*" She confirmed that this was something she would "*absolutely*" have investigated.[54] Given that this inspection took place in February 2016, this was important evidence.

Request for further data

7.41 On 15 February 2016, a senior analyst at CQC (Mr John Cunningham) sent a list of data requests to Ms Millward at the Countess on behalf of all the lead inspectors of the services being inspected.[55] Eighteen of the requests were for the Children's and Young People's services inspection. One of these data requests (DR35) was for "[i]*ncidents relating to neonates and paediatrics*" in the "[l]*ast 12 months*".[56] Ms Andrews confirmed that the data was provided by the Countess on 16 February 2016.

7.42 The spreadsheet produced was a list of 377 Datix reports covering the children's ward and the neonatal unit.[57] It had eight entries referring to deaths, two of which appear to refer to Baby A and two to Baby E. Datix forms were also listed for Baby C and Baby I. No Datix form was listed for Baby D.

7.43 Ms Andrews explained that analysts would not carry out a full or further analysis unless this was specifically requested by the core service lead. Ms Andrews' recollection was:

> "[A]*nalysts did not complete any further analysis of incident data supplementary to the standard data packs or intelligence presentation for COCH* [the Countess] *inspection. No further incident analysis was completed by analysts for the additional incident data requested on site for COCH inspection.*"[58]

7.44 In evidence, Ms Cain agreed that she had seen the spreadsheet and that she had noted the neonatal deaths, each of which had been categorised as 'no harm'. She said she "*would have looked at every incident*".[59] She said that she understood and accepted the categorisations as meaning "*that no harm had occurred as a … direct result of the clinical care provided*".[60] She stated: "*Overall, nothing from the table of incidents appeared*

immediately concerning when I reviewed it in advance of the inspection."[61] Ms Cain was asked in evidence how she could be satisfied with the categorisation when in some cases the death was unexpected and unexplained. She explained:

> "*The role of the inspection is not to look at … 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.*"[62]

7.45 She had in fact reviewed three specific incidents (from the 377 on the spreadsheet), but could not recall which three she had reviewed.[63] It is reasonable to observe that, where there were two deaths on a neonatal unit described as unexpected and without explanation, at least one of them should have been reviewed with a view to establishing that the process for categorisation was correct. Had that been done, further investigation would probably have ensued. Discussion with the Clinical Lead for Neonatology was one option. This does not appear to have happened; nor does the data appear to have been shared with the specialist advisers.

7.46 CQC's process, whereby Ms Cain, a non-clinically trained inspector, was responsible for filtering information to be provided to specialist advisers, in this case Dr Odeka, is flawed. Dr Odeka was clear in his evidence that, had he received the spreadsheet, he would have asked questions about the data.[64] More importantly, however, this points to a wider systemic failure on the part of CQC.

7.47 Independent of the failures by the Countess, which I shall set out, this was a significant failure on the part of CQC.

Inspection of Children's and Young People's services

7.48 The inspection of Children's and Young People's services involved a walk through the neonatal unit with Ms Farmer on the first day of the inspection, and interviews with multiple members of staff over the course of the remaining days.

7.49 Ms Cain accepted in evidence that she did not focus on issues concerning neonatal mortality during the inspection, and did not ask direct questions in that area because she was unaware of any concerns in respect of neonatal mortality.[65] She did not discuss an increase in neonatal deaths or any concerns about unexplained or unexpected deaths with any interviewee.[66]

7.50 There was an interview of the core service leads for Children's and Young People's services on 17 February 2016, attended by a number of staff members on the neonatal unit. The attendees recorded at this meeting included Dr Brearey, Dr Jayaram (who earlier that day had entered a nursery and had seen Letby fail to assist Baby K), Ms Anne Murphy, Ms Townsend, Ms Rees (who does not remember being at the meeting) and Ms Powell.[67] Each of these individuals confirmed in oral evidence that they were aware of the increase in mortality rate – either from the record of neonatal deaths that Ms Powell had compiled, from the Thematic Review, initiated by Dr Brearey and convened in order to consider these deaths, or as a result of the Brigham Review, which considered

obstetric care. All three inspectors for Children's and Young People's services attended. CQC's position is that it was not informed about the increased mortality rate until 29 and 30 June 2016.[68]

7.51 Dr Jayaram acknowledged that "*by this stage we had had the Thematic Review several, not all of us, had the specific concern*".[69] However, he stated that, "[g]*iven the make-up of the number of people in the room,* [the neonatal deaths and the Thematic Review] *would have been a difficult -- a difficult one to broach*".[70]

7.52 The notes of the meeting indicate that there was discussion of mortality and morbidity meetings. Ms Potter's note states: "*Mortality & Morbidity meetings – 5 last year. Planned 4 this year … Neonatal depend on number of cases to be discussed.*"[71] Ms Cain's note states: "*Mortality & morbidity meeting. Perinatal. x8 from nnu* [neonatal unit] *last year x4 this year. Neonatal mortality x2 last year (dep on cases to be discussed). x2 paed* [paediatric] *mortality meetings. Nos fairly small.*"[72] These notes do not describe discussions of the detail of the meetings but show that they were only about process. The discussions confirmed that there were meetings about mortality and morbidity and how often they took place. There was nothing about what was said and no determination of the quality or content of the meetings.

7.53 Dr Brearey confirmed that, in addition to attending the core service lead interview, he had a one-to-one interview with Dr Odeka.[73] He did not raise the increased neonatal mortality rate nor the Thematic Review with CQC. He conceded that in retrospect he should have.[74] He described his dilemma: knowing that he had provided the Thematic Review to the Medical Director and knowing they would be discussing it, he was not sure what to do. He decided to mention the mortality rate if he was asked about it.[75] Dr Brearey should have told Dr Odeka about the increased number of deaths.

7.54 Ms Powell confirmed that she did not raise the increased mortality rate or unexpected deaths with CQC.[76] She acknowledged that she should have.[77] I agree she should have. In addition to being interviewed on 17 February 2016, Ms Anne Murphy was interviewed again by CQC on 4 March 2016. This was two days after she was emailed the final version of the Thematic Review (on 2 March 2016). She did not recall raising the findings of the Thematic Review with CQC.[78] I am sure she did not. She too should have done so.

7.55 Ms Kelly was interviewed by CQC on 17 February 2016, and Mr Harvey was interviewed the following day. Ms Kelly accepted that, prior to the CQC interview, in July 2015 she was aware there had been an increase in neonatal mortality.[79] She knew that the three deaths in June 2015 were as many (or more) deaths as there had been on the unit in one full year of the previous five years. She also accepted that she was aware of the Brigham Review in November 2015 and that it highlighted that there had been more neonatal deaths since June 2015.

7.56 Ms Kelly confirmed that, on 15 February 2016, Mr Harvey had forwarded her Dr Brearey's email with the Thematic Review.[80] Ms Kelly did not mention the Thematic Review to CQC. When asked whether she should have done, she responded: "*I don't think so at that time because we had only just received it, we hadn't a chance to digest it and in actual fact it wasn't the full report.*"[81] In the context of the increased neonatal mortality rate, she accepted "*we could have told the CQC more at that time*".[82] Ms Kelly and Mr Harvey could and should have told CQC about the increase in the number of deaths on the neonatal unit.

7.57 Mr Harvey was confident that the Thematic Review was shared with CQC before its visit in February 2016. He told the Inquiry: "[W]*ith regard to the CQC, I am confident that I shared and we -- we're sort of moving on -- the Thematic Review of Dr Brearey with the CQC ahead of them -- their visit in February 2016.*"[83] This supports my view that he should have done so. However, I do not accept that he did in fact share it with CQC, before their visit or at all. His account is contradicted by Ms Millward. Ms Millward stated that, as far as she was aware, CQC had not been sent the Thematic Review in advance of the CQC inspection. She was asked directly: "*Did you submit the thematic review of neonatal mortality?*". She responded: "*Not at that time because that was February 2016 and obviously it was still being developed at that point … As far as I am aware, they did not see that, no.*"[84] She gave evidence that she had spent most of the six months leading up to the inspection preparing for it. Leaving aside the wasteful diversion of time from managing risk to preparing for an inspection of process, she is likely to be right when she says the hospital did not provide CQC with the Thematic Review.

7.58 In evidence, Mr Harvey said that he could not recall any conversation with the inspectors from CQC during their inspection in February 2016. That he met them is recorded. There was obviously a conversation. If Mr Harvey made any notes, they have not survived. Whatever he said, none of the CQC witnesses had any recollection of the issue of increased neonatal mortality being raised with them, and CQC has lost any notes that may have been relevant to that issue (and many others). At that stage, Mr Harvey had not informed Mr Chambers or the Board about the increase in mortality. I am satisfied that he did not tell CQC about it. He should have done.

7.59 One reason for that failure may be, as suggested by Family Groups 2 and 3, that he was seeking to cover it up. Another way of describing it is that he was putting off mentioning it in the hope that he would find an explanation for the increase in deaths that was satisfactory. Whatever the reason – and he did not give one, because he is confident he did disclose the mortality information – this was a serious failure by the Medical Director. It reveals a lack of candour. It foreshadows an approach that would repeat itself in the course of the next 18 months.

7.60 Ms Cain confirmed in evidence that there was no discussion of actual mortality rates, and the topic of unexpected and unexplained deaths was not discussed.[85] There was discussion of the fact that neonatal mortality meetings had not happened as frequently as the leads would have liked, but they were back on track.[86] There was no discussion as to how many cases were considered at the meetings, or any themes emerging from them.[87] Ms Cain could not recall any questions being asked by the inspectors relating to neonatal mortality, but she considered, in retrospect, that the discussion relating to mortality meetings should have elicited from the interviewees their concerns as to any increase in mortality.[88] The chances of the discussion having that effect would have been greater had the inspectors and advisers had the relevant information and asked questions about the reasons for the mortality meetings not happening as frequently as the leads would have liked.

7.61 Similarly, Dr Odeka's view was that there was no discussion of neonatal mortality because it was not volunteered by the interviewees, and also because he did not have the data showing incidents of neonatal death.[89] Ms Potter did not recall any discussion of neonatal mortality or concerns relating to it either.[90]

7.62 An issue that was explored in evidence was the form of questions put by inspectors during interviews, and whether they were sufficient to elicit concerns that staff had but might be reluctant to volunteer. Ms Childs agreed that a question such as "*Is there anything that you think you should tell us that we haven't already covered?*" would be better than an open question such as "*Anything you want to say?*".[91] Ms Cain's evidence was that she would finish interviews by asking, "[I]*s there anything else you think we should know, anything you would like to tell us?*".[92]

7.63 Whilst Ms Ford could not say with certainty what was asked at interviews, she considered it standard practice to ask at the end of an interview, "*Is there anything else that you would like to tell us? Is there anything that we have missed? Is there anything you want to share with us?*".[93]

7.64 Mr Dzikiti attributed CQC's failure to detect concerns at the hospital about neonatal deaths to the fact that staff and leadership at the Trust did not disclose them.[94] I accept that is part of the story. But it is reasonable to expect an inspection team to probe what they are told by those subject to inspection. The hospital had given them the data that showed the number of deaths and the fact that some of them were unexpected and unexplained. The hospital (doctors, managers, nurses) knew they had provided that information. It was for CQC to ask questions about it. If the provision of data does not have that effect, what is the point of providing it? It is not sufficient to check that processes are in place to deal with (e.g.) deaths. I note that in respect of safeguarding, which I deal with in detail in Chapter 12, CQC found that the Countess had safeguarding policies and procedures in place and that staff "*were aware of their roles and responsibilities and knew how to raise matters of concern appropriately*".[95] The confidence there was misplaced. When people are asked what the process is for dealing with a particular event, they can often answer accurately. The more important next question is, what happened the last time that event occurred? That the process is used effectively should be rigorously tested if a CQC report on process is to have credibility and value.

7.65 I am not confident that the CQC process, as it occurred at the Countess, is apt to find problems within a hospital. Whatever the aspiration, experience of human behaviour teaches us that, when faced with very difficult information and uncertainty, candour is not instinctive. A willingness to ask questions and probe information given should be a requirement for anyone carrying out an inspection for CQC.

What difference would it have made had CQC been informed of the increase in deaths on the neonatal unit?

7.66 Ms Ford's evidence was that, had information regarding an unexpected increase in neonatal mortality been available to the inspectors, it would have led to the issue being explored with the Trust. Assuming that this would have happened, it is likely that assurances would have been sought that the reasons for the increase were being investigated.[96] It is likely that CQC would have been told about the recently held Thematic Review, the final report of which was not yet completed. Given that the inspection was directed towards whether there was an appropriate process to consider any increase in mortality rates, it is likely that the fact of the investigation would have been sufficient for CQC and nothing further would have been done.

Consultants' focus group

7.67 Amongst the focus groups held was one for consultants. It was conducted by Ms Hughes and Dr Michael Rees, a specialist adviser for CQC. Ms Hughes recalls that about 14 or 15 consultants attended, but she does not recall the individuals or their specialties.[97] CQC has not found the note of that focus group.

7.68 Ms Hughes made some brief notes relating to the focus group in her diary.[98] The relevant part of her note states: "*Themes – bullying – lack of support – staffing.*"[99]

7.69 On 7 July 2023, Ms Hughes discussed the focus group with Ms Kristin Hannaford, a CQC senior media adviser. This discussion took place towards the end of Letby's criminal trial. The note of that discussion contains more detail than the diary, stating:

> "*On 17 Feb consultant focus group Training Room 2 at 2.30pm – attended by consultants across range of services not just CYP. Some Consultants raised concerns relating to: Staffing levels / lack of staffing; Bullying culture – senior medics who talked of a lack of support from leadership team; Oppressive air at leadership level.*"[100]

7.70 Ms Hughes confirmed that this fuller account was based on her notes and what she had left in her memory of the focus group.[101] She explained that what came across from the consultants at the focus group was a "*general oppressive air … they didn't feel supported to raise their concerns, they didn't feel listened to*".[102] She could not recall what concerns were being raised by the consultants, but was sure there were no specific concerns raised with her about the neonatal unit.[103]

7.71 The note of the discussion with Ms Hannaford goes on to state: "*A meeting was held with the* [Trust's] *Medical Director that same day at 4.30pm and the concerns expressed by consultants were discussed.*"[104] Ms Hughes said in evidence that the meeting with the Medical Director, Mr Harvey, would have been an ad hoc one. She said that was the standard practice, though she could not remember the meeting.[105] Mr Harvey could not remember this matter being raised with him. He said that if it had, it would have been a matter of concern since it would have marked a change from the staff satisfaction survey for 2015 and he would have acted upon it. Whatever was said in the meeting, this issue did not find its way into the CQC report.

7.72 Ms Hughes was asked whether it was appropriate to raise allegations of bullying of the consultants, who had complained of an oppressive air at leadership level, with the Medical Director. Her evidence was that it was appropriate as the Medical Director carried overall responsibility for medics across the Trust and there was no one else to go to.[106] This betrayed a lack of insight into how to deal with allegations of bullying. Ms Ford stated that, if the issue was not tackled by the Medical Director, then it would be raised with the Chair.[107] However, Mr Dzikiti's expectation was that this information would be discussed with someone more senior, the Chief Executive or the Chair. He commented that, where a team was reporting bullying or harassment, the most senior people in the organisation were the ideal people to have the conversation with.[108] That was, presumably, the expectation of the consultants and would obviously be the right approach. In fact, the consultants' concerns were ignored. These were serious complaints that should not have been dismissed without any discussion. They do not

feature in the CQC report, nor was the Board made aware of them. This was another failure by CQC. The issue should have been explored before the conclusion could be reached that the hospital was well led.

7.73 The report said: "*The hospital was led and managed by an accessible and visible executive team. This team were well known to staff, visited most wards and departments regularly, and responded to issues that staff raised.*"[109]

7.74 We know from Chapter 2 that "*most wards and departments*" did not include the neonatal unit.

Post-inspection

7.75 When the Countess eventually told CQC about the increased neonatal mortality rate on 29 and 30 June 2016, CQC should have insisted on seeing the Thematic Review and the other reviews that had been carried out. Additionally, having considered those and noted the dates upon which they had been commissioned and received, CQC should have challenged the Countess about the failure to provide the information sooner. It did not do so. CQC pointed out that it had been reassured in terms of the ongoing safety of the unit by the steps and actions that were proposed by the hospital, but accepted that it should not have been so readily reassured.[110] This was a simple continuation of a non-investigative approach to inspection.

7.76 I accept that until this time the relationship between CQC and the Countess was very good. A consequence of close working relationships is that they can lead to a misplaced confidence that all is well. Those conducting inspections must always approach the task with an open mind, unaffected by the results of the last inspection, and free of any bias. This means that questions should be asked about the available data and about what the staff are telling the inspectors. Most importantly, it means going beyond establishing that a process exists for a particular situation and testing whether in fact it is effective. In the absence of such testing, the inspection becomes only about the process. The outcome becomes irrelevant. This is unacceptable in an organisation with responsibility for ensuring that our hospitals are safe and effective.

Endnotes

1 Witness statement of Ian Trenholm INQ0012634/2/para 6

2 Witness statement of Ian Trenholm INQ0012634/2/para 7

3 Witness statement of Ian Trenholm INQ0012634/2/para 11

4 Chris Dzikiti 14 January 2025 26/5-24

5 Witness statement of Ian Trenholm INQ0017809/3/para 12

6 Witness statement of Ian Trenholm INQ0012634/13/para 61 to 14/para 64

7 Witness statement of Ian Trenholm INQ0012634/16/para 78

8 Witness statement of Ian Trenholm INQ0012634/7/para 33

9 Chris Dzikiti 14 January 2025 22/3 to 23/7

10 Witness statement of Ian Trenholm INQ0012634/17/para 83

11 Witness statement of Ian Trenholm INQ0012634/17/para 84

12 Witness statement of Ian Trenholm INQ0012634/18/para 85

13 Witness statement of Ann Ford INQ0107911/6/para 2.18

14 Witness statement of Ann Ford INQ0107911/17/para 4.13

15 Witness statement of Ann Ford INQ0108375/5/para 5.3 to 6/para 5.6

16 CQC 17 March 2025 60/14-23

17 Ann Ford 15 November 2024 12/8-12

18 Ann Ford 15 November 2024 13/6-11

19 Ann Ford 15 November 2024 14/14-23

20 Ann Ford 15 November 2024 15/10-17 and 16/20-25

21 CQC 17 March 2025 61/2-8

22 CQC 17 March 2025 61/21-23

23 Witness statement of Ann Ford INQ0102609/17/para 3.76

24 Ann Ford 15 November 2024 10/16 to 11/23

25 Witness statement of Ian Trenholm INQ0012634/27/paras 130-133

26 Witness statement of Ian Trenholm INQ0012634/27/para 134

27 Witness statement of Ian Trenholm INQ0012634/28/para 137

28 Witness statement of Lisa Annaly INQ0108742/17/para 5.6

29 Witness statement of Ian Trenholm INQ0012634/38/para 198 to 39/para 200; Witness statement of Lyn Andrews INQ0108743/7/para 34

30 Witness statement of Ian Trenholm INQ0012634/28/para 140 and 31/para 154

31 Witness statement of Ann Ford INQ0108375/2/para 2.11

32 Witness statement of Lyn Andrews INQ0108743/8/para 35

33 Witness statement of Lyn Andrews INQ0108743/12/para 48

34 Chris Dzikiti 14 January 2025 131/3-13

35 Chris Dzikiti 14 January 2025 63/23 to 64/8

36 Witness statement of Ann Ford INQ0107911/11/para 3.3

37 Witness statement of Lyn Andrews INQ0108743/4/paras 15-16

38 Witness statement of Lyn Andrews INQ0108743/10/para 41

39 Witness statement of Lisa Annaly INQ0108742/11/para 2.8.1; Witness statement of Lyn Andrews INQ0108743/6/para 26

40 INQ0101422/5/1

41 CQC 17 March 2025 76/18 to 79/22

42 Ann Ford 15 November 2024 31/3 to 32/25

43 Chris Dzikiti 14 January 2025 48/25 to 49/6

44 INQ0103620/27

45 Witness statement of Lyn Andrews INQ0108743/11/para 46

46 Witness statement of Lyn Andrews INQ0108743/11/para 43

47 INQ0103620/26

48 Chris Dzikiti 14 January 2025 57/6-10

49 Helen Cain 14 November 2024 50/11-15; Dr Benjamin Odeka 14 November 2024 98/14-20

50 Helen Cain 14 November 2024 26/1 to 27/25

51 INQ0106785/10

52 INQ0106785/19

53 Chris Dzikiti 14 January 2025 49/4-6

54 Helen Cain 14 November 2024 27/20-25

55 INQ0103249/3-5

56 INQ0103249/5

57 Chris Dzikiti 14 January 2025 58/22 to 59/6

58 Witness statement of Lyn Andrews INQ0108743/10/para 38

59 Helen Cain 14 November 2024 29/19

60 Helen Cain 14 November 2024 30/9-12

61 Helen Cain 14 November 2024 31/18-22

62 Helen Cain 14 November 2024 33/14-23

63 Helen Cain 14 November 2024 34/16-19

64 Dr Benjamin Odeka 14 November 2024 93/9 to 94/24

65 Helen Cain 14 November 2024 43/9-14

66 Helen Cain 14 November 2024 54/7-24

67 INQ0017339/206

68 CQC 17 March 2025 62/11-13
69 Dr Ravi Jayaram 13 November 2024 94/18-20
70 Dr Ravi Jayaram 13 November 2024 94/21-23
71 INQ0017339/164
72 INQ0017339/207
73 Dr Stephen Brearey 19 November 2024 192/14-21
74 Dr Stephen Brearey 19 November 2024 105/3-4
75 Dr Stephen Brearey 19 November 2024 104/1-25
76 Eirian Powell 17 October 2024 113/1-5
77 Eirian Powell 17 October 2024 115/11-21
78 Anne Murphy 21 October 2024 70/16 to 71/7
79 Alison Kelly 25 November 2024 266/12 to 268/18 and 269/25 to 270/8
80 Alison Kelly 25 November 2024 71/25 to 72/2 and 75/14-22; INQ0003140/1
81 Alison Kelly 25 November 2024 73/6-8
82 Alison Kelly 25 November 2024 271/6-7
83 Ian Harvey 28 November 2024 105/8-11
84 Ruth Millward 4 November 2024 129/5-13
85 Helen Cain 14 November 2024 55/10-15
86 Helen Cain 14 November 2024 57/12 to 58/5
87 Helen Cain 14 November 2024 58/20-25
88 Helen Cain 14 November 2024 61/12-15
89 Dr Benjamin Odeka 14 November 2024 100/20 to 102/8
90 Mary Potter 14 November 2024 130/5-11
91 Elizabeth Childs 14 November 2024 175/13-22
92 Helen Cain 14 November 2024 63/20 to 64/2
93 Ann Ford 15 November 2024 21/1-18
94 Chris Dzikiti 14 January 2025 77/1-4 and 80/8-21
95 INQ0017433/110
96 Witness statement of Ann Ford INQ0108375/5/para 4.8
97 Julie Hughes 15 November 2024 103/12-20
98 Julie Hughes 15 November 2024 109/7-12
99 INQ0017319/2
100 INQ0017319/1
101 Julie Hughes 15 November 2024 117/1-6
102 Julie Hughes 15 November 2024 112/23 to 113/2

103 Julie Hughes 15 November 2024 118/17 to 119/14

104 INQ0017319/1

105 Julie Hughes 15 November 2024 123/16-25

106 Julie Hughes 15 November 2024 124/11-24

107 Ann Ford 15 November 2024 91/16-21

108 Chris Dzikiti 14 January 2025 132/18-23

109 CQC, *The Countess of Chester Hospital: Quality Report*, 29 June 2016 (https://api.cqc.org.uk/public/v1/reports/7d84e4fd-bdbe-4e99-839d-df83baa36adc?20210123080129#page=2)

110 CQC 17 March 2025 62/11-23

Chapter 8. February to April 2016: Baby K, Baby L and Baby M

Baby K

Mother K: "[W]*e found ourselves pregnant in 2015 and we were obviously thrilled and happy and over the moon with it. We generally didn't foresee any issues with the pregnancy or anything like that.*"[1]

8.1 Baby K was born at the Countess at 25 weeks' gestation, weighing 692 grams. She was taken to the neonatal unit. Parents K told the Inquiry that they were aware that she "*was small and we knew that Child K was going to be poorly, but she was stable*".[2] They added that Ms Joanne Williams had told them that "*Child K was stable, Child K was fine*".[3]

8.2 Father K told the Inquiry that, when Baby K was taken to the neonatal unit, his wife, who was exhausted, went to sleep, and he phoned his mother "*to tell her that Child K was here*". He then went to the neonatal unit: "*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.*" He did not go into the unit but walked to a window onto the nursery. There was someone standing by Baby K. He stated: "*I didn't want to distract them from what they were doing … My focus was on Child K. I was so excited. I wanted to tell people that the baby had arrived and was okay.*" He continued: "*Now, I feel guilty that I didn't stay and watch for that little bit longer.*"[4]

8.3 In his oral evidence, Dr Jayaram said that, by February 2016, he had "*significant discomfort*" about Letby.[5] On 16/17 February 2016, he was working on the night shift. At about 3.50am (and after Father K had gone back upstairs to Mother K in the post-natal ward), Dr Jayaram was outside Baby K's nursery when Baby K's designated nurse (Ms Joanne Williams) told him that she was going to the delivery suite to update Baby K's parents on her progress and that Letby was "*baby-sitting*". Dr Jayaram said he "*felt uncomfortable knowing that Letby was in the room*".[6] He said that he walked into Baby K's nursery to check everything was okay and saw that Baby K's endotracheal tube was dislodged and her oxygen saturations were dropping but Letby had not flagged the deterioration. His thought process was: "[H]*ow has that happened? … was it just coincidence that this baby who had been stable to this point in the period where the nurse looking after the baby and Letby was supervising the baby, this event happened?*"[7]

8.4 Parents K came down to the neonatal unit with Ms Joanne Williams who took photographs of them with Baby K. The photographs are timed at 04:31. No mention was made to them of the incident with the tube. They were aware that Baby K would be transferred to Arrowe Park Hospital at some point.

8.5 Dr Jayaram confirmed that, after Baby K collapsed, he was involved in her successful resuscitation.[8] He called the transport team to organise Baby K's transfer to Arrowe Park Hospital.[9] Baby K collapsed again, at 06:15 and 07:25.

8.6 Baby K was handed over to Nurse W on the day shift of 17 February 2016. In answer to questions from Mr Baker KC, Nurse W recalled that, during the handover, she was informed that Baby K's endotracheal tube had previously been secured before it became dislodged. Nurse W commented that it is "*highly unlikely*" for a premature baby to pull out its own correctly secured endotracheal tube.[10]

8.7 Baby K was later transferred to Arrowe Park, where she died some days later.

8.8 Letby was tried on one count of attempted murder of Baby K. The jury were unable to reach a verdict in the first criminal trial and the case was re-tried. Letby was found guilty of the attempted murder of Baby K. It was the prosecution case that she had deliberately dislodged the endotracheal tube.

8.9 On behalf of the senior managers, Ms Kate Blackwell KC pointed out to Dr Jayaram that the record of his call to the transport team refers to Dr Jayaram saying, "*baby dislodged the tube*". Dr Jayaram accepted that "*that is what was recorded*" and said: "[T]*he person I spoke to wasn't a clinical person. It was an administrative person*." Dr Jayaram said: "*I would almost certainly have said the tube was dislodged*." He accepted in oral evidence that he had not made any medical notes of his own about the incident, did not mention it to anyone at the time and had not submitted a Datix report. He also accepted, in retrospect, that even situations of accidental tube dislodgement should be Datixed.[11]

8.10 Asked by Counsel to the Inquiry whether he had mentioned this event to Dr Brearey, he said: "*I can't remember in detail. I think I sort of mentioned it in the sense another event had happened and Letby was there but I don't think I specifically articulated the thought processes I was having at 3 o'clock in the morning.*"[12] Dr Brearey did not recall Dr Jayaram mentioning this incident which would, in my view, have been memorable.[13] Given Dr Jayaram's recollection that he "*sort of mentioned it*", whatever Dr Jayaram said to Dr Brearey, if anything, was not an account of his suspicion about what he had seen in the early hours of 17 February 2016.

8.11 Dr Jayaram spoke to the Inquiry at length about the thoughts and worries he had at the time of this incident and in the months thereafter. He was, he acknowledged, at fault for not raising this with anyone else, not Baby K's family, nor the Local Authority Designated Officer (LADO) nor the police (see Chapter 12). Amongst other things, he explained: "*There is a fear because it's such a seemingly outlandish and unlikely thing that someone is causing deliberate harm, it's the fear of not being believed, it is the fear of ridicule, it is the fear of accusations of bullying*" that prevented him from raising it.[14]

8.12 Dr Jayaram said that, by the time of Baby K's collapse, he had seen a draft version of the Thematic Review and was aware of "*the staffing mortality analysis that had been done had already flagged up Letby*". He said that, "*in the context of those, I should have been braver, I should have had more courage because it wasn't just an isolated thing, there was already a lot of other information*".[15] I agree. In the event, he told no one for over a year. I shall return to the circumstances of his disclosure in Chapter 26.

8.13 Father K told the Inquiry in his written evidence that the Countess did not tell them about the episodes when Baby K's breathing tube became dislodged and she required resuscitation:

> "*Nobody told us about these episodes whilst we were in Chester. We only became aware of these facts when we had a meeting with the Crown Prosecution Service … If I had known, I would have asked questions. I would have asked what they were doing. Dr Jayaram would have had to explain to me there and then why Child K's tube had moved and how it had moved.*"[16]

8.14 Furthermore, the Countess did not inform Parents K of any concerns about Letby in relation to Baby K. Father K's written evidence was: "*We didn't know anything about Lucy Letby or issues with Child K's treatment until my wife received a phone call from the police in May 2017*."[17] He asserted: "*The Trust haven't been open and honest with us about any suspicion of harm caused to Child K*."[18]

8.15 By that stage, the parents of Baby K had been grieving the loss of their baby for over a year. They had no idea what had been observed and what the consequences of it might have been. Father K told the Inquiry that he was in denial when the police called and told them they were investigating Baby K's death. He commented: "*You would never think in a million years that something would happen to your baby in hospital*."[19] Mother K echoed his words: "*Not for one minute did we ever foresee any of this at that time*."[20]

Email May 2017

8.16 After the evidence hearings were completed, an Inquiry document – disclosed to all Core Participants in September 2024 – was put into the public domain. It is an email dated May 2017 from Dr Jayaram to the consultants on the neonatal unit. It includes the following passage in respect of Baby K: "*Staff nurse Letby at incubator and called Dr Jayaram to inform of low saturations. Endotracheal tube had been secured properly and baby not over-active. No obvious reason for tube to have dislodged*." That Dr Jayaram had gone into the room because he was called by Letby was different from what he had said in evidence. No questions were asked about that. In their judgment on the application for leave to appeal against conviction in respect of Baby K, the Court noted that legitimate criticism could be made of Dr Jayaram's evidence at trial – including the length of time before he reported the event and the inconsistencies between his evidence and contemporaneous documents, all of which, with other matters, were before the jury. As set out earlier, the focus of the questions in the hearing was not about why he had gone into the room, but about what he had seen when he was in the room with Letby and Baby K and whom he had told about it (question asked by Counsel to the Inquiry), and what he had said to the team collecting Baby K (question asked by Counsel for the senior managers). Dr Jayaram made clear in his evidence that he had not seen Letby doing anything. His concern was that she was not responding at all as Baby K deteriorated.[21]

8.17 The impact of Baby K's death on her parents was expressed by Mother K: "[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*."[22]

April 2016: Letby moved to day shifts

8.18 On 7 April 2016, Letby was moved to day shifts.[23] This was Ms Powell's decision.[24] By this stage, there had been deaths that did not feature on the indictment – in December 2015, and January, February and March 2016.

8.19 One of the themes Dr Brearey had identified in the Thematic Review was that most of the babies had died at night.[25] In her evidence, Ms Powell said that the decision to move Letby to day shifts was made by herself, Ms Griffiths and Ms Farmer. The evidence of Ms Farmer,[26] and that of Ms Griffiths,[27] suggests they were not instrumental in making the decision. In any event, as the Manager of the neonatal unit, it was Ms Powell who was responsible for this decision, which was then implemented by Ms Griffiths on the rota. Ms Rees and Ms Anne Murphy were also made aware of the move. Ms Powell did not tell Dr Brearey or Ms Kelly that she had done this.[28] She said that the decision to change Letby's shifts was driven by a "*well-being approach*".[29] She explained:

> "[Letby] *had been involved in so many of the recent deaths that that must have a profound effect on her well-being.*
>
> *And, therefore, we felt that there would be more support on the days, on the day shifts, and also able to see how she was in herself because we would be there to -- to monitor.*"[30]

8.20 Ms Powell said that she told Letby that she was "*a commonality within, within the deaths*". She did not tell Letby that more eyes would be watching her on the day shift. She explained to Letby that she was changing her shifts for her well-being and "*to ensure that she had a respite from all the events that were happening as* [they] *appeared to be happening at night*".[31]

8.21 Ms Griffiths told the Inquiry: "*I was asked if I could allocate, take Lucy off the night shift and then allocate two months' worth of day shift.*"[32] She understood the rationale for this to be "*because of the thematic review, I think it was highlighted that a lot of the incidents occurred during the night shift and so just to look at that commonality I think the decision was to move her onto days*".[33]

8.22 Ms Farmer confirmed that she was aware that Letby had been moved from night to day shifts in early April 2016, and that six out of the nine deaths examined in the Thematic Review had occurred at night. Speaking to the Inquiry about the rationale to change Letby's shifts, she stated: "[I]*t was discussed with me that that was the plan; that because of all the recent incidents, deaths, that they had occurred during the night, so that's why she was being moved on to days as support for her. If, if it was a training issue or if she needed emotional support, then there were lots of people around, the managers were around.*"[34] Ms Farmer said that no part of the explanation to move Letby to day shifts concerned keeping babies on the unit safe.[35] I accept her evidence about that. They were not thinking about the safety of babies. Ms Farmer talked about a training issue even though it was being said that Letby was an excellent nurse.

8.23 In evidence, Ms Rees said she had asked Ms Powell what the rationale was for the decision to move Letby from night to day shifts. She told the Inquiry that Ms Powell's response was:

> "*that it was a neutral act to bring her on to days. It wasn't deemed as a punishment or a finger-pointing exercise. It was because there are more staff on days than on nights and because of what you alluded to earlier about predominantly a lot of these mortalities were happening on the night shift, she wanted to check her competencies and bring her on to days so she could be more supervised.*"[36]

8.24 Ms Powell was consistent in saying that there were no training issues with Letby, and yet her competencies were to be checked and she could be better supervised on the day shift. It is likely that part of the reason for moving Letby to days was to see whether anything changed – specifically, whether or not the deaths continued at night. Ms Rees, like everyone else, seems to have accepted this approach.

8.25 Ms Murphy said in evidence that she was aware that Letby was moved to day shifts at the beginning of April 2016. She stated: "[I]*t wasn't done because people were pointing the finger per se, that she was the person causing these babies to deteriorate*". She explained: "*Eirian and I had discussed that because she had been involved with so many of the deaths that it would be better for her mental health really to come on to days for a period of time. But because there were also more staff around during the day she would then not necessarily have to look after the sickest babies.*"[37]

8.26 Dr Brearey learnt of the decision to change Letby from night to day shifts in May 2016.[38] So did Ms Kelly.[39] This is an indication of Ms Powell's confidence in her own judgement and her desire to keep this matter at the lowest possible level – that is, the unit. It is surprising that she did not inform others of this decision.

Baby L and Baby M

Father L and M: "*We knew early on that we were having twins and, up until March 2016, my wife had a routine pregnancy … The plan, which my wife agreed with, was to deliver the twins with a caesarean section.*"[40]

8.27 Twin boys, Baby L and Baby M were born by caesarean section at 33 weeks and 2 days' gestation. Baby L weighed 1.465 kilograms. Baby M weighed 1.705 kilograms. Father L and M's evidence was that "*they both seemed fine*". He said:

> "*They were in Nursery 1 … I understood they were on the unit because they were small and they did not weigh very much – they each weighed just over 3lbs. I understood that we would be able to take them home within a few weeks. I have since learned that Child L had periods of low blood sugar which required treatment, but we were not aware of this at the time.*"[41]

8.28 Letby was convicted of the attempted murder of Baby L and Baby M on the day shift of 9 April 2016.

Baby L

8.29 A blood sample was taken from Baby L on 9 April 2016 while he had low blood glucose. As with Baby F (see Chapter 5), it was sent to the Liverpool Clinical Laboratories at Royal Liverpool University Hospital for testing. The laboratory received the sample on 11 April 2016 and it conducted various tests, including a C-peptide and insulin test. The results were:

- Insulin: 1,099 picomoles per litre
- Insulin C-peptide: 264 picomoles per litre[42]

8.30 In her oral evidence, Dr Shirley Bowles, a consultant chemical pathologist, confirmed that she was the person referred to in a screenshot of the Liverpool Clinical Laboratories system, which recorded a call made to "*Shirley*" at "*Countess of* [Chester] *Biochem*" on 14 April 2016 at 09:38:23. The call was about Baby L's insulin and C-peptide result.[43] Dr Bowles told the Inquiry that an external laboratory would "*ring through results that they felt needed someone to look at and possibly act upon*"[44] or if the results were "*urgent or unexpected or unusual*".[45] She could not recall the conversation; however, she assumed that "*the thrust of the conversation*" was in line with the contemporaneous record.[46] The note records that the advice given was "[d]*ifficult to interpret without the concurrent glucose but may be inappropriate if patient was hypoglycaemic at the time of collection*".[47] Baby L's medical records confirm that he was hypoglycaemic on the date of the blood test request.[48] Dr Bowles accepted in evidence that: "*The glucose was low, it was 2.8, not quite within the definition of hypoglycaemia, but certainly low*."[49]

8.31 Dr Bowles entered the results onto Baby L's electronic laboratory record at 09:38 on 14 April 2016. She gave oral evidence that she regarded Baby L's insulin and C-peptide result as a "*puzzling result in a patient on the neonatal unit*". She concluded: "[I]*t looks like there is external administration of insulin*."[50]

8.32 Baby L's medical records suggest that Dr Bowles made a call to the neonatal unit. Dr Bowles' name "*CON/BOWS*" appears on Baby L's records at 09:38.[51] At 09:40, the results were verified; the results would then have been on Baby L's electronic case record and thus visible to the clinical team involved in the care of Baby L.[52] Dr Bowles explained: "[If] *there's nothing untoward about* [the] *result, it's an instantaneous process … So the fact there was this two-minute gap was what made me think that … that I tried to telephone someone at that stage*."[53] She could not recall if she managed to speak to someone, however, but reflected: "*I obviously felt the need to ensure the tests were communicated rapidly*."[54]

8.33 At the criminal trial, Professor Peter Hindmarsh, Professor of Paediatric Endocrinology at University College London Hospital, gave expert evidence that Baby L's hypoglycaemic event continued from 9 April 2016 until about 3pm on 11 April 2016, with the insulin being infused intravenously, having been added to the TPN bags that had been made up. Letby was convicted of attempted murder by adding insulin to Baby L's TPN bag.

8.34 In oral evidence, Dr Bowles agreed that the most likely scenarios producing the blood test results were: (a) the child was hyperglycaemic but received too much exogenous insulin and thus almost became hypoglycaemic; (b) exogenous insulin was given to the child in error; or (c) exogenous insulin was given to the child deliberately.[55] She went

on to explain: "*I can't say whether I thought through that clearly at the time about the possible scenarios. I possibly just thought this is something I need to convey and find out a bit more about*."[56] However, it is clear that Dr Bowles did not consider whether someone was deliberately harming babies. She described that as "*unthinkable*", saying: "*I suppose you always tend to think* [of] *those as being one-offs and you don't expect them to be in your own institution*."[57] In that respect, her response was exactly the same as those of the doctors, nurses and managers. This could not happen here. But she had in front of her clear evidence that something had (or at least may have) happened there. That is why she rang the ward.

8.35 Dr Bowles was critical of the consultant paediatricians' failure to share their concerns with the Blood Sciences Department. She said:

> "[I]*f I -- I had been aware that there had been problems with babies on the unit, then obviously this would have been a huge red flag, but at that stage I had absolutely no knowledge of any problems on the unit. So it was like having a piece of a jigsaw but I didn't actually know there was a jigsaw. So, you know, it was standing alone as an isolated result, and obviously looking at it now it's very obvious what it was saying, but at that time I -- I guess I just didn't -- it didn't fire that suspicion.*"[58]

8.36 This was not a piece of a jigsaw. It was a self-contained piece of hard evidence, which showed, on its own, that exogenous insulin had been administered. That was why the Liverpool laboratory had contacted her. It is why she contacted the ward. Having attempted, and it would appear failed, to contact a clinician on the neonatal unit, Dr Bowles verified the results, so that they appeared on Baby L's electronic case record, visible to the clinical team. Following that, she took no further action.

8.37 Dr Bowles made the point that, as duty biochemist, she looked at 200 to 300 sets of results a day.[59] I accept that, but this was a telephone call about "*urgent or unexpected or unusual*" results.[60] When asked whether she had an obligation to complete a Datix form for potential clinical issues that needed further investigation, she agreed that she did and reflected that "*in retrospect it may have been a reasonable thing to do*".[61] She confirmed that she had access to the Datix system in 2016. She stated that Baby L's C-peptide and insulin result "*may have merited a Datix*", but said: "*I probably felt I didn't have the complete picture at that stage*."[62] She had enough of the picture to sound the alarm but that did not occur to her.

8.38 Dr Bowles said that it was standard practice for a paper copy of results to be sent to the neonatal unit via the internal mail. The insulin and C-peptide results were written by hand by a junior doctor into Baby L's medical records at 09:30 on 15 April 2016, a full day after the electronic record was updated.[63] However, the significance of the results was clearly missed.

8.39 It was Dr Jessica Burke who recorded Baby L's insulin and C-peptide results in the ward round at 09:30 on 15 April 2016. At the time, Dr Burke was a junior doctor completing her paediatric training. She informed the Inquiry she copied Baby L's insulin results from the computer and wrote them into the paper notes. She said that she did not expect to transcribe abnormal results from the computer because her experience was that abnormal results were usually called through by telephone from the laboratory to the clinical team.[64] This supports the conclusion that Dr Bowles probably telephoned the ward but did not speak to anyone.

8.40 Dr Burke told the Inquiry: "*At that time as an ST2* [specialty trainee]*, my experience of hypoglycaemia screens was limited*." She was candid, saying, "*I would not have been familiar in 2016 with the units or ranges used for these values*" and "*I do not remember understanding the significance or interpretation of the insulin and C-peptide results on Twin 2 at that time*." She "*noticed that the computer displayed what the expected ranges were for the results and that the insulin reading was flagged by the computer system as being high and out of range*".[65]

8.41 Dr Burke recollects that she "*approached the middle grade (registrar) that day on the NNU* [neonatal unit] *who I think from memory was Dr U to ask him about the results … I cannot remember if I read the results aloud to the registrar, or if I showed him the results … but I do remember flagging these results to him*." Dr Burke stated that Dr U's advice was that the insulin and C-peptide result could not be interpreted without the glucose results.[66] Dr U was a registrar.

8.42 Dr Burke reflected:

> "*I now understand with the benefit of hindsight from the trial and also from my greater experience with hypoglycaemia screens that it was highly unusual for the blood glucose result to not yet be available when the insulin and C-peptide were resulted and that actually the blood glucose result may have been missing rather than not yet available. I also now understand, with the years of experience I have gained since both clinically and through the police investigation and trial, that a high insulin and a low C-peptide result indicate exogenous insulin administration and that in the context of an NNU patient who has never been home and is not prescribed insulin for any reason, that deliberate harm on the part of a healthcare professional is a possible cause.*"[67]

8.43 Dr U cared for Baby L during a night shift on 9 April 2016. Despite giving evidence that it was common for him to look back 24 hours in a patient's medical records, he stated that he had not seen that a hypoglycaemia blood test had been ordered for Baby L earlier that day. He later gave evidence that he had understood the tests were ordered; however, the results had not yet been received by the time of the night shift. In fact, Baby L's results had been entered onto Baby L's electronic laboratory records at 09:38 on 14 April 2016 (see above).

8.44 Dr U worked on the neonatal unit on 14 and 15 April 2016 and made entries in Baby L's medical records. Dr U accepted that Baby L's blood test results were handwritten in the medical notes during a ward round at 09:30 on 15 April 2016. Shortly before the afternoon shift handover, Dr U attended Baby L to conduct a cranial ultrasound and recorded this in Baby L's notes at 16:00.[68] He accepted that he did not look at the entries in Baby L's medical records made earlier that day to see what had been recorded or if the hypoglycaemia results had been received.[69] He should have looked for – and at – them. His failure to do so meant that no one picked up this second example of insulin poisoning on the neonatal unit.

8.45 In Dr U's evidence to the Inquiry and in his statement to the police, he made no reference to Dr Burke flagging with him that Baby L's insulin results were high. His evidence was that any abnormal results from the morning ward round would be discussed with the consultant responsible for the week. He could not recall who that was.[70]

8.46 About Baby L's insulin and C-peptide result, Dr U said: "[T]*he insulin level is unusually high*."[71] He added: "[T]*hey are abnormal results and I would have expected that they had flagged some sort of warning or alert*."[72] He agreed that the results indicated that insulin was given deliberately or by mistake to Baby L and needed investigation.[73] Dr U also agreed that not seeing the test results at the time was a missed opportunity to detect the deliberate administration of insulin.[74] Dr U died in 2026.

8.47 Dr Gibbs explained that he did not care for Baby L when his blood sugars were low and found out about the results two years later when he reviewed the records for a police statement. However, he acknowledged that the result had been recorded by a junior paediatrician in Baby L's medical records. He stated: "[T]*he result was sitting in their* [Baby L's] *notes*."[75] Dr Gibbs conceded: "*I think we all collectively have responsibility for missing that.*"[76] Dr Brearey agreed it was a collective failure.[77] Dr Saladi,[78] Dr ZA[79] and Dr V[80] also agreed. I do not think that this was a collective failure. It was a failure by the doctor who was responsible for caring for Baby L at the time, namely Dr U.

8.48 Dr Jayaram told the Inquiry that Baby L's hypoglycaemia happened on the same day as Baby M's non-fatal collapse. He was aware that Letby was present but at the time did not have any suspicions about Baby L's state of hypoglycaemia being unnatural. Dr Jayaram cared for Baby L a few days after his blood test and noted that Baby L's hypoglycaemia had resolved. He stated that it was handed over to him that the blood test results were back and everything was normal. Thus, he was not prompted to look back in the notes at the results.[81] Had he done so, he would have seen the results. Dr Jayaram was candid about the fact that the significance of the results not being picked up was a missed opportunity.[82]

8.49 Speaking of Baby L's insulin result, Mr Harvey said: "*There should have been cross reference with Child F. I think if this had been identified and reported, it would have influenced our decision to go to the police*."[83] Given that exogenous insulin had been administered to two babies when there was no clinical reason to do so, it is incontrovertible that the police should have been contacted.

Parents L and M

8.50 Parents L and M told the Inquiry: "[W]*e were not informed that Child L had notable hypoglycaemia requiring high concentration dextrose*."[84] They stated: "[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.*"[85] Dr U accepted that Parents L and M should have been told and it was a mistake that they were not.[86]

8.51 Parents L and M spoke candidly about "*the enormous amount of stress and anxiety* [the Letby case] *has placed on us as a family*".[87] Father L and M shared personal details about the "*toll … both physically and mentally*" on him and their family.[88] He 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*."[89]

8.52 Father L and M observed that Dr Brearey, in his police statement dated 16 April 2019, had stated that in August 2018, after reviewing all the insulin and C-peptide results from babies on the neonatal unit, "*it became clear that his insulin and C-Peptide results were abnormal and 'suggestive of exogenous insulin administration'*".[90] Despite this, Father L and M's evidence was that they were still not informed of this by the Countess. Father L and M stated: "*It was the police that first informed us in 2019 that they thought insulin had been used to harm Child L*."[91]

Baby M

8.53 Baby M collapsed unexpectedly at about 4pm on 9 April 2016. At the request of Letby, a resuscitation crash call was put out. Nurse W assisted Letby in giving resuscitation breaths to Baby M until the doctors arrived. Dr Anthony Ukoh (a locum registrar), Dr Cassandra Barrett (a junior doctor) and Dr Jayaram attended. The resuscitation continued for approximately 30 minutes and reached a point where withdrawing support needed to be considered. However, at that point Baby M suddenly recovered.

8.54 In oral evidence, Nurse W stated that she was in the room when Baby M collapsed. She recalled that Baby M was "*stable in terms of his observations on that day*". Regarding Baby M's collapse, she stated: "*I did not think what happened on that day would happen.*"[92]

8.55 Nurse W told the Inquiry that, after Baby M's collapse, "*I was trying to find an answer because it, it was unexpected and I almost needed an answer for what had happened*."[93]

8.56 Parents L and M told the Inquiry that they were on the maternity ward "*when a nurse came rushing in to tell us we needed to come back to the neonatal unit immediately because something was wrong*".[94] Father L and M described arriving on the neonatal unit and seeing one of the doctors doing chest compressions on Baby M. He recollected that staff on the ward thought Baby M's collapse was unexpected. He 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*."[95] Father L and M spoke candidly about the impact of Baby M's collapse and resuscitation on him, saying: "*Even to this day I get flashbacks to what I saw on the unit*."[96]

8.57 Nurse W recalled seeing Dr Brearey performing an echo scan on Baby M to see if there was an underlying cardiac condition that had caused his collapse. She said she asked Dr Brearey about the outcome of the scan and Dr Brearey reported that it was normal.[97] In oral evidence, Dr Jayaram confirmed that he was involved in Baby M's resuscitation and noticed an unusual blotching similar to what he had seen on Baby A. His thought process was:

> "[A]*lthough myself and colleagues were -- had begun to wonder about the possibility of Letby deliberately doing something, we hadn't really started actively thinking about what might be being done.*
>
> *And again in these situations Letby was there, it was an unusual, very unusual collapse and this unusual discolouration. Again we are thinking along the lines could this be sepsis? But it doesn't quite seem to quite fit, could this be some kind of cardiac event didn't seem to quite fit.*"[98]

Skin changes

8.58 Dr Jayaram stated that he "*discussed with Dr Brearey*" that there was another case "*with the blotching*".[99] Dr Brearey recalls Dr Jayaram informing him that Baby M had needed to be resuscitated, although he does not recall Dr Jayaram mentioning any "*blotching*". Dr Jayaram also approached Dr Gibbs with his concern that Baby M's collapse was sudden. Dr Gibbs was asked why he did not do anything at that time when he already held concerns that Letby was deliberately harming babies.[100] Dr Gibbs responded that it still was not clear that harm was happening to the babies. It was pointed out to Dr Gibbs that the *Working Together to Safeguard Children* 2015 guidelines refer to the safeguarding principles being engaged if there is concern that someone **may** have harmed a child. Dr Gibbs confirmed that this reflected his state of mind at the time. He reflected: "[W]*e should have involved the police earlier some time in 2016 and I feel I was at fault*."[101] Dr Gibbs was right.

8.59 Acknowledgement of their errors and failings was characteristic of the consultant paediatricians. Acceptance was given without prompting at all stages. The doctors' reflective and self-critical approach is in marked contrast to that of the managers to whom they turned for assistance.

8.60 Baby M had collapsed in the afternoon of 9 April 2016. Dr U worked the night shift later that evening. He gave evidence that, around Baby M's collapse: "*There was discussion about babies with rashes and we I don't think had been able to come up with a clear reason for why those rashes were occurring and that continued through to the time that I finished at the Countess*."[102]

8.61 Dr Jayaram spoke to Baby M's parents about his collapse. However, he did not inform them about the unusual patches and discolouration on his skin or the possibility of deliberate harm. Dr Jayaram told the Inquiry:

> "*The discussion that I had with Baby M's family after he was resuscitated was I -- I discussed that again I couldn't explain it. It didn't fit with things … at this stage, yes, we were thinking the unthinkable, but it was this issue of not having evidence and I wish I could turn the clock back and wish I could have said it, and I didn't, or later on.*"[103]

8.62 Dr Jayaram did not disagree that candour required him to alert the parents of Baby M that one possibility regarding Baby M's collapse was that it was a result of deliberate harm.[104]

8.63 Father L and M said, about the discussion with Dr Jayaram: "*Dr Ravi Jayaram … took me and my mum into a side room on the unit. My wife was not present. He explained to us that these things can happen with premature babies. I understood that he was referring to Child M's collapse and the need for resuscitation. I saw no reason to question that at all.*"[105]

8.64 The first time Parents L and M learnt about the discoloration on Baby M was at Letby's criminal trial. Father L and M told the Inquiry:

> "*Dr Jayaram explained that he had been involved in the resuscitation of Child M and had seen weird patches and discolouration on Child M's skin when they were trying to resuscitate him. I also understand now that this would have been very rare and*

highly unusual. At no point was this mentioned to us as parents. We had no idea that anyone thought anything about Child M's condition or presentation was unusual or suspicious."[106]

8.65 There was no Datix report for Baby M's non-fatal collapse and resuscitation. Father L and M commented on this in oral evidence:

"*Given the rarity of the skin discolouration, I do not understand why more steps were not taken to consider the cause, or a discussion about it amongst the doctors, or with other doctors on a wider scale. If there had been, there may have been more weight to the suspicion that this was purposefully caused. Given how unusual it was, I really do not understand why it was not taken further by the clinical staff.*"[107]

8.66 A paper towel with the drug administration notes relating to Baby M was found at Letby's home (along with many other documents relating to babies on the neonatal unit), and she recorded in her diary for 9 April 2016: "*LD* [meaning long day] *extra twin resus*".

Endnotes

1 Mother K 23 September 2024 92/10-14
2 Father K 23 September 2024 154/4-6
3 Father K 23 September 2024 153/15-16
4 Father K 23 September 2024 151/21 to 153/3
5 Dr Ravi Jayaram 13 November 2024 37/23
6 Dr Ravi Jayaram 13 November 2024 37/24-25
7 Dr Ravi Jayaram 13 November 2024 38/6-25
8 Dr Ravi Jayaram 13 November 2024 38/16-17
9 Dr Ravi Jayaram 13 November 2024 202/19-20
10 Nurse W 14 October 2024 150/9-10
11 Dr Ravi Jayaram 13 November 2024 202/19 to 203/22
12 Dr Ravi Jayaram 13 November 2024 41/1-6
13 Dr Stephen Brearey 19 November 2024 206/6 to 208/3
14 Dr Ravi Jayaram 13 November 2024 39/13-15
15 Dr Ravi Jayaram 13 November 2024 39/24 to 40/6
16 Father K 23 September 2024 154/22 to 155/11
17 Father K 23 September 2024 160/17-19
18 Father K 23 September 2024 167/17-18
19 Father K 23 September 2024 161/14-15
20 Mother K 23 September 2024 135/20-21
21 Dr Ravi Jayaram 13 November 2024 38/7-15
22 Mother K 23 September 2024 141/6-8
23 Witness statement of Dr Stephen Brearey INQ0103104/36/para 212
24 Eirian Powell 17 October 2024 123/10 to 124/25
25 Dr Stephen Brearey 19 November 2024 111/24 to 112/6; INQ0003251/7
26 Yvonne Farmer 16 October 2024 51/18 to 52/4
27 Yvonne Griffiths 16 October 2024 153/5-12
28 Eirian Powell 17 October 2024 124/20 to 125/17; Witness statement of Dr Stephen Brearey INQ0103104/36/para 212
29 Eirian Powell 17 October 2024 123/17-18
30 Eirian Powell 17 October 2024 123/17-24
31 Eirian Powell 17 October 2024 125/18 to 127/10
32 Yvonne Griffiths 16 October 2024 153/10-12
33 Yvonne Griffiths 16 October 2024 153/24 to 154/4

34 Yvonne Farmer 16 October 2024 51/20 to 52/1
35 Yvonne Farmer 16 October 2024 51/20 to 52/1
36 Karen Rees 21 October 2024 124/21 to 125/3
37 Anne Murphy 21 October 2024 78/7-16
38 Witness statement of Dr Stephen Brearey INQ0103104/36/para 212
39 Witness statement of Alison Kelly INQ0107704/72/para 238
40 Father L and M 24 September 2024 6/20 to 7/4
41 Father L and M 24 September 2024 7/20 to 8/5
42 Dr Shirley Bowles 9 October 2024 31/15 to 32/4
43 INQ0001176
44 Dr Shirley Bowles 9 October 2024 92/24-25
45 Dr Shirley Bowles 9 October 2024 93/9-10
46 Dr Shirley Bowles 9 October 2024 89/5-6
47 INQ0001252/2
48 INQ0001169/12 and 216
49 Dr Shirley Bowles 9 October 2024 86/7-9
50 Dr Shirley Bowles 9 October 2024 94/9-10 and 94/17-18
51 INQ0001169/217
52 Dr Shirley Bowles 9 October 2024 101/16 to 102/16
53 Dr Shirley Bowles 9 October 2024 99/1-7
54 Dr Shirley Bowles 9 October 2024 97/18-19
55 Dr Shirley Bowles 9 October 2024 95/4 to 96/3
56 Dr Shirley Bowles 9 October 2024 96/16-20
57 Dr Shirley Bowles 9 October 2024 102/13 and 105/11-13
58 Dr Shirley Bowles 9 October 2024 105/14-24
59 Dr Shirley Bowles 9 October 2024 108/7-8
60 Dr Shirley Bowles 9 October 2024 93/9-10
61 Dr Shirley Bowles 9 October 2024 113/8-9
62 Dr Shirley Bowles 9 October 2024 111/23 and 112/6-7
63 Witness statement of Dr Shirley Bowles INQ0099066/13/para 56
64 Witness statement of Dr Jessica Burke INQ0101089/31/para 210
65 Witness statement of Dr Jessica Burke INQ0101089/31/paras 210-212
66 Witness statement of Dr Jessica Burke INQ0101089/32/paras 214-215
67 Witness statement of Dr Jessica Burke INQ0101089/33/para 224
68 Dr U 7 October 2024 227/3 to 230/11

69 Dr U 7 October 2024 180/4-14 and 229/7 to 230/24
70 Dr U 7 October 2024 230/6-24
71 Dr U 7 October 2024 233/24-25
72 Dr U 7 October 2024 232/11-13
73 Dr U 7 October 2024 234/1-8
74 Dr U 7 October 2024 180/22-25
75 Dr John Gibbs 1 October 2024 96/25 to 97/1
76 Dr John Gibbs 1 October 2024 97/5-6
77 Dr Stephen Brearey 19 November 2024 64/1-23
78 Dr Murthy Saladi 3 October 2024 77/3-6 and 77/18
79 Dr ZA 7 October 2024 48/13-20
80 Dr V 7 October 2024 124/5-8
81 Dr Ravi Jayaram 13 November 2024 51/18 to 53/5
82 Dr Ravi Jayaram 13 November 2024 51/12-15
83 Witness statement of Ian Harvey INQ0107653/30/para 136
84 Father L and M 24 September 2024 15/9-11
85 Father L and M 24 September 2024 13/20 to 14/1
86 Dr U 7 October 2024 225/18-23
87 Father L and M 24 September 2024 4/8-9
88 Father L and M 24 September 2024 4/20
89 Father L and M 24 September 2024 5/9-13
90 Father L and M 24 September 2024 15/12-21
91 Father L and M 24 September 2024 15/23-25
92 Nurse W 14 October 2024 111/20-24
93 Nurse W 14 October 2024 114/4-6
94 Father L and M 24 September 2024 8/13-15
95 Father L and M 24 September 2024 9/16-19
96 Father L and M 24 September 2024 5/16-17
97 Nurse W 14 October 2024 114/17-19
98 Dr Ravi Jayaram 13 November 2024 44/7-17
99 Dr Ravi Jayaram 13 November 2024 44/18-20
100 Dr John Gibbs 1 October 2024 97/22 to 98/10
101 Dr John Gibbs 1 October 2024 98/11 to 99/22
102 Dr U 7 October 2024 235/12-16
103 Dr Ravi Jayaram 13 November 2024 248/4-13

104 Dr Ravi Jayaram 13 November 2024 249/4-9

105 Father L and M 24 September 2024 10/7-12

106 Father L and M 24 September 2024 10/15-22

107 Father L and M 24 September 2024 20/21 to 21/4

Chapter 9. April to May 2016: The executives

Ms Kelly's and Mr Harvey's response to the Thematic Review

9.1 On 11 April 2016, in a one-to-one meeting with Mr Harvey, Ms Kelly noted that the Thematic Review was mentioned.[1] At a Serious Incident Panel meeting on the same day when the Thematic Review was discussed, Ms Kelly noted that Mr Harvey was going to follow up the feedback from Dr Subhedar and speak to Dr Brearey.[2] So far as I can tell, Mr Harvey did neither of these things. Ms Kelly's notes also record that the review was to go to QSPEC for noting, with Dr Brearey attending.

9.2 By 14 April 2016, Ms Powell had still not received any response from Ms Kelly to her email of 21 March 2016, attaching the Thematic Review (see Chapter 6). That day, Ms Powell prompted Ms Kelly for a reply, asking for her thoughts and enclosing an updated version of the neonatal mortality table (Appendix 1). This table again showed that Letby (whose name was in red) was associated with nine deaths. The names of the consultants involved with each child appeared in the table, as did the names of all the junior doctors who were involved with the babies who collapsed and died. The name of Dr Harkness was in red next to Baby E, although not in the entry next to Baby A.[3] Ms Kelly conceded that she did not recall looking at Appendix 1 when she received the Thematic Review from Ms Powell on 21 March 2016.[4]

9.3 Ms Powell gave evidence that the pace of the response from the senior executives was not as quick as she would have liked. In oral evidence, Ms Kelly said: "*I recognise there could have been a faster response*." When asked directly, she denied that she had been "*too slow*".[5] In my judgement, there should have been a faster response. It is likely that she responded far too slowly because she had not read the email when it was sent.

9.4 On 18 April 2016, Ms Kelly emailed Mr Harvey to let him know that the Thematic Review was not going to QSPEC that day but that it should go to the May 2016 meeting. Ms Kelly suggested that she and Mr Harvey meet with Dr Brearey and Ms Powell in "*early May to check on actions*" from the review that were due to be completed.[6] It did not go to the May 2016 meeting, nor is there any record of it ever going to QSPEC.

9.5 In the week commencing 25 April 2016, Ms Kelly had a one-to-one meeting with Mr Harvey in which the pair discussed the Thematic Review. Ms Kelly's record of the meeting in her notebook has an entry "*NNU mortality review … – ? review by Hill Dicks*".[7] Ms Kelly confirmed that by this date she was aware the document contained individual references to members of staff and that she and Mr Harvey discussed it. She confirmed that Hill Dickinson were the Trust's clinical negligence solicitors and accepted that it

would be logical to assume she had noted the firm because the pair discussed whether they needed to ask Hill Dickinson to review the issue. However, she had no positive recollection of why she had written it.[8]

9.6 Mr Harvey accepted that in April 2016 he was aware that Letby was associated with some but not all of the deaths.[9] As was clear, Letby was present for all of the deaths. However, he did not consider deliberate harm and thought the most likely reason for the association was because "*she was more commonly on duty, on duty for longer, tended to care for the sicker babies*".[10] That information is likely to have come from Ms Powell at some point before April 2016. Mr Harvey relied on it and repeated it frequently. It does not deal with the unexpected nature of the collapses, particularly when the babies were stable.

Dr Gibbs' concerns

9.7 Dr Gibbs was not aware of Letby's shift change from night to day shifts until a few weeks afterwards.[11] He told the Inquiry that, by April 2016, his suspicions that something was not right on the unit had started to coalesce.[12] He confirmed that the nature of his suspicions was that Letby may pose a danger and that the deaths may not have been natural. Dr Gibbs agreed that the suspicions he held required immediate action.[13] He was aware that Dr Brearey was seeking to raise concerns with Mr Harvey and Ms Kelly. Nevertheless, no immediate action was taken.

9.8 Dr Gibbs reflected that he and his colleagues may have been "*influenced by the conviction that we were wrong from the nursing side*".[14] He added: "[T]*here was a very strong argument being put forward from the senior nurse on the unit that this suspicion was totally wrong and that we were maligning Nurse Letby and that she was a very competent, safe nurse*."[15] Notwithstanding this, Dr Gibbs was candid: "*I regret that we or I didn't go to the police at this time after the thematic review*."[16] It is clear from this answer, which was echoed several times in Dr Brearey's evidence, that these two paediatricians, at least, were far too deferential to Ms Powell. They were too influenced by her views and by their own doubts about whether this could be deliberate harm. They had far more medical expertise about cause of death. They knew there was something wrong and yet they allowed her far too much influence over the approach they took to these unexplained deaths. Both of them acknowledged this failing in evidence.

9.9 A meeting arranged for 4 May 2016 was rearranged at Dr Brearey's request. It took place on 11 May 2016. This served to satisfy the requests for a meeting from Dr Brearey and Ms Powell, who were concerned about the Thematic Review and the high mortality and commonality of the presence of a nurse.

4 May 2016

9.10 On 4 May 2016, at 16:10, Dr Brearey sent the following message to Ms Kelly:

> "*There is a nurse on the unit who has been present for quite a few of the deaths and other arrests. Eirian* [Powell] *has sensibly put her on day shifts only at the moment, but can't do this indefinitely. It would be very helpful to meet before she is due to go back on night shifts. There is some pressure regarding staffing numbers with this at the moment.*"[17]

9.11 This was the first time any senior manager was told that a member of staff had been put onto day shifts, having been present for quite a few deaths and other arrests. Ms Kelly had already been told in March 2016 by Ms Powell about the commonality of the same nurse being on duty for what was an increased number of child deaths and had been sent the Thematic Review.

9.12 Ms Kelly said in evidence that she interpreted "*Eirian* [Powell] *has sensibly put her on day shifts*" as referring to "*provid*[ing] *support and welfare for Letby, as we would with any other nurse who was struggling. We would sensibly move them from nights to days*."[18] She said that the reference to "*pressure regarding staffing numbers … felt to me that there was some staffing challenges and that they were lacking on the night shifts. So, therefore, we needed to have a conversation to make sure that the unit was sensibly staffed.*"[19]

9.13 Ms Kelly's evidence to the Inquiry was in marked contrast to her response at the time of receiving the email. Within four minutes of receipt, at 16:14, she had forwarded Dr Brearey's email and thread to Ms Rees. She copied in Ms Sian Williams, Deputy Director of Nursing, with the following message:

> "*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!!*
>
> *I will check the report they sent through – I did not notice there was a staff trend!!*"[20]

9.14 Only two hours later, Ms Kelly again emailed Ms Rees. At 18:04, she wrote:

> "*Hi Karen*
>
> *Please see attached (not sure you will have had previous sight of this), Lucy Letby highlighted in red!! I have not noticed this when I first reviewed. Can you please look into this as per my previous email*."[21]

9.15 In Ms Kelly's written evidence, she told the Inquiry she was "*quite alarmed*" when she typed this email as she "*assumed that the shift patterns had been changed as a direct result of the staffing trend identified*".[22] I am satisfied that her assumption was correct. In oral evidence, Ms Kelly described herself as "*quite concerned*".[23] Alarm and concern were the natural responses to the information she had now read. I would add that reference to a "*staffing trend*" was frequently used code; the staffing trend identified was the presence of Letby.

9.16 Ms Kelly conceded that Ms Powell had already informed her about the "*staff trend*" in her email in March.[24]

5 May 2016

9.17 On 5 May 2016, Ms Powell, Ms Rees and Ms Anne Murphy had a meeting about Letby and the neonatal unit. Afterwards, Ms Powell produced a review titled 'Neonatal Unit Review 2015-16' which was used as a basis for discussion at the later meeting on 11 May 2016.[25] Although Dr Brearey is recorded as present, he was certain that he was not involved.[26] It is likely that this was a meeting of nurses only; no reference is made to anything said by Dr Brearey. He was copied in on a note made by Ms Powell after the meeting.

9.18 Ms Anne Murphy said the discussion took place because they felt unable to manage the situation further and it had become a matter of urgency. The urgency presumably came from the delay that had already occurred and the fact that there was a risk that Letby would be going back onto night shifts. Following the meeting, Ms Powell sent a number of documents to Ms Rees, copying in Ms Griffiths, Dr Brearey and Ms Anne Murphy.[27] One of the documents was the now familiar schedule of deaths and the staff on duty, dated 19 January 2016, that highlighted Letby's name in red.[28] The second document was a schedule titled 'Additional Information – Monitoring', dated 15 April 2016, also prepared by Ms Powell.[29] This listed babies who had died or suddenly and unexpectedly collapsed from February 2016. It records the collapse of Baby M on 9 April 2016 during a day shift when Letby was on duty. It records that Letby was in the room at the time of Baby M's collapse and was nearest to Baby M when his alarm sounded.[30] There was also Ms Powell's Neonatal Unit Review (also known as the assurance document), dated 5 May 2016, which 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.*"[31]

9.19 In her covering email to Ms Rees, Ms Powell wrote:

> "*Hi Karen,*
>
> *Thanks for seeing us this lunchtime regarding this matter.*
>
> *I have attached the relevant documents to state the relevant information.*
>
> *1. Lucy's shifts*
>
> *2. NNU Mortality document*
>
> *3. Continued NNU monitoring process*
>
> *4. Neonatal Unit review assurance*
>
> *Obviously we would like to have a meeting with Alison Kelly and Ian Harvey as a matter of urgency primarily for reassurance and to ensure that we have covered all the relevant actions.*"[32]

9.20 Dr Brearey referred during his evidence to the conclusions Ms Powell had reached in the Neonatal Unit Review assurance document.[33] He considered that her opinion showed "*a lack of objectivity*".[34] He observed, correctly, that she had strayed into areas that were outside her expertise.[35] Dr Brearey told the Inquiry that the conclusions concerned him because Ms Powell "*had developed this document for assurance with Karen Rees with her lack of neonatal expertise and without discussion with any of the Consultants and the -- the arguments and the summary of this report was essentially what was used in the meeting that we had with Alison Kelly and Ian Harvey the following week on 11 May*".[36]

9.21 Ms Powell did not include any details of any of Letby's errors or failings. She should have done. When Ms Rees was asked whether she would have wished to know about the incident three years earlier when Letby had set a pump to infuse ten times the prescribed amount of morphine to a baby, she said she would have wished to know that.[37] See Chapter 2.

9.22 In Ms Rees's oral evidence, she described Ms Powell as "*persistent*" in her defence of Letby.[38] It is not apparent that Ms Rees appreciated quite how misleading Ms Powell's Neonatal Unit Review document was. It was referred to as an assurance document. Its opening paragraph was highly partisan. Ms Rees said in evidence that she believed that, in sending it and the other documents to Mr Harvey and Ms Kelly, Ms Powell was seeking "*to gain reassurance from the Executive team that they hadn't missed anything*" because the concerns remained and yet "*there were no answers*" to the issues on the unit.[39] I accept that Ms Powell was putting everything together in a search for answers, but the opening lines of the 'Neonatal Unit Review 2015-16' make clear that she did so from her firm position that Letby had nothing to do with the collapses and deaths. That affected the way she presented matters in her document. It may explain why she did not include anything about Letby's failings. The result was not balanced or accurate.

6 May 2016

9.23 On 6 May 2016, Ms Kelly forwarded Dr Brearey's email of 4 May 2016 about Letby's shift changes to Mr Harvey. In the body of her email, Ms Kelly wrote:

> "*Hi Ian,*
>
> *Please see Steve's* [Brearey] *comments below which alarmed me!! Since receiving this, I have asked Karen Rees to liaise with Eirian* [Powell] *regarding this particular nurse (Eirian*['s] *further review is attached for info), I am currently reassured that there are no issues but I think this is worthy of a wider review hence our planned meeting.*
>
> *This has been arranged for next Wed to review all the issues with us. Something we need to discuss at our 121 on Monday!*"[40]

9.24 I note Ms Kelly's reference to being alarmed. She understood exactly what Dr Brearey was saying in his email. It was nothing to do with staffing generally; it was to do with an individual nurse. Ms Rees had conveyed to her "*that Eirian* [Powell] *did not feel that there were any issues of concern with Letby and that she had changed her shifts for reasons connected to her wellbeing rather than anything more serious*".[41] Ms Kelly was asked how she could be reassured there were no issues when she had not yet heard from Dr Brearey. She accepted that she should have heard from Dr Brearey before coming to that conclusion.[42]

9.25 Mr Harvey said in his written statement that Dr Brearey's email did not make it clear what the concern about the nurse was.[43] Mr Harvey knew there was a concern. If it was not clear, he was the Medical Director and he should have asked Dr Brearey what he was concerned about.

9.26 In oral evidence, Mr Harvey was taken to his email response to Ms Kelly:

> "*I see what you mean, although perhaps he* [Dr Brearey] *just meant that he was concerned for her* [Letby]*?*"[44]

9.27 Mr Harvey was asked why he thought Dr Brearey may have been concerned for the nurse. He responded:

> "[T]*he tone of Dr Brearey's email, and his description of Eirian* [Powell] *'sensibly' putting her on to day shifts and more a concern with regard to staffing numbers, I didn't read that as a particular concern other than for the well-being of the nurse. I didn't read that as an indication he was concerned about that nurse's performance in some way … I believe that was reflected in my response to Alison Kelly's email that, as I read it, it may well just be that he was concerned regarding her welfare or words to that effect.*"[45]

This evidence found its voice in the closing submissions on behalf of the executives that Ms Kelly's view was that Dr Brearey's concern was entirely pastoral. I reject that submission. Ms Kelly's response to Dr Brearey's email was one of alarm at the fact that a nurse had been moved to day shifts because she had been present for deaths and collapses on night shifts. Even Mr Harvey's response began with the acknowledgement "*I see what you mean*", before he offered an alternative explanation.

9.28 Mr Harvey was asked what his understanding was at this stage of concerns about Letby in relation to the sudden, unexpected and unexplained collapses and deaths. He stated:

> "[W]*ith the Thematic Review, I was aware that there were concerns with regard to an increased number of deaths, that they were being investigated, that whilst one member of staff had been on duty more frequently, the individual case reviews, whilst highlighting some themes, had not caused any major concerns to be raised.*"[46]

This response omitted the fact that the deaths had all happened at night, as he knew, and that they were sudden and unexpected. At best, his response to the question and to the situation about which he was being asked revealed a continued, striking lack of curiosity.

Meeting, 11 May 2016

9.29 The 4 May 2016 meeting that was rearranged at Dr Brearey's request took place on 11 May 2016. This meeting served to satisfy the requests from Dr Brearey and Ms Powell, who were concerned about the Thematic Review, the high mortality rate and the commonality of the presence of a specific nurse. In attendance were Mr Harvey, Ms Kelly, Dr Brearey, Ms Powell and Ms Anne Murphy.

9.30 It is clear from Ms Kelly's contemporaneous, brief notes that Dr Brearey opened the meeting with an account of his concerns. In evidence to the Inquiry, he said:

> "*I was trying to be objective and measured and stating the facts and essentially I was interrupted by Anne Murphy and Eirian Powell with quite a forceful view expressed by both of them with a fair amount of emotion, essentially saying this was wrong, and it's just coincidence that, you know, there is no evidence, these are our assurances, as mentioned in that document.*"[47]

He also said:

> "*I put forward the results of the Thematic Review, the association with Letby, the concerns of myself and my colleagues about this and how we were worried. The new information at the meeting was that Letby had been moved on to day shifts as well*

in April for a matter of mentoring reasons and support and that there had been no collapses or deaths at night between the beginning of April and this meeting which was further weight to everything."[48]

9.31 Ms Kelly made two sets of notes of the meeting.[49] Both support Dr Brearey's account of the meeting: that he spoke first, referred to the matters in the Thematic Review, and was interrupted by Ms Powell and Ms Anne Murphy.

9.32 In the first set of notes, the following is included, after Dr Brearey's account of the Thematic Review:

"*Deteriorated 9pm –*

→ 6 x midnight – 4

External cons – ve+ about care

Since review 2 further deaths

2 transferred out recently."[50]

9.33 The section above is a summary of what Dr Brearey said in the meeting. The reference to six babies having suffered an arrest between midnight and 4am is something that was pointed out in the Thematic Review and which Dr Brearey clearly emphasised at the meeting. As the notes make clear, and as Dr Brearey said in evidence, he then updated the meeting on the number of deaths on the unit since the Thematic Review. There is then a section about the Neonatal Network, Neonatal Network meetings and mortality reviews, and a reference to one baby having been transferred six times between sites. This all appears to have been said by Dr Brearey. What follows is the interruption by and views of Ms Powell and Ms Anne Murphy:

"*– absolutely no issues c nurse*

– circumstantial

– 1 dr also themed across a no of cases."[51]

9.34 It is likely that the next two lines are taken from Dr Brearey:

"*6 babies – nurse LL*

→ sudden deterioration."[52]

9.35 In her statement to the Inquiry, Ms Kelly stated that Ms Powell talked through the Neonatal Unit Review assurance document, titled 'Neonatal Unit Review 2015-16' (created on 5 May 2016) with her and Mr Harvey on 11 May 2016. Ms Kelly wrote: "*The overall impression I got from this note* [Neonatal Unit Review] *was that there was a reasonable explanation for Letby being on shift for more of the deaths than other nurses due to the hours she worked and that she was a well-regarded nurse.*"[53]

9.36 The meeting actions were recorded as:

> "*– Review all babies who deteriorate*
>
> *– Stay on days x 3 months*
>
> *– 2 further months to go*
>
> *– Review of deaths on nights – looked at pre 1 hour before arrest*
>
> • *last incident – April without cause*
>
> *1 month since last collapse*
>
> *Meet in 2 months time.*"[54]

9.37 The second version of the notes was almost the same, except for the addition of:

> "• *Happy to review in 2/52 IH* [Mr Harvey] *in agreement – all happy c actions*
>
> • *No hard evidence – PM* [post-mortem] *inconclusive*
>
> • *No explanation*
>
> • *No competency issues c nurse*
>
> • *Being supported by team re stress.*"* [55]

9.38 When giving evidence, Mr Harvey was reminded of the account Dr Brearey had given of the meeting. Mr Harvey responded: "*That doesn't accord with my recollection of that meeting. I don't recall Dr Brearey being that detailed or that assertive.*"[56] Having seen Dr Brearey give evidence at length, I can readily accept that he did not come across as assertive. I accept that he was objective and measured. As to the detail, it is all there in Ms Kelly's notes. I am sure that Dr Brearey was detailed. It should not be necessary for any whistleblower to be assertive. It is the duty of a Medical Director to listen and respond.

9.39 In her police statement, Ms Kelly described Ms Powell as being vociferous at this meeting, saying that there were no issues with Letby whatsoever.[57] In evidence to the Inquiry, Ms Kelly described Ms Powell and Ms Anne Murphy as "*very professional, but they were very assertive and they were very passionate about articulating the assurance provided for their member of staff. But in addition to that, they were also equally as assertive about some of the clinical challenges … on the unit at that time, for instance transport issues.*"[58] This was in response to a question about whether, as Dr Brearey had said, Ms Powell was acting in an emotional state when speaking. Mr Harvey also rejected that characterisation.[59] I have no doubt that Ms Powell spoke up for Letby vociferously. Of course she did. She thought that the concerns were misconceived. She was very angry about them and very supportive of her nurse. When giving evidence, she agreed that she had been "*vociferous, vocal*" in her support for Letby at this meeting.[60] She said that she was not being defensive, just honest. She did not believe that Letby was harming babies. She also agreed that, in her view, Letby "*was crème de la crème*" and she had expressed this.[61] She went on to accept that "*it would have helped*" if she had been more reflective

* The reference to 2/52 (two weeks) is an error. It was two months, not two weeks.

in her views.[62] It would have helped had she brought to mind the incidents of which she was aware when Letby's conduct gave cause for concern. Ms Anne Murphy described Ms Powell as defensive about Letby.[63] She was.

9.40 Mr Harvey said that what Dr Brearey was saying about the association with Letby was balanced "*with regard to the detail that both Eirian Powell and Anne* [Murphy] *presented, in terms of presence on the unit, activity level, staffing levels, her frequency of attendance or work on the unit and I believe that there was a full discussion*".† [64] That the unit was short-staffed and busy and that Letby worked full time were not in doubt, and yet these facts did not explain the deaths. That is why Ms Powell kept asking 'Are we missing something?' Her views and those of Ms Anne Murphy did not negate the doctors' concerns about sudden and unexpected collapses, unexplained deaths, the timing of deaths and so on. They were just expressed more forcibly than the views of Dr Brearey.

9.41 In Mr Harvey's written evidence, he stated:

> "*My understanding at the end of the meeting was that we were dealing with a spike in deaths on the NNU which were unexplained despite thorough review, and … we were reassuring Dr Brearey we, the Executives, were aware and supported the actions being undertaken by the clinical team. 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.*"[65]

In oral evidence, it was put to Mr Harvey that it was made known to him that the clinicians thought Letby was harming babies. Mr Harvey said this: "*I would not accept that, as a result of the 11 May meeting and the conversations that we had and the approach that Dr Brearey and the nursing staff had, that there was anything that would have supported any action.*"[66] I cannot accept this. First, the question he was being asked was whether he learnt in the meeting that the clinicians were concerned that Letby was, or at least might be, harming babies. He did not answer that directly. The answer could only be yes. That was why Ms Powell and Ms Anne Murphy were so assertive and passionate in their interventions. The notion that there was nothing that would have supported any action was just plain wrong. It was essential to protect babies on the unit.

9.42 In Ms Kelly's oral evidence to the Inquiry, she conceded that, in this meeting, Dr Brearey raised concerns that the increase in neonatal mortality may be attributable to Letby. Although he did not explicitly say that he had concerns about deliberate harm, Ms Kelly accepted that concerns about Letby's involvement in the deaths could only mean one of two things: incompetence or deliberate harm. She acknowledged that she knew "*from his* [Dr Brearey's] *perspective there was a possibility that that was deliberate*".[67] This is important as it is the first admission from a member of the Executive Team that they were aware that deliberate harm was a possibility. If it was plain to Ms Kelly, it was plain to Mr Harvey. This was in May 2016.

9.43 The agreement to 'wait and see' – or 'monitor and alert', as Mr Harvey characterised it when giving evidence – was a serious mistake. Whilst 'wait and see' may be a well-recognised approach in clinical practice, it could never be appropriate when what is being waited for is, at a minimum, harm to a baby. It was clear that the nurses in the room, including Ms Kelly, simply did not believe Letby was responsible for any deaths,

† The reference to Anne Martyn in the transcript is incorrect; it should read 'Anne Murphy'.

and so 'waiting and seeing' would presumably be expected to reveal nothing. Had they stepped back and looked at this carefully, they would have realised that it was risk-taking of a high order. They knew the doctors were very concerned. In those circumstances, the obvious and safest thing for senior managers to do was to remove Letby from the unit. That this was not considered is plain. They did not even consider obtaining advice from HR.

9.44 In addition to being the Director of Nursing and Quality, Ms Kelly was also the Executive Lead for Safeguarding (see Chapter 12). Ms Kelly accepted that she was the only safeguarding person in the meeting and that her primary duty was her safeguarding responsibilities. Despite this, she stated: "*At that time, it -- it wasn't clear to me that this was a safeguarding issue.*"[68] Ms Kelly stated that she considered the matter "*from a nursing perspective*" and thought it "*could have been a competency issue*".[69] If it were a competency issue, it would still be fraught with risk. She was asked whether she should have regarded the matter as a safeguarding issue at the meeting on 11 May 2016. She responded: "*I have reflected a lot about my safeguarding role in all of this case and reflecting back, maybe I should have done, yes.*"[70] She should have acted to safeguard the babies on the unit in the face of honestly held concerns expressed by the doctors. Even if she did not agree they were well founded (and she was not in a position to make that judgement), her responsibility was to take action. Immediately.

9.45 Ms Kelly recorded in her handwritten notes of this meeting that the 'action plan' was that a review would be conducted of any further sudden collapse or deterioration of babies; a further deep dive would be conducted into neonatal deaths which had taken place during the night; and a follow-up meeting would be held in July 2016. Ms Kelly also recorded that the plan was for Letby to stay on day shifts for three months and that there were a further two months to go.[71]

9.46 In oral evidence, Ms Kelly stated: "[W]*e all felt by the end of that meeting that we could review the situation in a number of weeks' time*."[72]

9.47 Ms Kelly was asked whether, if she had considered the issue a safeguarding concern, she would have viewed it as appropriate to wait and see if further harm was caused. She acknowledged that, if it had been viewed as a safeguarding issue, "*then actions may have been different*".[73] She specified that potentially she would have taken the following actions:

a. spoken to members of her safeguarding team – this may have involved a discussion about placing Letby under formal supervision or suspension

b. made a referral to the LADO

c. involved the police as part of the multi-agency process.[74]

9.48 Ms Kelly should have done all of the above. Had she done so in May 2016, any risk that Letby posed could have been removed then.

9.49 Ms Kelly conceded: "*Looking back, and reflecting on that meeting, there should have been a safeguarding conversation.*"[75] I would go further. There should have been safeguarding action. The route chosen risked the lives of babies who were likely to come onto the

unit, as far as anyone knew. I do not doubt that had Letby been suspended she would have been upset and Ms Powell would have felt it unjust, but these matters were far less serious than the risk that was being guarded against – death and serious injury.

9.50 In oral evidence, Dr Brearey said he thought the appropriate reaction from the executives to the issues he had raised in the meeting was to escalate the concerns to safeguarding experts, the police or NHS England and assure the safety of the unit.[76] Dr Brearey stated he was worried and disappointed by the outcome of the meeting.[77] "*It just felt like so much of a significant concern that doing nothing didn't seem to be an option.*"[78] He undoubtedly was clear and detailed in his description of his concerns, provoking the response from Ms Powell, but by the end of the meeting he seems to have been defeated. He had not achieved any action by the executives in respect of the paediatricians' concerns. The fact that he acquiesced must have had the effect of undermining the strength of his concerns in the minds of the other people in the meeting. It may even be that, not for the first or last time, Dr Brearey was second-guessing himself about whether he was right to suspect Letby. It was no less shocking to him than to Ms Powell that a nurse might be responsible for the deaths. If he was sure he was right in his suspicion, he could not have agreed to 'wait and see'. The risks, as I have already said, were far too great. To take safeguarding steps (as everyone in the meeting knew) suspicion was enough. But no one was thinking of safeguarding.

Dr Brearey's email, 16 May 2016

9.51 On 16 May 2016, Dr Brearey emailed his fellow consultant paediatricians (copying in Ms Powell and Ms Anne Murphy). He wrote:

> "*Dear all,*
>
> *Eirian* [Powell] *and Anne* [Murphy] *and myself met Ian Harvey and Alison Kelly last week to discuss the rise in neonatal mortality last year. It was a helpful meeting and they were grateful for the work we have done in the various reviews and involving an external clinician.*
>
> *Naturally, we will be keeping* [a] *close eye on things in the immediate future.* ***If you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on NNU, please could you let me and Eirian know*** [emphasis in original]. *We will keep a record of these cases and review them as soon as practicable.*"[79]

9.52 In oral evidence, Dr Brearey said he regretted characterising the meeting as helpful. He told the Inquiry: "*I didn't think there was anything helpful in the meeting at all and I regret writing that.*"[80] He explained that describing the meeting as helpful was an attempt to be positive. This was a feature of Dr Brearey's actions throughout this period. He was becoming more and more concerned about the babies on the unit and the deaths that had occurred. He was worried that Letby was responsible. At the same time, he understood what a repugnant notion that was – to him as well as to everyone else. He was endeavouring, it seems to me, to stay on the right side of everyone, especially Ms Powell and the senior managers. Sometimes that just is not possible. There was no good reason to tell his colleagues that it had been a helpful meeting when it was no such thing. It was misleading. I understand that he needed to maintain polite working relationships. I also understand that he believed, rightly, that Ms Powell in particular

had very strong feelings about this. She believed that he was completely wrong. All Dr Brearey achieved was appeasement of Ms Powell and the senior managers. Everyone at the meeting left babies at risk.

9.53 Dr Gibbs gave evidence that he spoke to Dr Brearey after the meeting. He told the Inquiry "*I understood it wasn't a helpful meeting*" and that the "*outcome was disappointing*".[81] In hindsight, Dr Gibbs reflected that the outcome of the meeting "*should have been a trigger that we bypass managers and went to the police. And we failed to do that.*"[82]

9.54 Dr U recalled that around the time of Dr Brearey's email, Dr Jayaram and Dr Brearey informed staff in a handover that "*there were more events occurring on the neonatal unit than had been in previous years and we were I think during that handover asked just to keep our eyes open … for things that may be the cause of the deteriorations*".[83] Ms Powell could not recall whether she asked nurses to report such incidents. No incidents were reported by nurses.

9.55 Dr Brearey's email accords with part of Ms Kelly's handwritten note of the 'action plan' and what Mr Harvey has told the Inquiry was his expectation: "[F]*ollowing this meeting, I would have expected to have been made aware of any concerning issues on the NNU by the neonatal team.*"[84]

9.56 Baby N collapsed on 3 and 15 June 2016. Baby O died on 23 June 2016. Baby P died on 24 June 2016 and Baby Q collapsed on 25 June 2016. Despite this, Dr Brearey's evidence was that no one responded to him as a consequence of his email.[85] That said, he was on the scene when Baby N collapsed. He was involved in the failed resuscitation of Baby O and knew of the death of Baby P. The whole of the neonatal unit knew about the deaths of Baby O and Baby P.

Endnotes

1 INQ0107095/148

2 INQ0107095/148-149

3 INQ0003190 (original table sent 21 March 2016); INQ0003277 (updated table sent 14 April 2016)

4 Alison Kelly 25 November 2024 99/10-19

5 Alison Kelly 25 November 2024 103/13-22

6 INQ0003121/1

7 INQ0003385/1

8 Alison Kelly 25 November 2024 232/20 to 235/17

9 Ian Harvey 28 November 2024 138/3-11

10 Ian Harvey 28 November 2024 138/17-24

11 Dr John Gibbs 1 October 2024 91/12-13

12 Dr John Gibbs 1 October 2024 91/14-19

13 Dr John Gibbs 1 October 2024 93/5-12

14 Dr John Gibbs 1 October 2024 93/14-16

15 Dr John Gibbs 1 October 2024 91/21-25

16 Dr John Gibbs 1 October 2024 93/16-17

17 INQ0005724/2

18 Alison Kelly 25 November 2024 281/7-14

19 Alison Kelly 25 November 2024 282/3-10

20 INQ0003138/1

21 INQ0003138/1

22 Witness statement of Alison Kelly INQ0107704/76/para 252

23 Alison Kelly 25 November 2024 110/13

24 Alison Kelly 25 November 2024 109/24 to 110/1

25 INQ0003243/1-2

26 Dr Stephen Brearey 19 November 2024 120/19-22

27 INQ0003115/1

28 INQ0003277

29 INQ0049390/1-2

30 INQ0049390/1-2

31 INQ0003243/1

32 INQ0003115/1

33 INQ0003243/1-2

34 Dr Stephen Brearey 19 November 2024 126/2-3
35 Dr Stephen Brearey 19 November 2024 121/8-11
36 Dr Stephen Brearey 19 November 2024 126/3-9
37 Karen Rees 21 October 2024 131/2-11
38 Karen Rees 21 October 2024 194/22 to 195/3
39 Karen Rees 21 October 2024 134/19 to 135/14
40 INQ0005724/1
41 Witness statement of Alison Kelly INQ0107704/78/para 255
42 Alison Kelly 25 November 2024 114/11-16
43 Witness statement of Ian Harvey INQ0107653/33/para 148
44 INQ0107818/1
45 Ian Harvey 29 November 2024 151/5-16
46 Ian Harvey 29 November 2024 152/22 to 153/3
47 Dr Stephen Brearey 19 November 2024 127/11-17
48 Dr Stephen Brearey 19 November 2024 127/2-10
49 INQ0003181/1-2; INQ0015537/2-3
50 INQ0003181/1
51 INQ0003181/1
52 INQ0003181/1
53 Witness statement of Alison Kelly INQ0107704/78/para 258; INQ0003243
54 INQ0003181/2
55 INQ0015537/3
56 Ian Harvey 28 November 2024 143/25 to 144/2
57 INQ0001923/5
58 Alison Kelly 25 November 2024 284/23 to 285/4
59 Ian Harvey 28 November 2024 146/11-22
60 Eirian Powell 17 October 2024 134/11-14
61 Eirian Powell 17 October 2024 134/17-20
62 Eirian Powell 17 October 2024 134/21 to 135/1
63 Anne Murphy 21 October 2024 83/15
64 Ian Harvey 28 November 2024 144/13-18
65 Witness statement of Ian Harvey INQ0107653/36/para 162
66 Ian Harvey 29 November 2024 67/20-23
67 Alison Kelly 25 November 2024 8/8-9
68 Alison Kelly 25 November 2024 9/3-4

69 Alison Kelly 25 November 2024 8/13-15
70 Alison Kelly 25 November 2024 9/13-15
71 INQ0003181/2
72 Alison Kelly 25 November 2024 10/13-14
73 Alison Kelly 25 November 2024 10/23
74 Alison Kelly 25 November 2024 11/14 to 12/16
75 Alison Kelly 25 November 2024 12/21-22
76 Dr Stephen Brearey 19 November 2024 129/12-18
77 Dr Stephen Brearey 19 November 2024 211/19-24
78 Dr Stephen Brearey 19 November 2024 129/18-20
79 INQ0005721
80 Dr Stephen Brearey 19 November 2024 212/11-13
81 Dr John Gibbs 1 October 2024 101/22 and 102/10
82 Dr John Gibbs 1 October 2024 101/8-10
83 Dr U 7 October 2024 193/21 to 194/9
84 Witness statement of Ian Harvey INQ0107653/38/para 165
85 Dr Stephen Brearey 19 November 2024 81/10-17

Chapter 10. June 2016: Baby N, Triplets O, P and R

Baby N

Father N: "[T]*he plan was that he would be delivered by caesarean section several weeks earlier than normal. We were both aware of this and the reasons for it.*"[1]

10.1 Despite the decision that Letby would work only on days for another two months, she worked four nights at the end of May and beginning of June. She was on the night shift of 2/3 June 2016.[2]

10.2 Baby N was born at 34 weeks and 4 days' gestation, weighing 1.67 kilograms. Baby N collapsed on 3 June 2016 and twice on 15 June 2016. On the night shift of 2/3 June 2016, Baby N was in Nursery 1. Mr Booth was his designated nurse.

10.3 Mr Booth set out in his Inquiry statement a passage from the nursing notes that he made about what had happened during his break when another nurse, whom he could not remember, was looking after Baby N. He said that he had been given the information by someone, but again he could not remember who. During his break, Baby N had an episode where he 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.*"[3] Mr Booth said that there was no corresponding note in the medical records. The prosecution case was that this episode, and quick recovery, was consistent with an inflicted injury caused by Letby. Letby was convicted of attempted murder in relation to the collapse on 3 June 2016.

10.4 The Countess did not tell Baby N's parents about his collapse on 3 June 2016. Father N said:

> "*We now know that Child N's oxygen saturations dropped very low overnight to 40% … The Inquiry has asked whether we were told about this deterioration at the time and how and when we were told about it. We were not told about this deterioration. 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.*"[4]

10.5 Mother N echoed Father N's account of being kept in the dark about Baby N's collapse. She stated:

> "*I was not made aware there had been any problems with Child N's condition in the early hours …*
>
> *The Inquiry has asked me for my views on the adequacy of the information on the neonatal unit at* [the hospital] *… I considered the information to be inadequate, in terms of the processes on the neonatal unit, how to care for a baby there, and also information about Child N's condition.*"[5]

10.6 Two further charges of attempted murder of Baby N were brought against Letby in respect of two collapses on 15 June 2016. The jury could not agree on a verdict on either case. The prosecution case was that, on 15 June 2016, Baby N again suffered an inflicted injury, this time resulting in heavy bleeding in the throat area. Baby N had been deteriorating from 1am. The first collapse was just before the day shift began, when Letby was already on the neonatal unit, having arrived early. The second collapse was at about 2pm. Letby was his allocated nurse. The damage was such that it was difficult to intubate Baby N. Staff from Alder Hey came to assist in his intubation. Baby N was subsequently transferred to Alder Hey and survived the trauma.

10.7 Speaking about Baby N's deterioration on 15 June 2016, Mother N told the Inquiry:

> "[That] *day we were called to the neonatal unit 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.*"[6]

She added: "*I just kept questioning why our healthy baby boy was fine one minute and then bleeding from the mouth and needing CPR the next.*"[7]

10.8 Father N's evidence was that:

> "*Lucy Letby told me he had been a bit unwell in the night but did not explain what that meant or what was wrong with him. No one did. We had not received a call in the night to alert us to any problems or that anything had happened.*
>
> *… when I saw Child N, I was shocked. 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.*"[8]

10.9 Father N said that on 15 June 2016:

> "*A nurse came to speak to us … The nurse said that Child N was now really unwell and if we wanted we could see a priest.*
>
> *Mother N went into the ITU and the priest arrived to talk to us. I 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 and I had the impression that we were being ushered out of the way.*"[9]

Father N stated that it was Letby who recommended they get Baby N baptised, and that they ultimately did so out of desperation.[10]

10.10 Dr Brearey was involved in Baby N's care on the afternoon of 15 June 2016, when he collapsed and required intubation. He and his colleagues had been discussing Baby N's management and difficulties with intubation. In oral evidence, Dr Brearey said: "*It is worthwhile saying that Child N was a morbidity case and I have said in my statement as well, that I was -- I was blinded by the medical issues in the case in terms of the haemophilia that Child N had and the difficulty with the airway that was -- was encountered which blinded me to the actions of Letby*."[11]

10.11 Dr Saladi was involved in Baby N's resuscitation on the afternoon of 15 June 2016. He agreed that Baby N's deterioration was sudden and unexpected. However, he did not speak to Dr Brearey or Ms Powell about it, as directed by Dr Brearey's email of 16 May 2016, because Dr Brearey was involved in the resuscitation.[12]

10.12 There is no evidence that the collapses of Baby N were escalated to Ms Kelly or Mr Harvey. They should have been.

10.13 Datix forms were not completed for Baby N's collapses. See also Chapter 4 for more on failures to complete Datix forms. Following the deaths of Baby O and Baby P in June 2016, there was a great deal going on, but Dr Brearey accepted that he should have looked at Baby N's care in more depth at the time and apologised for this.[13] Baby N's case was added by Ms Powell to her Additional Monitoring Report.[14]

10.14 Father N spoke candidly about visiting Baby N on the neonatal unit and being "*a bit scared to go there alone as he was so small and vulnerable*". He recounted that "*when Child N was about 10 days old Lucy Letby said to me 'Hold him! He is your son'. She was very abrupt and short with me. I did not say anything in reply. Child N was just lying happily in his cot and he was settled and not crying. She did not hand him to me and I did not pick him up*."[15]

10.15 Parents N were not informed of any reviews into Baby N's collapse. Mother N said: "*Once Child N had left the care of* [the hospital]*, we did not hear anything from the hospital about the causes of the collapses or any investigation into them.*"[16] Mother N told the Inquiry that, when Baby N was a few months old, Parents N attended an appointment with Dr Saladi. Mother N described Dr Saladi as "*unable to give a reason for why the collapses had occurred*" and that "*it seemed that Dr Saladi did not have any answers*".[17] Dr Saladi recalled that he had a meeting with Parents N, in which he informed them that he was not able to give them a reason for the collapse, and that he did not have answers.[18] They were not told about any investigations that were being carried out.[19]

Messages between Dr U and Letby

10.16 Dr U informed the Inquiry that he began Facebook messaging Letby in June 2016.[20] The Inquiry are aware of approximately 1,355 messages they exchanged between June and September 2016. Dr U acknowledged that this was a large volume of messages.[21] Dr U was invited to explain why the pair messaged to that extent. He replied:

> "*Letby was struggling with her mental health and I think I picked up on that and I'd offered some support, and that support, it grew, and I understand that she slept very poorly because of worry and anxiety, and there were often messages that were passed throughout the day and sometimes late at night, earlier in the morning.*"[22]

10.17 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. Dr U acknowledged that he and Letby "*passed several messages*" during 14 and 15 June.[23] The messages included personal topics and matters relating to Baby N, including his deterioration and intubation attempt at around 7.15am (which both Dr U and Letby were involved in).[24]

10.18 The following is an excerpt from the transcript of Dr U's evidence:

> "**Ms Langdale KC:** *Do you think it was appropriate to be messaging about Baby N with her at this time?*
>
> **Dr U:** *In hindsight, no.*
>
> **Ms Langdale KC:** *Why not?*
>
> **Dr U:** *Looking at the content of the messages here, I've shared too much, and from my reflections since this has happened, it's common to give updates on how patients are without naming them, without giving lots of clinical detail to help the recipient understand where that patient is up to. I gave, at the time, details that I thought were helpful but I see now that that probably wasn't the case.*
>
> **Ms Langdale KC:** *And how do you think Baby N's parents would feel about that?*
>
> **Dr U:** *I'm sure that's very upsetting.*
>
> …
>
> **Ms Langdale KC:** *And within those messages, it* [flits] *from information about the child to quite frivolous, casual conversation in the way that friends do, doesn't it?*
>
> **Dr U:** *It does.*
>
> **Ms Langdale KC:** *Entirely inappropriate to have somebody's baby in the centre of that communication after such a serious deterioration and now we know an attack --*
>
> **Dr U:** *Yes.*"[25]

10.19 When Mother N learnt about the messages that Dr U and Letby shared, she "*lodged a complaint against Doctor U*".[26] She explained:

> "*I made this complaint when it was revealed at the criminal trial that he had discussed Child N with Lucy Letby on Facebook and by private text message, even referring to Child N by their surname. There were several grounds to my complaint. One was his disregard for, and blatant breaches of, patient confidentiality. In addition, he shared emails that had been exchanged between Consultants in regard to Lucy Letby's conduct with her, and should not have done that … I raised the complaint with PALS.*"[27]

10.20 On 16 June 2016, the Women and Children's Care Governance Board met. The Thematic Review had been received by the meeting. It is not clear whether this was the February 2016 version or, as it should have been, the March 2016 version. In attendance were Ms Fogarty, Dr Davies, Ms Lawrence, Dr Jayaram, Ms Anne Murphy and others. The minutes read: "*There was no common theme identified in all the cases.*"[28] This was a direct quotation from the Thematic Review.[29] There was no discussion. By that stage, the 'monitor and alert' approach, which is effectively 'wait and see', had been in place for a month.

Baby O, Baby P and Baby R

Father O, P and R: "*I remember the day we found out we were having triplets really clearly. It was at the 12-week scan and while the sonographer was checking the imaging I was sure I could see two heads on the screen. I told Mother O, P and R what I could see and she thought I was being silly, but the sonographer replied that she thought that there were more than two. We then found out there were three babies.*"[30]

"*We were so shocked that Mother O, P and R burst into tears; partly from surprise/excitement and partly because it suddenly hit us both that we would need to find a way to … support three babies as well as ourselves and our oldest child. It felt like a once in a lifetime opportunity to welcome three children at once. I felt really blessed in that moment.*"[31]

10.21 Mother O, P and R received her antenatal care at the Countess. Dr McCormack was her consultant. In the weeks running up to the birth of their babies, the parents were told that the chances of giving birth at the Countess were "*quite slim*" as staff thought it unlikely they would have enough beds and nurses available to care for them.[32] Mother O, P and R told the Inquiry: "*I was warned by Consultants that it was likely that we would have to travel to another hospital. We were told that this could be Birmingham or London but we had to be ready to go anywhere.*"[33] However, when she went into labour, she "*was told that there were enough nurses and beds to deliver the babies* [at the Countess]".[34] Father O, P and R described the conditions of the operating theatre in his evidence. He recalled being "*struck*" by "*how cold looking and dingy the room felt*".[35] He added: "[I]*t didn't fill me with confidence. The state of the theatre was like something out of a horror film; when I walked in there I immediately felt uneasy. It was very cold and unhygienic.*"[36]

10.22 Unfortunately, Dr McCormack was on leave when Baby O, Baby P and Baby R were to be born, and they were delivered by a doctor their parents did not know.[37] All three babies were delivered quickly by caesarean section. Mother O, P and R felt rushed, and experienced some pain during the delivery for which she required medication, but all three babies were born in good condition. Baby O, Baby P and Baby R were born at 33 weeks and 2 days' gestation. Baby O weighed 2.020 kilograms and Baby P weighed 2.066 kilograms. Baby R weighed 1.865 kilograms.

10.23 Dr McCormack told the Inquiry that the triplets were born "*in excellent condition*".[38] Mother O, P and R told the Inquiry: "*Father O, P and R was asking the nurses if the babies had come out fine, and if their weights were okay. We were reassured that their weights were better than expected and that they had been born healthy.*"[39]

10.24 Around this time, Dr U and Letby were messaging regularly, and some of the messages were about the triplets. On 22 June 2016, the day Letby returned from a holiday abroad, and the day before the death of Baby O, Letby asked Dr U: "*What gestation are the trips?*"[40] Dr U said in evidence that he thought Letby was asking for information about the triplets in preparation for returning to work, as she had recently been on holiday.[41]

Baby O

10.25 Ms Taylor worked the day shift on 23 June 2016. She told the Inquiry that Baby O was initially in Nursery 1. Letby was Baby O's designated nurse on the day shift.[42] Baby O was later moved to Nursery 2 to be with his brothers. In Nursery 2, Ms Taylor felt uneasy (she described it as a 'gut feeling') about his condition and suggested to Letby that they should move him to Nursery 1. Ms Taylor explained that Nursery 1 had more emergency equipment accessible if a child deteriorated. However, Letby said she wanted him to stay in Nursery 2.[43]

10.26 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.

10.27 Mother O, P and R described Dr U and Father O, P and R coming to her bedside at around 3pm on 23 June 2016. Dr U informed them that Baby O needed extra breathing support, but he told her that was not uncommon for babies on the unit. Mother O, P and R wished to see Baby O for herself and went down to the neonatal unit. In fact, Baby O had deteriorated, and was moved to Nursery 1. His mother described being confronted with "*complete chaos*" and that the healthcare staff were running around doing everything they could to help Baby O.[44] She stated that Dr U looked panicked and did not know what was going on. She commented: "*It was clear that Child O's collapse was a complete shock to them.*"[45]

10.28 Because Baby O was suffering an "*unusual and unexpected event*" with an "*unknown cause*", the neonatal unit contacted Dr Oliver Rackham, a consultant paediatrician on the neonatal intensive care unit at Arrowe Park Hospital, and a consultant on the neonatal transport team which serves Cheshire and Merseyside.[46] The intention was to take Baby O from the Countess and transfer him to an intensive care unit. Very sadly, Baby O died before this could happen.[47] Dr Rackham commented on the gestational age of Baby O, Baby P and Baby R (33 weeks and 2 days) and stated "*babies of that gestation are normally relatively well … those babies in general we would expect to do well and survive*".[48]

10.29 Dr Brearey assisted with the resuscitation of Baby O. He did not see Letby do anything untoward. In evidence, he said he was "*exceedingly worried*" after Baby O died.[49] He had noted the rash earlier, and connected this to the rashes that had been observed on babies in June 2015 (on Baby A, Baby B and Baby D). He considered this unusual. Father O, P and R described Baby O's rash as follows: "*His skin was a different colour and it looked almost like there was something pulsating through his veins.*"[50] He also described swelling on Baby O's abdomen and that "*his stomach had popped out almost like a pot belly*".[51]

10.30 Father O, P and R commented: "*The doctors seemed as baffled as we were, and no one could tell us why things had suddenly gone so wrong. It was really shocking. I have no medical training and it felt like the doctors were essentially in the same boat as me.*"[52]

10.31 When Baby O died at 17:47, Mother O, P and R told the Inquiry: "*No one seemed to know how this had happened. Everyone was in shock and disbelief.*"[53]

10.32 Letby was convicted of Baby O's murder.

10.33 Dr Huw Mayberry, a registrar, had cared for Baby O on the night shift of 22/23 June 2016. He said Baby O had a mildly distended stomach. However, this is a common finding in a child on high-flow nasal cannula oxygen and he "*wasn't particularly concerned about him*".[54] When Dr Mayberry returned to work on 23 June 2016, he learnt that Baby O had died earlier that day. He told the Inquiry he was "*shocked because nothing seemed unusual on that nightshift*".[55]

10.34 This was a death that shocked all those on duty. In evidence, Ms Taylor told the Inquiry that there were "*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*."[56]

10.35 Ms Bennion's written evidence was similar:

> "*I was personally alarmed or alerted to the number of child deaths when one of the triplets died … It was completely unexpected, they were mature babies born at 33 weeks, good weights and although they were receiving respiratory support, they were very stable. I wondered if there was a significant infection on the unit that we were missing.*"[57]

There was no such infection, as I explain in Chapter 11.

10.36 Dr Brearey also said that, although Baby O's resuscitation was well performed, Baby O did not recover.[58] Dr Brearey confirmed that, after Baby O's death, he intended to raise concerns with Ms Powell and escalate them to the executives that same day. Ultimately, however, he did not escalate his concerns to anyone senior that day, because it was early evening and senior people had left the hospital. He reflected: "*I regret waiting until the following day to act. It would have been far more appropriate to trigger something on that Thursday evening rather than wait to the following morning.*"[59] I agree, although what would have happened is far from certain, given what did happen the following day.

10.37 Ms Griffiths was referred to Dr Brearey's comment in his Inquiry statement that he could not conceive how Letby had been allowed to work on the neonatal unit the day after Baby O died.[60] She knew, as she accepted, that Dr Brearey was concerned about Letby. She was responsible for managing the rota. Her view was that, if somebody had directly approached her with concerns that Letby should not work with nor care for the surviving triplets, then she would have reallocated her.[61] This is not an acceptable answer for two reasons. First, Ms Griffiths, despite her shifting evidence about Baby I, accepted that, by the time of the deaths of Baby O and Baby P, she knew about Dr Brearey's concerns. She even commented on the look on his face.[62] She inferred at the time of the resuscitation that Dr Brearey was worried that Letby was involved. She did not have to wait for Dr Brearey to tell her again. She knew it. She had personal responsibility for safeguarding (see Chapter 12). The fact that others had the same responsibility did not remove hers. Second, she seems to have given no consideration to the wisdom of putting someone back in charge of surviving triplets when she had been part of a failed resuscitation just the evening before.

10.38 After Baby O's death, Dr U and Letby exchanged messages about the resuscitation and debrief. At 22:07 on 23 June 2016, Dr U messaged Letby: "*I think the debrief was good – we didn't come up with anything missed or delayed*."[63]

Baby P

10.39 Baby P collapsed on the morning of Friday 24 June 2016. He received adrenaline and CPR and seemed to have improved, but he collapsed again in the afternoon when he was about to be transferred to Liverpool Women's Hospital. He deteriorated despite resuscitation and died. Letby was convicted of his murder.

10.40 Mother O, P and R stated that, on 24 June 2016, she was very worried for her surviving sons, Baby P and Baby R. She recalled 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*".[64] She later found out at the criminal trial that Baby P had been unwell in the night. Mother O, P and R went back to the maternity ward. Later, a nurse ran into her room and told her that Baby P was really poorly and she needed to go down to the unit right away. Mother O, P and R told the Inquiry that, when she got to the unit, she was confronted with the same panic as the day before. She stated that, while Baby P was being resuscitated, "*I felt entirely forgotten and ignored*".[65]

10.41 Father O, P and R said that, when he and his dad arrived on the neonatal unit:

> "*It was almost an exact repeat of the day before.*
>
> *Everyone was running around like headless chickens looking like they had no idea what was wrong. I asked one of the doctors what was going on and said 'it's happening again, isn't it'. Nothing was said to me; no one could explain it, again.*
>
> *They couldn't tell me what was happening.*"[66]

10.42 Father O, P and R observed: "*Child 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.*"[67]

10.43 After contact from the Countess during the course of the day, the plan was to transfer Baby P to the neonatal intensive care unit at Liverpool Women's Hospital. Dr Rackham had made arrangements for a cot space to be made available, and travelled to the Countess with the intention of transferring Baby P. Baby P collapsed shortly after Dr Rackham arrived, and Dr Rackham led the unsuccessful resuscitation. 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*".[68] Mother O, P and R told the Inquiry that Dr Rackham "*said that he didn't know what had happened and could not believe what was happening, but that he could not do anything else for Child P*".[69] Mother O, P and R recalled:

> "*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.*"[70]

Father O, P and R also had similar concerns that something was not right.[71]

10.44 Dr V was involved in Baby P's care. She informed the Inquiry that, prior to Baby P's collapse, he had appeared stable and reasonably well. She considered that his deterioration was very unexpected.[72] She recalled "*begging in my head*" for Dr Rackham to take Baby R, because she feared that he would die next.[73]

10.45 Dr Rackham told the Inquiry that the thought of deliberate harm was not in his mind after Baby O's and Baby P's deaths, and no one had mentioned concerns about Letby to him.[74] There were no medical concerns regarding Baby R, but he agreed to transfer Baby R to Liverpool Women's Hospital 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.*"[75] 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 Hospital and remained well.

10.46 At the close of Dr Rackham's oral evidence, Parents O, P and R, via their counsel, expressed their view that Dr Rackham's actions had saved Baby R's life. For this they expressed their "*profound gratitude*" to Dr Rackham.[76]

10.47 Dr Mayberry worked the night shift of 23/24 June 2016. He told the Inquiry that he received a call from a nurse that there was concern that milk had been aspirated from Baby P's nasogastric tube. He described this as a relatively common occurrence and that "*there was no other concern about Child P at the time*".[77] In his statement to the Inquiry, Dr Mayberry wrote that he was "*devastated, shocked and bewildered*" to learn that Baby P had died when he arrived for his night shift of 24/25 June 2016.[78]

10.48 Ms Percival-Calderbank told the Inquiry that she was "*stunned*" to learn that Baby P died.[79] She stated that, prior to their deaths, both Baby O and Baby P had been generally well. Ms Percival-Calderbank was not aware of any discussions of an unnatural cause of death, or Letby's involvement in the deaths of Baby O and Baby P. However, she stated that she had a "*niggle*" or a "*concern*" about the deaths being untoward.[80]

Letby's response to the deaths of Baby O and Baby P

10.49 Dr V told the Inquiry that, up until Baby O's and Baby P's deaths, she did not have concerns that the deaths on the neonatal unit were unnatural. However, she had "*overheard remarks being made about how when Lucy was around -- around things were happening, and it was more so not being able to quantify, well, is it because she's unlucky that she has shifts which has really sick babies and things happen*?"[81] Dr V told the Inquiry that Baby P required resuscitating twice on 24 June 2016. She said that, after his first resuscitation, Letby commented: "*He's not leaving here alive, is he?*"[82] Dr V said she was in "*disbelief*" and had never heard a healthcare professional make that type of remark.[83] She informed Ms Powell of Letby's comment at a meeting on 27 June 2016.[84]

10.50 Ms Powell recalled Dr V informing her that Letby had made an "*inappropriate comment*"; however, she said Dr V could not remember the details of it.[85] Ms Powell did not take steps to find Dr V and ask further questions about the comment.[86] When invited to give her view on the alleged comment, Ms Powell stated: "*It's totally unacceptable.*"[87]

10.51 It is highly unlikely that Dr V would report an inappropriate comment made on 24 June 2016 without being able to remember the details of it on 27 June 2016. She remembered them at the Inquiry, eight years later. It is not a complex utterance. I accept that she told Ms Powell that Letby had said: "*He's not leaving here alive, is he*?" I find that Ms Powell did not mention this callous remark to anyone else. Given that she was well aware of the concerns being raised about Letby, she should have informed Ms Rees or Ms Kelly. It was another example of Letby's disturbing comments and behaviour towards the death of babies she was caring for.

10.52 Ms Lightfoot was Deputy Ward Manager, Children's Unit, at the Countess. She told the Inquiry that, following Baby P's death, she was coming out of the break room and heard Letby greet a member of the night staff who was coming on duty with "*something along the lines of,* '*You*['ll] *never guess what just happened*'".[88] Ms Lightfoot said: "*I felt it was inappropriate*",[89] and that Letby spoke of the death as if it was an "*exciting event*".[90] Ms Lightfoot stated: "*I have never, and I have never since seen a response like that to a nurse involved in a patient's passing.*"[91] This is a further example of disturbing behaviour which echoes Letby's enjoyment of dealing with arrangements for babies after death, taking pleasure from talking about her involvement in resuscitation. No one said anything at the time, other than that it was odd.

10.53 Ms Lightfoot said, after Baby P died, there was a moment where she perhaps thought something significant was happening, because it "*seemed unusual to have two deaths in two days*".[92] She reflected: "[I]*n hindsight, you know, perhaps I -- I could have escalated it but I -- there was nothing substantiated. There was just an inappropriate response and I didn't have the full awareness of what had been happening on the unit and their mortality rate for me to put two and two together*."[93]

10.54 Nurse ZC was a children's nurse (band 5). In the week Baby O and Baby P died, she was working on the children's ward when the doctor's crash bleep went off for the neonates.[94] She confirmed in her oral evidence that: "*The link for me was following the event of the death of the triplets that made me concerned. This was potentially more than an experienced nurse always being allocated the unwell babies.*"[95] She also told the Inquiry her concerns arose on "*the second day* [24 June 2016] *and realising that actually she was on -- had chosen to look after those babies again*".[96] I remind myself that Baby O and Baby P were good weights for triplets at 33 weeks, and they were not "*unwell babies*".

10.55 Nurse ZC explained that most nurses who have suffered a death find the experience mentally and physically exhausting: "*So for me to go back the next day on shift, if -- you know, if it was me going back on shift, I would want the lowest acuity patient. So, for me, I found it quite strange that she chose to go back.*"[97] Taking account of the fact that people are different, this was at least consistent with Letby's preference not to be in the nurseries looking after the special care babies (see Chapter 5) because it was boring, and to prefer the drama of deterioration, resuscitation, death, and how to deal with it. I note in particular her behaviour post-death in respect of Baby C, Baby E and then, while he was still alive, Baby P. Only in retrospect was this behaviour considered all together.

10.56 In evidence, Ms Lightfoot was asked about Nurse ZC's evidence that she had raised the link between Letby and the deaths of babies on the unit, and had been ignored. Ms Lightfoot said: "*That is not the first time that I have heard Nurse ZC comment about Lucy. I had heard her and a couple of medical colleagues on a number of occasions*

discussing that Lucy must be involved. I felt it was quite malicious, it was gossip. It was, at that point as far as I was aware, unsubstantiated."[98] When, after the death of Baby P, Dr Barrett said to her, "*I see Nurse Death's on again*",[99] Ms Lightfoot dismissed it on the grounds that Dr Barrett and Nurse ZC were friends, and so "*I didn't feel they were independent concerns*".[100] Ms Lightfoot said that, if she had been approached with a professional concern about Letby, then she would have escalated it appropriately.[101] I infer from that that Ms Lightfoot did not think that Letby's excitement at the death of a baby led to a professional concern.

10.57 Dr Barrett gave evidence to the Inquiry. She was clearly mortified by what she had said about Letby in June 2016. She said that, although she had noted the fact that Letby was there at a couple of the unexplained collapses and child deaths, and commented on it, it never crossed her mind that Letby was responsible for the deaths.[102] I accept her explanation. Almost no one thought it possible that a nurse was harming babies. The deeply held belief that no nurse, particularly one you know, would deliberately harm babies was impossible to shift.

10.58 Nurse ZC gave evidence that, after Baby O's and Baby P's deaths, there were safety huddles during which staff were informed by management that there was a potential infection on the unit, and that "*disciplinary measures would be considered if you were found talking about*" Letby's association with the deaths.[103] Nurse ZC recalled Ms Anne Murphy being present, but could not recall which manager had delivered the message.[104] In the event, as Dr Saladi said, there was no infection on the unit at all, still less one that could explain the deaths. There had been two periods of concern about infections on the unit – in 2012 and 2015, pseudomonas was found on the taps, and was dealt with and had no consequences for babies.[105] In February 2016, it was thought that there was an RSV outbreak on the unit. This turned out to be a false alarm.[106]

10.59 After Baby P died, Dr V spoke to Parents O, P and R. Letby accompanied her. Dr V said in evidence that Letby asked Parents O, P and R if they would like her to make them a memory box for Baby P, in a manner that was "*very inappropriate*".[107] Dr V was invited to expand on why it was inappropriate. She explained: "[I]*t was the inappropriate jolliness, brightness to it … my experience of previously doing this with other nurses is it can be done in a calm, peaceful, reassuring manner, but not in the manner that she did.*"[108] Father O, P and R recalled that Letby dressed Baby P. He stated Letby made a "*big deal about taking photos of the boys and making memory boxes*".[109] This is further evidence of her apparent enjoyment of the drama and ritual around death.

10.60 Letby sent Dr U a running commentary on her actions. For example, at 18:34 on 24 June 2016, she texted: "*Just going to* dress *him &* [t]*ake footprints. Hope you are ok.*"[110]

10.61 Post-mortems took place in respect of Baby O and Baby P on 28 June 2016, and a subsequent secondary obstetric review of Mother O, P and R was completed on 20 July 2016. Baby O's recorded cause of death at post-mortem was '1a. Haemorrhage to peritoneal space', '1b. Rupture of subcapsular haematoma', '1c. Prematurity'. Baby P's recorded cause of death at post-mortem was '1a. Prematurity'.[111] The deaths of Baby O and Baby P were reported to StEIS.

10.62 On 29 June 2016, Ms Powell created Datix forms for Baby O's and Baby P's deaths. On both forms, Ms Powell listed Letby as the sole employee involved.[112] She explained that she did this because Letby was the designated nurse for Baby O and Baby P.[113]

10.63 On 30 June 2016, Letby completed a Datix form about Baby P, to the effect that there had been no sodium bicarbonate available (other than drug resuscitation boxes which were already in use). This had nothing to do with his death.[114]

10.64 Father O, P and R told the Inquiry: "[W]*e had never seen the Datix reports* [of Baby O and Baby P] *before the trial. I didn't even know they existed until the trial.*"[115]

10.65 In her evidence, Mother O, P and R talked about the lack of information that she and the babies' father were given about Baby O's and Baby P's deaths. She said:

> "*The information sharing with us was not adequate. It was worse than that – it was basically non-existent. Everything I have since found out about what really happened I have learned through the police, through the trial and through my solicitors. Within the NHS there is supposed to be a duty of candour. Nobody at the Countess of Chester Hospital was candid with us.*"[116]

10.66 She added:

> "*I do not believe that the Countess of Chester Hospital were honest with us at any stage. In my view, they never should have taken on our care in the first place. We were not made aware of the higher mortality rate in the Neonatal Unit – which we now know they were aware of at that stage. I think as parents we should have been informed of this.*
>
> *They knew that something untoward was going on and continued to take on my care, even though we could have been sent to a Neonatal Unit elsewhere.*"[117]

10.67 The first time that Parents O, P and R learnt about the suspicions that Baby O and Baby P had been murdered was in July 2018 via a family liaison officer. Mother O, P and R stated that Father O, P and R "*got the call before we saw it on the news*".[118] She described feeling "*devastated and in a state of disbelief because Lucy Letby was the one who was looking after the boys … It was Lucy Letby's idea to take photos of the boys. She dressed them and then took photos of them together. I was never told anything about Letby by the Countess of Chester Hospital.*"[119]

Bereavement support

10.68 Even though two of their babies had died at the Countess, Mother O, P and R informed the Inquiry that she and her husband "*were not offered any support or counselling by the Countess of Chester Hospital. The possibility of support was never even mentioned. The first time we were offered support was through Homicide Support and then at the criminal trial.*"[120]

10.69 The absence of any support in these circumstances was inexcusable.

Endnotes

1 Father N 24 September 2024 52/12-15
2 INQ0003181/2
3 Witness statement of Christopher Booth INQ0098315/4/para 17
4 Father N 24 September 2024 56/5-14
5 Mother N 24 September 2024 32/18 to 33/2
6 Mother N 24 September 2024 25/5-12
7 Mother N 24 September 2024 26/7-9
8 Father N 24 September 2024 58/11-19
9 Father N 24 September 2024 59/16-25
10 Father N 24 September 2024 60/6-10
11 Dr Stephen Brearey 19 November 2024 213/7-12
12 INQ0103144; Dr Murthy Saladi 3 October 2024 79/7-9 and 79/20 to 80/6
13 Dr Stephen Brearey 19 November 2024 245/13-23
14 INQ0049390/3
15 Father N 24 September 2024 54/12-13 and 55/19-24
16 Mother N 24 September 2024 37/13-15
17 Mother N 24 September 2024 37/16-24 and 38/11-12
18 Dr Murthy Saladi 3 October 2024 82/15-22
19 Mother N 24 September 2024 37/13 to 38/10
20 Dr U 7 October 2024 183/15-19
21 Dr U 7 October 2024 183/20-24
22 Dr U 7 October 2024 184/1-7
23 Dr U 7 October 2024 182/18-24; INQ0000569/2-4
24 INQ0000569/2-4
25 Dr U 7 October 2024 186/8 to 187/17
26 Mother N 24 September 2024 43/20
27 Mother N 24 September 2024 43/20 to 44/9
28 INQ0003212/5
29 INQ0003251/7
30 Father O, P and R 25 September 2024 30/11-18
31 Father O, P and R 25 September 2024 30/23-25
32 Father O, P and R 25 September 2024 32/2
33 Mother O, P and R 25 September 2024 3/21-24

34 Mother O, P and R 25 September 2024 4/2-3
35 Father O, P and R 25 September 2024 35/1-2
36 Father O, P and R 25 September 2024 35/2-6
37 Mother O, P and R 25 September 2024 5/21-23
38 Dr Jim McCormack 8 October 2024 43/14-15
39 Mother O, P and R 25 September 2024 9/9-12
40 INQ0000569/7/para 125
41 Dr U 7 October 2024 198/7-20
42 Eirian Powell 17 October 2024 50/4 to 51/9
43 Melanie Taylor 10 October 2024 35/10 to 38/5 and 62/11-19
44 Mother O, P and R 25 September 2024 10/16 to 11/6
45 Mother O, P and R 25 September 2024 11/22-23
46 Dr Oliver Rackham 26 November 2024 255/12-13
47 Dr Oliver Rackham 26 November 2024 248/10-18
48 Dr Oliver Rackham 26 November 2024 248/18-23
49 Dr Stephen Brearey 19 November 2024 87/20
50 Father O, P and R 25 September 2024 40/9-11
51 Father O, P and R 25 September 2024 40/8-9
52 Father O, P and R 25 September 2024 40/12-16
53 Mother O, P and R 25 September 2024 12/18-19
54 Dr Huw Mayberry 2 October 2024 126/6
55 Dr Huw Mayberry 2 October 2024 127/16-17
56 Melanie Taylor 10 October 2024 35/24 to 36/3
57 Witness statement of Caroline Bennion INQ0017826/4/para 21
58 Dr Stephen Brearey 19 November 2024 88/2-7
59 Dr Stephen Brearey 19 November 2024 89/9-12
60 Witness statement of Dr Stephen Brearey INQ0103104/42/para 239
61 Yvonne Griffiths 16 October 2024 159/12 to 160/25
62 Yvonne Griffiths 16 October 2024 157/24 to 158/23
63 INQ0000569/9/para 222; Dr U 7 October 2024 199/11-12
64 Mother O, P and R 25 September 2024 14/16-17
65 Mother O, P and R 25 September 2024 15/16-17
66 Father O, P and R 25 September 2024 43/3-10
67 Father O, P and R 25 September 2024 43/12-15
68 Dr Oliver Rackham 26 November 2024 249/15-18

69 Mother O, P and R 25 September 2024 16/11-14
70 Mother O, P and R 25 September 2024 16/17 to 17/1
71 Father O, P and R 25 September 2024 51/22 to 52/4
72 Dr V 7 October 2024 132/8-13
73 Dr V 7 October 2024 136/2-6
74 Dr Oliver Rackham 26 November 2024 259/10-11
75 Dr Oliver Rackham 26 November 2024 250/23 to 251/7
76 Dr Oliver Rackham 26 November 2024 260/22-23
77 Dr Huw Mayberry 2 October 2024 127/22 to 128/3
78 Dr Huw Mayberry 2 October 2024 129/5
79 Kathryn Percival-Calderbank 10 October 2024 159/18
80 Kathryn Percival-Calderbank 10 October 2024 159/7-11 and 161/23 to 162/4
81 Dr V 7 October 2024 125/25 to 126/8
82 Dr V 7 October 2024 133/14
83 Dr V 7 October 2024 133/15 and 133/23 to 134/1
84 Dr V 7 October 2024 163/18 to 164/4
85 Eirian Powell 17 October 2024 53/7-10
86 Eirian Powell 17 October 2024 53/24 to 54/2
87 Eirian Powell 17 October 2024 54/6-7
88 Nicola Lightfoot 15 October 2024 26/3-10
89 Nicola Lightfoot 15 October 2024 26/11-12
90 Nicola Lightfoot 15 October 2024 26/13
91 Nicola Lightfoot 15 October 2024 26/19-21
92 Nicola Lightfoot 15 October 2024 33/7-8
93 Nicola Lightfoot 15 October 2024 27/12-18
94 Nurse ZC 14 October 2024 171/10-12
95 Nurse ZC 14 October 2014 171/4-7
96 Nurse ZC 14 October 2014 171/20-22
97 Nurse ZC 14 October 2024 172/15-18
98 Nicola Lightfoot 15 October 2024 28/13-18
99 Nicola Lightfoot 15 October 2024 29/24 to 30/4
100 Nicola Lightfoot 15 October 2024 30/21-22
101 Nicola Lightfoot 15 October 2024 28/23 to 29/1
102 Dr Cassandra Barrett 2 October 2024 159/4-21
103 Nurse ZC 14 October 2024 175/17 to 176/3

104 Nurse ZC 14 October 2024 176/7-13

105 Dr Murthy Saladi 3 October 2024 120/12 to 121/15

106 INQ0105507/1

107 Dr V 7 October 2024 135/7

108 Dr V 7 October 2024 162/13-22

109 Father O, P and R 25 September 2024 47/14-17

110 INQ0000569/11/para 324

111 INQ0108782/3

112 INQ0008615/2; INQ0008624/2

113 Eirian Powell 17 October 2024 50/4 to 51/9

114 INQ0001457/1-2

115 Father O, P and R 25 September 2024 59/1-3

116 Mother O, P and R 25 September 2024 28/13-19

117 Mother O, P and R 25 September 2024 26/18 to 27/2

118 Mother O, P and R 25 September 2024 25/20-24

119 Mother O, P and R 25 September 2024 26/3-14

120 Mother O, P and R 25 September 2024 27/6-10

Chapter 11. 24 and 25 June 2016: Exchanges between the doctors and managers; Baby Q

Dr Jayaram raises concerns with Ms Townsend, 24 June 2016

11.1 In his capacity as Lead Clinician for Children's Services, Dr Jayaram regularly met Ms Townsend. He explained that, at some point before Baby O's death, he had arranged to meet Ms Townsend.[1] They met on 24 June 2016. By the time they met, he had learnt that Baby O had died. He had been working in Liverpool on 23 June 2016.

11.2 Dr Jayaram said in evidence that he wished to discuss several issues about the department with Ms Townsend, including his concerns about Letby. He explained he wanted Ms Townsend's "*help and support*" because the consultants were not comfortable with Mr Harvey's and Ms Kelly's 'monitor and alert' approach.[2]

11.3 Dr Jayaram told the Inquiry that in the meeting he said to Ms Townsend: "*I stated that as a group of Consultants we were concerned, extremely concerned, about these events and we were all at a point as a group where we felt that natural causes had been excluded as far as they could be and we were really concerned about her* [Letby] *being on the unit.*"[3]

11.4 Ms Townsend's evidence was that she met Dr Jayaram in a coffee shop on the hospital premises, by agreement, at approximately 11am on Friday 24 June 2016.[4] She thought the location was an "*unusual forum*" for Dr Jayaram to raise his concerns, and she was "*shocked*" to hear them.[5] She said that she had met Dr Jayaram on a couple of occasions between September 2015 and 24 June 2016, and he had not raised his concerns.[6]

11.5 Ms Townsend's notes of the meeting are: "*24/6/16 RJ/KT* [Dr Jayaram/Ms Townsend] … *NNU* [neonatal unit] *triplets (1 dec'd? 2nd) concerns?*"[7] Ms Townsend confirmed that this was a reference to Dr Jayaram discussing Baby O's death, and that he had concerns about Baby P.[8] She stated that Dr Jayaram told her that "*himself and Dr Brearey and potentially others* [were] *concerned around the individual being on the unit*".[9]

11.6 Ms Townsend said in evidence that Dr Jayaram referred to a "*drawer of doom*" in which Dr Brearey had clinical evidence related to their concerns.[10] She told the Inquiry that, hearing these concerns for the first time, her immediate concern was to speak to someone to see if any action needed to be taken prior to the weekend. She told the Inquiry: "[T]*he risk was that there was going to be further harm to babies on the neonatal unit.*"[11] That was a clear description of the obvious risk that required action.

11.7 Ms Rees was junior to Ms Townsend in the management structure, but Ms Townsend decided to speak to her about Dr Jayaram's concerns. She told the Inquiry she did this because she did not have a clinical background, and she wanted to obtain "*support and advice and kind of ask her what should we do in terms of those immediate next steps*".[12]

She conceded that, on reflection, approaching Ms Rees was a move down the hierarchy rather than an escalation.[13] No reflection was needed. She knew Ms Rees was junior to her. If she thought it appropriate to go to a nurse, she should have gone to someone more senior. There was no reason not to go to Ms Kelly. When asked why she did not choose to escalate the concerns directly to the executives, Ms Townsend responded that she did not because of her "*naivety*" in her role.[14] This was a major error of judgement in light of the seriousness of the situation and the seniority of her position. Ms Rees had no relevant clinical experience. Ms Townsend should have escalated the matter directly to the executives.

11.8 In oral evidence, Ms Rees recalled that Ms Townsend bleeped her on Friday 24 June 2016. She thought it was early to mid-afternoon when she spoke to Ms Townsend in her office.[15] It is likely that it was earlier than that, as I explain below.

11.9 Ms Rees confirmed she was told that Dr Jayaram and Dr Brearey both thought Letby was "*purposefully harming babies*".[16] Ms Rees stated she was "*horrified*" to hear this, "*particularly when there was no forthcoming rationale to support these allegations*".[17] Ms Rees told the Inquiry: "*I informed Karen Townsend that I needed to go and find both Ravi Jayaram and Steve Brearey to ascertain what exactly did they mean.*"[18]

11.10 It had been Ms Rees to whom Ms Kelly had turned in early May 2016, when she first reacted with shock to the email about the "*staff trend*" revealed in the documents forwarded by Ms Powell.[19] Ms Rees had met Ms Powell, at Ms Kelly's request, on 5 May 2016 to discuss the issue. She was party to the documents that had been produced.[20] The fact of the doctors' concerns cannot have been a surprise to her. There was no real point in her going to see the doctors. She had no relevant clinical expertise. Their concerns were clear. What was needed was immediate action to protect babies. She should have focused on that, rather than confronting the doctors.

11.11 Dr Jayaram told the Inquiry he was in his office when Ms Rees came to see him. His summary of their conversation was as follows: "*Karen Townsend had told her that myself and Dr Brearey thought that Letby was deliberately harming babies and wanted her moved from the unit and she said to me: I can't do that without evidence, give me some evidence.*"[21] Dr Jayaram directed Ms Rees to speak to Dr Brearey if she wanted specific evidence.[22]

11.12 Dr Jayaram spoke reflectively about his interactions with Ms Townsend and Ms Rees:

> "[M]*y request really of Karen Townsend and Karen Rees was to sort of say: look, we are really worried about this, we are not as a group reassured that keeping her working unsupervised is safe. Please do something.*
>
> *I could have been more forthright. I could have said specifically, 'You must remove her from the unit' and I didn't say that.*"[23]

Whilst there are a number of criticisms to be made of Dr Jayaram, I do not think this is one of them. Ms Rees knew what Dr Brearey and Dr Jayaram wanted.

11.13 Ms Rees's recollection of her conversation with Dr Jayaram was that he told her: "*Steve Brearey and I have got concerns about the clinical practice of a nurse.*"[24] Ms Rees told Dr Jayaram that he needed to give her more information. He did not, so she went to speak to Dr Brearey. I cannot accept that Ms Rees, knowing that Ms Townsend had told

her that Dr Jayaram and Dr Brearey thought that Letby was deliberately harming babies, would have let Dr Jayaram get away with saying that he had concerns about the clinical practice of a nurse. I am satisfied that she left that meeting, as she had gone into it, knowing that the doctors thought Letby may be deliberately harming babies.

11.14 There is a factual dispute between Ms Rees and Dr Brearey as to what time their conversation took place on 24 June 2016. I do not need to resolve the dispute. Ms Rees's recollection of her conversation with Dr Brearey was as follows:

> "*Steve Brearey's clinic had overrun so he was still in clinic in the Women's and Children's building and so I made my way over there and sat outside his clinic until he had finished his clinic.*
>
> *When he came out I said: I need to discuss something important with you, but clearly not in this environment, so we went back to his office.*
>
> *Ravi Jayaram had left, he wasn't in the office. So I said to Steve Brearey, I said: look, I said you need to share with me why you have got these concerns and why and how do you think that she's purposefully harming babies and his answer to me and I remember it clearly because he says: I have got a gut feeling and I have got a drawer of doom, and he pointed to a drawer in his desk so I said to him: well, share the contents of that drawer of doom with me, of which he refused. And he just said: she needs to be moved off the neonatal unit, I am aware that she is on this weekend.*
>
> *So I said to him: I can't remove a nurse from a clinical practice just because of gut feeling and a drawer of doom of which contents you will not share.*"[25]

11.15 This was a regrettable reaction. Ms Rees was a relatively senior nurse; she knew that babies were dying unexpectedly on the neonatal unit. She knew that the number of deaths was significantly higher than in previous years. She knew well before this meeting that the doctors were worried. She did not need experience of neonates to know that she should act to keep babies safe.

11.16 Dr Brearey's recollection was that, in the morning and early afternoon of 24 June 2016, he was in his clinic performing echocardiograms when one of the junior doctors asked him to perform an urgent echocardiogram on Baby P. In a supplementary Inquiry statement, dated 4 November 2024, Dr Brearey informed the Inquiry that the last scan he performed in his clinic was at 13:19, and the image was stored at 13:23. Dr Brearey then went to the neonatal unit and performed an echocardiogram on Baby P; this scan is recorded as starting at 13:30. Dr Brearey's evidence was that the seven-minute interval – in which he closed the scanner down, packed up his notes, walked to the neonatal unit, rebooted the scanner and received a handover on Baby P – meant it was inconceivable that, between finishing the scan in the clinic and walking to the neonatal unit to scan Baby P, he and Ms Rees had a conversation in his office.[26] I accept his evidence about that. I bear in mind Ms Rees's confusion about who she spoke to the following day, believing it was Ms Powell when in fact it was Ms Farmer, as she said in evidence. Even at the time of the grievance hearing in November 2016, she said that she had spoken that day to Ms Powell when she had not. It suggests that Ms Rees's memory of some of these events is not entirely reliable.

11.17 Dr Brearey did say that he could recall commenting to someone that he had a "*drawer of doom*"[27] (and I remind myself that Ms Townsend said Dr Jayaram used the same expression to her). It is likely that it was to Ms Rees that he said it that day, since she then repeated it. He said: "*I can vaguely remember* [the conversation] *was with somebody who was standing in the doorway.*"[28] This seems likely to have been Ms Rees. It took place in a hurry in a doorway as Dr Brearey was in the middle of clinical duties, preparing to go to the neonatal unit to care for Baby P.

11.18 Dr Brearey told the Inquiry the "*drawer of doom*" was where he kept his medico-legal files, documents related to inquests and reports of babies that died. He said he highlighted the drawer because it was rarely used. However, during the indictment period, it was getting full. It was his opinion that the way the phrase 'drawer of doom' was used from that point onwards was "*belittling the concerns that we had and distracting from the concerns*".[29] I agree with this assessment but, in fairness to those who did so, it was Dr Brearey who gave those records that name.

11.19 Ms Rees said in evidence that, after speaking to Dr Brearey, she spoke to Ms Kelly and relayed the events of that afternoon. She stated Ms Kelly told her to speak to Mr Harvey; however, he was not in the office. She confirmed that Ms Kelly told her she was going to contact Mr Harvey.[30] Mr Harvey does not remember being spoken to that afternoon.[31] I do not think it makes much difference whether he was or he was not. Nor does the precise time when Ms Rees spoke to Ms Kelly matter very much either. Baby P died at 16:00, but I do not think that anything being done by the managers at that time would have made any difference to that dreadful outcome.

11.20 Ms Kelly told the Inquiry: "[T]*hat Friday afternoon, Karen Rees did come to speak to me very concerned about what she had been told from the doctors.*"[32] She confirmed that Dr Brearey and Dr Jayaram were concerned that Letby was intentionally harming babies, and that the trigger was Baby O's death the previous day.[33] She described what the consultants told Ms Rees as a "*serious concern*".[34]

11.21 Having described what the consultants had said was a serious concern, Ms Kelly sought to stress that Dr Brearey and Dr Jayaram had not directly said they were concerned that Letby was murdering babies. She stated: "*That was the problem. There was no clear articulation of the facts and how that was -- how they were coming to that conclusion.*"[35]

11.22 In the course of her evidence, Ms Kelly repeatedly said that the doctors had not clearly "*articulated their concerns*".[36] Their concerns could not have been clearer. They were concerned that Letby was deliberately harming children and that the trigger for speaking out was Baby O's death the previous day. I accept that neither of them said directly, 'Letby is killing babies' or 'Letby is murdering babies', but their concerns as expressed could mean only one thing. I accept that it is hard to say out loud that someone is murdering tiny babies. Anyone in the hearing room will remember the silence there was each time counsel used the words 'murder' or 'killing'. And that was in the context of an Inquiry that came into being because a nurse had been convicted of killing babies. It is still truly shocking to hear.

11.23 The other part of Ms Kelly's explanation was that the doctors did not 'articulate the facts' and explain how they had come to have those concerns.[37] It was not for Ms Kelly to assess the detail underpinning the concerns. She knew that babies were dying, she knew that their deaths were unexpected and that many were unexplained, she knew that one

nurse had been present at most of the collapses and deaths. She knew that the doctors were very worried. As the head of safeguarding (see Chapter 12), she knew she had to act when there was a suspicion that a baby had been harmed and that others may be at risk. She did not do so.

11.24 Ms Kelly was asked what she did after receiving the information. She responded: "*Personally I didn't do anything after I spoke to Karen because as I mentioned before my duties are discharged to my team, I -- I have Karen Rees held in very high regard. She was going to do a set of actions and I was happy with that.*"[38] Given the nature of the concerns conveyed by the consultants, I cannot see how Ms Kelly was comfortable to delegate (or, as she put it, 'discharge') her responsibilities to Ms Rees, her junior by two management levels. Ms Kelly had been at the meeting in May 2016 at which Dr Brearey had expressed his concerns. She knew that there was monitoring of the deaths after that meeting, and that day, Baby O had died. This was not delegating; it was abdicating responsibility.

11.25 The "*set of actions*" to which Ms Kelly referred in evidence amounted to Ms Rees going to the neonatal unit to speak to Ms Powell, who, as I have said above, was not in the hospital that day. She spoke instead to Ms Farmer and asked whether she had any concerns about the competence of any of the nurses on the neonatal unit. She did not ask her about Letby; she did not mention the doctors' suspicions. Ms Farmer "*gave me assurance saying: absolutely not*".[39] Competence was not the issue. No one on the neonatal unit thought that any of the nurses were incompetent. The concern was about deliberate harm. This action could not and did not deal with the concerns at all.

11.26 Ms Rees was asked why she did not ask Ms Farmer outright whether she had concerns that a nurse was deliberately harming babies. She responded that if the senior nurses had these concerns, "*I think that would have been brought to my attention rather than wait for me to ask it*".[40] She may have been right about that, but her approach meant that her mind was closed to the possibility that harm was being done. Going to see Ms Powell (in the end, Ms Farmer) was an empty exercise. Because the senior nurses had not brought anything to her attention, she was satisfied there was nothing to be brought to her attention, and did not even ask about deliberate harm. This underlines the foolishness of Ms Kelly taking reassurance from Ms Rees's "*set of actions*". There was one action which would undoubtedly give assurance, which was neither sought nor obtained – removing Letby from the neonatal unit.

The evening of 24 June 2016

11.27 Dr Brearey spoke to Ms Rees by telephone in the early evening on Friday 24 June 2016. She was at home when she received the call.[41]

11.28 Dr Brearey gave oral evidence that, on the evening of 24 June 2016, he called the hospital switchboard and asked to speak to the duty executive. He emphasised that he did not ask to speak to Ms Rees specifically; however, she was on duty and answered. Dr Brearey said that he informed her that Baby P had died, and that he was concerned that Letby may be working the next day.[42] Dr Brearey explained:

> "*I wanted the neonatal unit to be safe and the only way for us to be sure that it was safe at that stage was for her not to come to work the following day.*
>
> *Karen Rees then as I have described previously said no to this. She said that I had no evidence, was quite categorical. I said: well, if you are saying 'no', does that mean that you -- that you are happy to take responsibility if anything were to happen on the following day with any further babies and override the wishes of seven Consultants? And she said 'yes' to both of these.*"[43]

11.29 Ms Rees disagreed with some of Dr Brearey's evidence about the phone call. She believed he had telephoned her directly, somehow obtaining her number.[44] I think that is unlikely. Dr Brearey was extremely concerned. He wanted to speak to a senior executive. He got Ms Rees.

11.30 Ms Rees agreed that Dr Brearey asked her to remove Letby from the unit, and she reiterated that she would not do this without further information or "*just cause*".[45] She denied telling Dr Brearey she would take responsibility for Letby remaining on the neonatal unit.[46] That is puzzling. In refusing to remove Letby from the unit, which she undoubtedly did, she was taking responsibility for her remaining there. I cannot see why she would not say so to Dr Brearey when he asked her, as I find he did, and she refused to remove Letby from the neonatal unit. Her view that she could not remove Letby from the unit without further information or 'just cause' ignored the doctors' concerns. She knew that at least two paediatricians were concerned that Letby was deliberately harming babies. She had known for some months that babies were dying on the unit and that at least some of the deaths could not be explained. She knew that Letby was on shift for many of them. The safety of the babies on the unit should have been her paramount concern. Instead, she used the language of 'just cause', putting first the interests of the nurse. That she was hostile to Dr Brearey was revealed in this exchange:

> "**Mr Baker KC:** *All Stephen Brearey is asking you to do is to take Lucy Letby off the ward so she doesn't harm another baby, that is all he was asking, wasn't it?*
>
> **Ms Rees:** *Yes, he was demanding. He wasn't asking, he was demanding, yes.*
>
> **Mr Baker KC:** *Did that put your back up, that he was demanding it?*
>
> **Ms Rees:** *I wouldn't say put my back up but why wasn't he working with me? You know, like I have said previously just because a Consultant makes a demand, as* [a] *senior nurse, you -- you don't -- when they click their fingers you don't jump how high.*"[47]

She added: "*I mean, I accept, and looking back at all of these things, yes, and that is why we are here today so we can learn lessons and I am sorry for all of that.*"[48]

11.31 The truth is that Ms Rees did not accept that the doctors' concerns were held in good faith. As she said in evidence, she believed that there was a personal motive behind Dr Brearey's request.[49] Her first thought, when being asked by Dr Brearey to stop Letby coming on the unit the next day, was that Dr Brearey and Letby were, or had been, in

a relationship. This, she surmised, caused Dr Brearey to seek Letby's removal from the neonatal unit. This was ridiculous. It is not clear to me that Ms Rees ever properly thought it through. There was no evidence in support of this theory, but she believed it. That is why she later asked Letby whether Dr Brearey had ever made a pass at her. Letby made it clear that he had not.[50] When asked to explain in evidence why she had formed that view, she related her experience of having consultants on another ward, where she was the ward manager, demand that she remove nurses either from their team or from their ward or unit, because personal and professional relationships had broken down.[51] She refused, quite rightly. That was the basis for her belief that there was a relationship between Dr Brearey and Letby, and that he was seeking her removal in bad faith. In other words, there was no basis for it at all.

11.32 Everything about Ms Rees's reaction here was wrong. First, she was dealing with paediatricians of whom she had little knowledge or experience. Second, there was nothing to support her theory. A moment's thought would have led her to acknowledge that falsely accusing a nursing colleague of harming (or even killing) babies would be an extreme way of removing a nurse from a unit. What is worse, when she rang Ms Kelly on 24 June 2016, she told her that her view was that there was something personal between Dr Brearey and Letby. Ms Kelly confirmed this in evidence.[52] That unfounded allegation, having been made, went round the hospital like wildfire and came to feature in the grievance many months later.

11.33 That Ms Rees was comfortable making such an extreme allegation against a paediatrician without any basis demonstrates that she had lost all judgement in the face of what she had been told. Whether this was because of her long-standing belief that nurses were not treated with the same respect as doctors, or her conviction that there was nothing in the doctors' concerns, her hostile approach was deeply unfortunate, and it would continue for many months. She was later to assert in the grievance and in evidence that she felt that Dr Brearey bullied her in the conversation on 24 June 2016.[53] She did not suggest that he was openly aggressive. Instead, she described him as passive aggressive.[54] It is plain on the evidence that he was desperate to get Letby off the ward, and she was determined not to agree to it. She objected to being told that she would be responsible for the consequences of her decision. This was not bullying, nor did she experience it as such. I say that having considered all the evidence about her and about Dr Brearey. Against that backdrop, I also observed Dr Brearey in the witness box for a prolonged period, and Ms Rees in the witness box for long enough to assess the likelihood of her being bullied by anyone, still less Dr Brearey. The likelihood is nil.

11.34 In evidence, Ms Rees said: "*I've been in to see Alison Kelly and she is discussing the whole episode of that afternoon* with *Ian Harvey*."[55] Mr Harvey has no memory of anyone speaking to him about this on 24 June 2016. Ultimately, no steps were taken to prevent Letby from working on the neonatal unit. This was a failure of all the managers involved. Ms Rees, Ms Townsend and Ms Kelly.

11.35 Ms Townsend was asked why she did not take action to remove Letby from the unit. She stated she thought the concerns lacked detail and needed further investigation.[56] Of Dr Brearey and Dr Jayaram, she said: "*I do feel if there was that urgency … they could have gone direct to the Executives themselves*."[57] This too was abdication of responsibility. The appropriate route for a doctor was to go through the management structure. Dr Jayaram had raised it with Ms Townsend who, extraordinarily, sent it down the chain

rather than up. Dr Brearey had sought to speak to the duty executive on 24 June 2016. He was put through to Ms Rees. The doctors were not to blame for Ms Townsend's failure to escalate this issue to Ms Kelly and Mr Harvey as she should have done. She was Divisional Director. She could take decisions about the deployment of nurses. The fact that the doctors did not go over her head was not a justification for her own failure to take action to safeguard babies on the unit.

11.36 Ms Townsend was asked whether she thought it was safe to go home that Friday afternoon without taking any action. She responded that she believed Ms Rees had spoken to Dr Jayaram and Dr Brearey, and later with two of the executives, and left it with the executives. She stated that, from their perspective, "*little else*" could have been achieved that day because the consultants were not forthcoming with further details.[58] No details were needed beyond the fact that there were a number of babies who had died, without explanation, and the doctors were concerned that a nurse may be behind it. It is not apparent that she gave any thought to any potential harm to babies, or to the need for safeguarding steps. As a matter of fact, several of the deaths had occurred at night. Deaths at night stopped when Letby was moved to day shifts. Baby O and Baby P had died during the day. On any view, this was sufficient to require action to safeguard the other babies on the unit. Removing Letby to protect babies was an obvious step, neutral in HR terms, but not even considered. Ms Townsend did not seek HR advice, or consult any person senior to herself.

11.37 Ms Rees conceded that she did not take steps to speak to the other consultants about their views on the cause of the neonatal deaths and collapses.[59] She accepted that she "*possibly*" had a degree of bias in her decision-making when she concluded that the consultants had a personal issue with Letby.[60] She came to that view almost immediately. She was biased against the doctors.

11.38 Ms Rees was asked whether she thought she should have contacted Safeguarding when she became aware that the consultants suspected that Letby may be deliberately harming babies. She responded:

> "*I have reflected upon that and perhaps that is what – that's an action I should have perhaps taken on Friday. But equally neither Consultant did neither. I just think yes, on reflection, I perhaps should have done and I am sorry for that. I am sorry.*"[61]

That she should have taken steps to protect babies is inescapable.

11.39 In oral evidence, Ms Kelly was asked why she took no action. Ms Kelly replied that she understood that Ms Rees had been to the unit, and the nursing staff did not have any concerns about any staff on the unit, including Letby, working over the weekend.[62] She stated: "*I had that assurance from Karen* [Rees] *that staffing had been reviewed and everyone was satisfied.*"[63] I have dealt with that earlier in this chapter.

11.40 Ms Kelly conceded: "*What I didn't ask or didn't clarify was whether she was on duty the day after and I should have done.*"[64] She also conceded that she did not approach Dr Brearey or Dr Jayaram about their concerns.[65] She should have done both.

11.41 Ms Kelly told the Inquiry: "[O]*n reflection, I -- I -- I could have done something differently and maybe that was a missed opportunity*."[66] She sought to explain why she did nothing: "[I]*t was a very difficult thing to hear. So maybe I didn't, I didn't process it as -- as I*

should have done at the time."[67] In my judgement, she should have done a lot of things differently. The language of missed opportunity is wholly inapposite when talking about the failure to protect small babies. This was not something that '**could** have been done differently'. It was a gross error. She **should** have done something differently; that is, removed Letby from the neonatal unit.

Infection

11.42 An email from Ms Townsend to Dr Brearey on 28 June 2016 set out several action points that were made in response to the consultant paediatricians raising concerns about the deaths. One of these included: "*Microbiology/infection control review to be undertaken within the NNU … to undertake Deep Clean of the unit.*"[68] The 'Position Paper: Neonatal Unit Mortality' confirmed that an infection control review occurred.[69] There was no evidence that infection caused any death.

Pseudomonas

11.43 Several witnesses (consultant paediatricians and nurses) raised the question of pseudomonas. Ms Powell told the Inquiry: "*We had two incidences of pseudomonas. And that was tested. The estates came to test … filters then had to be applied to the taps and then they were retested*."[70] In line with Ms Powell's evidence, a document titled 'Time Lines of External Influences on the Neonatal Unit March 2012–July 2016' sets out that pseudomonas was found in the taps twice, once on 31 December 2012 and again on 14 December 2015.[71]

11.44 A contemporaneous note from a meeting that took place between the executives and the consultant paediatricians on 29 June 2016 records Dr Brearey saying: "*Pseudomonas growing from taps but not evident in incidents.*"[72] There was no evidence that pseudomonas played any part in any of the deaths on the neonatal unit.

RSV

11.45 On 12 April 2016, Ms Millward wrote to CQC to confirm that there had been no outbreak of a respiratory virus on the ward. She stated: "*RSV outbreak: An issue was identified with the testing of the samples sent to the laboratory … In summary – the Trust did not have an outbreak of RSV on the NeoNatal Unit and it would appear that the issue was with the testing kits*."[73] A Countess document, 'Time Lines of External Influences on the Neonatal Unit March 2012–July 2016', makes it clear: "*RSV OUTBREAK (FALSE POSITIVE) – FEB 2016.*"[74]

Mortality review of Baby O's and Baby P's deaths

11.46 Dr U attended a review of the deaths of Baby O and Baby P on 5 July 2016. The meeting was also attended by Dr Brearey, Dr ZA, Ms Powell, Ms Griffiths, Ms Sian Williams and Ms Cooper. Dr U was asked about Dr ZA's oral evidence that concerns about Letby were discussed at this meeting; Dr U could not recall these concerns being discussed. It is highly unlikely that they were not. He said that at some point he left the meeting and the conversation continued. He emphasised that he was not aware of his colleagues' concerns about Letby at this time and that he did not have concerns.[75]

11.47 Dr U was taken to a message which he sent to Letby following the meeting (Dr U to Letby on 6 July 2016 at 00:54):

> "***You need to keep this to yourself*** [emphasis added]. *The meeting this afternoon looked at everything with Child O and P from birth onwards, reviewed everything, the room, beds, medical views and actions. We looked at all documentation, medicine. If you have any doubt about how good you are at your job stop now, documentation was perfect. Everyone commented about the appropriateness of your request for review following the vomits*."[76]

11.48 Dr U was asked why he sent that message to Letby when she had not been invited to the meeting. He replied that he was seeking to reassure her because she was upset by the deaths.[77] He went further than that. Dr Brearey emailed him on 6 July 2016. He said that there was likely to be an inquest into the deaths of Baby O and Baby P. He suggested that Dr U prepare a statement while matters were fresh in his mind, and said that the statement "*can include things we discussed yesterday that might not be in the notes*".[78] Dr U could not remember what was not in the notes of the meeting of 5 July, but accepted it may have been about Letby. He had not been present towards the end of the meeting.[79]

11.49 Dr U most unwisely forwarded Dr Brearey's email to Letby. He wrote: "[T]*his email has to stay between us, is that okay*."* He was asked why he sent the email to Letby. Again, Dr U stated that he was trying to reassure her and "*give her some insight into what was going on*". He then added: "[I]*n hindsight that was an error on my part*" and "*I shouldn't have sent it*".[80] I agree with him. It is another example of the blurring of boundaries. Here, between his duties to his patients, and his desire to help and support a young nurse who had, as he did not realise, many people supporting her. He put her first.

11.50 His support for Letby continued well into 2017.

25 June 2016, Baby Q

11.51 Letby remained on the shift rota and worked on Saturday 25 June 2016. Given the concerns at this stage, this should not have happened.

11.52 Baby Q was born at 31 weeks and 3 days' gestation, and weighed 2.076 kilograms. On 25 June 2016, Baby Q collapsed unexpectedly.[81] Letby was Baby Q's designated nurse on the day shift.

11.53 In Baby Q's nursing notes, Letby records: "*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*."[82] Letby was charged with Baby Q's attempted murder. The prosecution's case was that around 9am on 25 June 2016, Letby injected air and clear fluid into Baby Q's stomach via his nasogastric tube. The jury were unable to reach a verdict.

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* This message was sent on 7 July 2016 at 00:05.

11.54 Ms Kelly has told the Inquiry that she was not informed about Baby Q's collapse. She said she would have expected to be notified, given what was agreed at the 11 May 2016 meeting in relation to being informed of all unexpected collapses. I agree she should have been notified, but in light of the response to the deaths of Baby O and Baby P, I doubt it would have made any difference.

11.55 Dr Brearey accepted Baby Q's collapse should have been reviewed at the time, and there should have been a discussion with Parents Q.[83] He explained this did not take place because of the number of meetings that happened following the deaths of Baby O and Baby P.[84] He also pointed out that, following Baby Q's collapse, Mr Harvey and Ms Kelly promised a review into the deaths, and that was how the matter would be taken forward (see Chapter 14). In Dr Brearey's view, from this point Mr Harvey took over communication with the families and the additional investigations being carried out.

11.56 After Baby Q's collapse, on 25 June 2016, Dr Gibbs told the Inquiry that he asked the nurses which nurse was looking after Baby Q. He said that he was expecting that his question would get back to all the nursing staff. He explained that it was his "*rather feeble attempt to try and offer some protection, if some harm was going on*", by monitoring who was caring for which babies.[85]

11.57 Dr Gibbs' question did get back to Letby. That evening, on 25 June 2016, she exchanged messages with Dr U. I have set some of them out below:

> **22:46, Letby to Dr U:** "*Do I need to be worried about what Dr Gibbs was asking?*"
>
> **22:54, Dr U to Letby:** "*No.*"
>
> **22:58, Dr U to Letby:** "*He was asking to make sure that normal procedures were being carried out.*"
>
> …
>
> **23:25, Dr U to Letby:** "*Lucy, if anyone knows how hard you've worked over the last three days it's me … if* ***anybody*** [emphasis in original] *says anything to you about not being good enough or performing adequately I want you to promise me that you'll give my details to provide a statement.*"[86]

11.58 Dr U was asked what he understood Letby was worried about. He responded: "*I think, having looked after the two babies on consecutive days, she was concerned that she would be thought to be responsible for the deaths.*"[87] Dr U stated that he was trying to reassure her because he was aware that she had mental health problems. He told the Inquiry that he mistook her behaviour at the time for anxiety. However, he agreed that "*in hindsight, yes*", she was worried about people asking questions about the deaths.[88]

11.59 Like other parents, Mother Q did not know that Baby Q had suffered a collapse at the Countess. She was informed by the police.[89] Her evidence to the police was: "*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*."[90] I agree. It was not for the medical and nursing staff to decide what was best for the parents. Their duty was to be candid. I accept that such situations are difficult and demanding. I also accept that doctors and nurses are often working under great pressure of time. Each case will be different in terms of the timing and content of any communication with parents. But communication there must be. The duty of candour requires it.

11.60 Mother Q's victim impact statement from the criminal trial was disclosed to the Inquiry. Mother Q 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 of happened to Child Q.*"[91]

11.61 Before turning to what happened next, I consider a matter of central importance. Safeguarding.

Endnotes

1 Dr Ravi Jayaram 13 November 2024 53/12 to 54/12

2 Dr Ravi Jayaram 13 November 2024 54/10-11 and 55/7

3 Dr Ravi Jayaram 13 November 2024 54/22 to 55/2

4 Karen Townsend 4 November 2024 50/19-22

5 Karen Townsend 4 November 2024 35/6-9

6 Karen Townsend 4 November 2024 31/20 to 32/3 and 52/8-12

7 INQ0102357/2

8 Karen Townsend 4 November 2024 54/25 to 56/18

9 Karen Townsend 4 November 2024 33/8-10

10 Karen Townsend 4 November 2024 33/20

11 Karen Townsend 4 November 2024 34/22-23

12 Karen Townsend 4 November 2024 36/12-15

13 Karen Townsend 4 November 2024 58/21 to 59/1

14 Karen Townsend 4 November 2024 37/12

15 Karen Rees 21 October 2024 136/1-20

16 Karen Rees 21 October 2024 137/17-25

17 Karen Rees 21 October 2024 138/6-8

18 Karen Rees 21 October 2024 138/9-11

19 INQ0003138/1

20 Karen Rees 21 October 2024 128/25 to 129/17

21 Dr Ravi Jayaram 13 November 2024 56/9-13

22 Dr Ravi Jayaram 13 November 2024 56/15-16

23 Dr Ravi Jayaram 13 November 2024 56/22 to 57/4

24 Karen Rees 21 October 2024 138/20-22

25 Karen Rees 21 October 2024 139/4-25

26 Dr Stephen Brearey 19 November 2024 90/4 to 91/6

27 Dr Stephen Brearey 19 November 2024 91/8-14

28 Dr Stephen Brearey 19 November 2024 92/3-5

29 Dr Stephen Brearey 19 November 2024 91/16 to 92/15

30 Karen Rees 21 October 2024 140/14-21

31 Witness statement of Ian Harvey INQ0107653/40/para 172

32 Alison Kelly 25 November 2024 123/8-10

33 Alison Kelly 25 November 2024 123/11-16

34 Alison Kelly 25 November 2024 125/4
35 Alison Kelly 25 November 2024 123/22-24
36 Alison Kelly 25 November 2024 83/13-14 and 123/22-24
37 Alison Kelly 25 November 2024 123/22-24
38 Alison Kelly 25 November 2024 124/17-21
39 Karen Rees 21 October 2024 140/22 to 141/6
40 Karen Rees 21 October 2024 142/2-4
41 Karen Rees 21 October 2024 145/14-17
42 Dr Stephen Brearey 19 November 2024 93/3-11
43 Dr Stephen Brearey 19 November 2024 93/12-23
44 Karen Rees 21 October 2024 145/13-19 and 208/16-20
45 Karen Rees 21 October 2024 145/13 to 146/1
46 Karen Rees 21 October 2024 200/11-19
47 Karen Rees 21 October 2024 199/20 to 200/7
48 Karen Rees 21 October 2024 200/8-10
49 Karen Rees 21 October 2024 143/3-4
50 Karen Rees 21 October 2024 143/19-25
51 Karen Rees 21 October 2024 142/19-25
52 Alison Kelly 25 November 2024 297/13-25
53 Karen Rees 21 October 2024 146/24-25
54 Karen Rees 21 October 2024 162/23
55 Karen Rees 21 October 2024 146/2-4
56 Karen Townsend 4 November 2024 39/10-13
57 Karen Townsend 4 November 2024 39/14-18
58 Karen Townsend 4 November 2024 41/18 to 42/2
59 Karen Rees 21 October 2024 213/8-11
60 Karen Rees 21 October 2024 213/4-7
61 Karen Rees 21 October 2024 149/1-5
62 Alison Kelly 25 November 2024 126/6-10
63 Alison Kelly 25 November 2024 127/23-25
64 Alison Kelly 25 November 2024 129/25 to 130/2
65 Alison Kelly 25 November 2024 127/2-6
66 Alison Kelly 25 November 2024 128/1-3
67 Alison Kelly 25 November 2024 128/25 to 129/2
68 INQ0005749/2

69 INQ0004593/2
70 Eirian Powell 17 October 2024 40/6-12
71 INQ0010036
72 INQ0003371/1
73 INQ0105507
74 INQ0010036
75 Dr U 7 October 2024 205/18 to 207/4
76 Dr U 7 October 2024 204/14-21
77 Dr U 7 October 2024 208/5-12
78 INQ0001445/1
79 Dr U 7 October 2024 209/13-14
80 Dr U 7 October 2024 210/23 to 211/9
81 INQ0001522/18
82 INQ0001522/48
83 Dr Stephen Brearey 19 November 2024 245/24 to 246/7
84 Dr Stephen Brearey 19 November 2024 246/7-10
85 Dr John Gibbs 1 October 2024 109/11-19
86 INQ0000569/13-14
87 Dr U 7 October 2024 201/15-17
88 Dr U 7 October 2024 202/1-8
89 INQ0001582/2
90 INQ0001542/2-3
91 INQ0001582/1-2

Chapter 12. Safeguarding

Background

12.1 I am required to consider whether, and to what extent, in 2015/16, the Countess had guidance or procedures in its policies about the steps that should be taken if a staff member was suspected of harming a child. The Inquiry sought evidence from those working at the Countess, as to whether such policies and procedures that existed were followed.

12.2 Keeping children safe is everyone's responsibility. Principles in statute and statutory guidance about safeguarding children apply to NHS organisations. In addition, hospitals have their own internal safeguarding policies. Such policies, including those at the Countess, often focus on protecting children from abuse by parents and family members. That is because it is within the family that most abuse occurs. In the Countess's safeguarding policies, there is no explicit reference to the possibility that members of staff, including healthcare professionals, may be responsible for deliberate harm to a patient. Whilst this is very uncommon and highly unlikely, it happens. The crimes of Harold Shipman, Beverly Allitt and Victorino Chua, amongst others, are plain evidence of that. That the issue is touched on in other policies at the Countess (HR/Grievance) does not address this significant omission from a hospital safeguarding policy.

Legal framework

12.3 The Children Act 2004 (the 2004 Act) amended the Children Act 1989 and introduced obligations upon local authorities to promote cooperation between the authority and each of its 'relevant partners' with a view to improving the well-being of children in a number of areas, including protecting them from harm and neglect.[1] NHS England and any ICB which falls within a local authority area are both 'relevant partners' within the meaning of the 2004 Act.

12.4 Section 11(2) of the 2004 Act requires each person and body to whom the section applies to ensure that:

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

12.5 Section 11 of the 2004 Act applies to NHS England, all ICBs, all NHS Foundation Trusts and any NHS Trust where all or most of its hospitals, establishments and facilities are situated in England.[2] This legislative framework governs child protection in the context of health agencies and places obligations on NHS Trusts and hospitals to protect and promote the welfare of children.

12.6 The statutory guidance in relation to safeguarding, *Working Together to Safeguard Children* (usually referred to as Working Together), first published in 1999, is a long-standing document* with various iterations. It was in force in 2015/16 and was most recently updated in March 2026. Working Together is a fundamental document for all professionals and bodies with safeguarding obligations.

12.7 The 2015 version of the Working Together guidance includes that:

a. "[T]*he child's needs are paramount.*"[3]

b. "[A]*ll professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children.*"[4]

c. "[A]*ll professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care.*"[5]

d. "*Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.*"[6]

e. "[S]*afeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part.*"[7]

f. "[E]*veryone who comes into contact with them* [children] *has a role to play in identifying concerns, sharing information and taking prompt action.*"[8]

g. "*Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children.*"† [9]

h. "*Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:*

…

no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care."[10]

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* A version of 'Working Together to Safeguard Children' with similar obligations was initially published in 1999. It was revised in 2006 following the public inquiry into the death of Victoria Climbié. It has been subject to various updates since.

† Dr Joanna Garstang agreed that this was an important principle.

12.8 Critically, Chapter 2 of Working Together 2015 also states that all NHS organisations are required to have "*clear policies in line with those from the LSCB* [Local Safeguarding Children Board] *for dealing with allegations against people who work with children*":

> "*Such policies should make a clear distinction between an allegation, a concern about the quality of care or practice or a complaint. An allegation may relate to a person who works with children who has:*
>
> - *behaved in a way that has harmed a child, or may have harmed a child;*
> - *possibly committed a criminal offence against or related to a child; or*
> - *behaved towards a child or children in a way that indicates they may pose a risk of harm to children.*"[11]

12.9 Whilst Working Together still sets out the statutory guidance, NHS England in their closing submissions made reference to the current existence of the National Safeguarding Steering Group, chaired by the Deputy Chief Nursing Officer for England, which is charged with identifying and disseminating common issues, emerging trends and learning. It also mentioned the fact that safeguarding issues can now be referred to NHS England's regional teams. NHS England also referred to *Managing Safeguarding Allegations Against Staff: Policy and Procedure (Updated 2019)*, which provides that the LADO and, where necessary, the police must be notified in writing within 24 hours of the allegations being received.[12] These current policies and steering groups are dependent for their effectiveness on the initial sharing of information.

12.10 Dr Joanna Garstang is an expert on the investigation of unexpected child deaths. She is a community consultant paediatrician and Clinical Associate Professor of Child Protection at the School of Nursing, University of Birmingham. She gave detailed and authoritative evidence about safeguarding. She pointed out that it was one of the key mantras of safeguarding that no child has ever died because people shared too much information: it is always better to share information. Furthermore, she stated: "[P]*rotecting children is your fundamental responsibility and not the adults or organisations or anything else around them and … always keep children at the forefront.*"[13]

Safeguarding policies at the Countess in 2015/16

12.11 The Countess's Safeguarding and Promoting the Welfare of Children Policy in 2015/16[14] (the Safeguarding Policy), dated September 2015, opens with an executive introduction by Ms Kelly, who is described in the document as Executive Lead for Safeguarding. It referred to the Children Act 1989 and the Children Act 2004, as well as Working Together 2013. The policy was updated over time, with minor changes to various appendices and the reference to Working Together 2013 being changed to Working Together 2015.[15]

12.12 The policy offers limited guidance in respect of steps to take if a staff member is suspected of harming a child.

12.13 Section 5 of the policy addresses the issue of: 'Supporting Staff and Voicing Concerns'. Under the subheading 'Escalation and Resolution', it states:

> "*If at any point a member of CoCH* [the Countess] *staff feels that their concerns about a child are not being acted upon appropriately they must discuss this with the safeguarding children team who will take responsibility for ensuring the case is appropriately managed within the CoCH … If the child is within the hospital setting, he/she should not be discharged until CoCH staff can conclude that their concerns are being addressed in the child's best interests. Any unresolved issues will* [b]*e managed as per LSCB escalation policy which can be accessed via (CoCH intranet).*"[16]

12.14 It continues with the subheading 'Speak Out Safely (Raising Concerns about Patient Care) and Whistle Blowing Policy', which sets out the following:

> "*It is the responsibility of all members of staff, medical, clinical or non- clinical, to ensure that high standards of care, treatment and services are provided at all times for patients and that all patients are* ***safely*** [emphasis in original] *in our care. From time to time, staff may have concerns about the care or treatment given to any patient(s), including* ***children and young people*** [emphasis in original]*, and may wish to discuss these with managers. 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. All staff must comply with the Trust Values and put patients at the heart of everything they do.*"[17]

12.15 Whilst this section contemplates allegations being made against staff, there is no guidance about what to do about protecting the patient.

12.16 The final subheading in section 5 of the policy is 'Human Resources Department'. It reads:

> "*The Trust will comply with current National Guidance on the recruitment of staff and will act with speed to any allegations of 'professional abuse' in accordance with the guidelines set out in* ['*]Working Together to Safeguard Children' (DCSF 2015) and the Cheshire LSCB Manual of Procedures. The CoCH will identify a senior manager who will have responsibility for referral* ***(where appropriate)*** [emphasis in original] *and ongoing liaison with the Local Area Designated Officer (LADO) in the LSCB regarding an allegation made against a CoCH member of staff. More information regarding Safer Recruitment, Guidance for Safer Working Practice for adults who work with children and young people, Allegations Procedures, are all available via the LSCB website see (CoCH intranet).*"[18]

The contact details for the LADO then follow.

12.17 This suggests that such issues were categorised as an HR or disciplinary issue rather than principally a safeguarding matter.

12.18 The hospital's Speak Out Safely (Raising Concerns about Patient Care) and Whistleblowing Policy (known as the Speak Out Safely Policy) also addresses the situation where there are concerns about a staff member who has or may have harmed a child. It employs the wording of Working Together 2015 and states:

> "*If there is a concern raised or an allegation made about a person who works with children, whether a professional, staff member, foster carer or volunteer that they may have: -*
>
> - *behaved in a way that has harmed a child, or may have harmed a child*
> - *possibly committed a criminal offence against or related to a child or*
> - *behaved towards a child or children in a way that indicates s/he is unsuitable to work with children, then the process outlined below should be followed.*"[19]

12.19 The process outlined in the Speak Out Safely Policy is as follows:

> "*The member of staff raising the concern should first discuss this matter with the Professional Head / Lead Clinician or Head of Service for their Division (named senior officer). These managers will have responsibility for allegations management and will liaise with the LADO within the children's safeguarding unit, Local Authority.*"[20]

12.20 The requirement to make a LADO referral was also contained in the Trust's Disciplinary Policy. The Inquiry's version of the Trust's Disciplinary Policy was provided by Ms Dee Appleton-Cairns, Deputy Director of People and Organisational Development (HR).[21]

12.21 Appendix 6 of the Disciplinary Policy states:

> "*If there is a concern raised or an allegation made about a person who works with children, whether a professional, staff member, foster carer or volunteer that they may have: -*
>
> - *behaved in a way that has harmed a child, or may have harmed a child*
> - *possibly committed a criminal offence against or related to a child*
>
> …
>
> *The member of staff raising the concern should first discuss this matter with the Professional Head/Lead Clinician or Head of Service … These managers will have responsibility for allegations management and will liaise with the LADO within the children's safeguarding unit, Local Authority*."[22]

12.22 In addition to the Countess's internal guidance, there was also Pan-Cheshire guidance. The local guidance in the Pan-Cheshire CDOP protocols stated (in the context of child deaths): "*Where, at any stage, a child may have been or* [is] *likely to be harmed* [emphasis in original]*, there will need to be interagency child protection and/or criminal investigation led by the Police*."[23]

12.23 The evidence of Mr Paul Jenkins (the LADO at the time, employed by Cheshire West and Chester Council) was: "[I]*t is my view that once hospital employees started to suspect an individual, a LADO referral should have been made.*"[24]

12.24 Save for referral to the LADO, there is no practical guidance regarding the steps to be taken where there are allegations against a staff member. Who should be spoken to first if abuse is suspected (the individual's line manager or the safeguarding team, for example)? When should the LADO referral be made? Notably, the details of the senior manager who is responsible for referrals to the LADO, as a point of contact for staff, are absent.

12.25 Dr Garstang's evidence was that a healthcare professional with concerns about a member of staff harming children should go to the safeguarding team in the organisation. She said she would not expect a paediatrician on the ward to directly call the local authority, but the safeguarding team should support or encourage the paediatrician to make the referral.[25] At the Countess, the consultant paediatricians raised their concerns with the most senior managers, including Ms Kelly, but no one recognised that their concerns raised safeguarding issues.

The safeguarding team at the Countess

12.26 The principal members of the Countess's safeguarding team were:

a. Ms Kelly – Executive Lead for Safeguarding

b. Dr Howyada Isaac – Named Doctor for Safeguarding

c. Ms Karen Milne – Named Midwife/Professional Safeguarding Children/Lead Domestic Abuse

d. Ms Sindall – specialist safeguarding children's nurse (band 7).

12.27 In addition to these individuals, Dr Mittal was the Designated Doctor for Safeguarding and Child Deaths, employed by what was the CCG and is now the ICB. He was also a member of the Pan-Cheshire CDOP.

12.28 The safeguarding team were responsible for training staff on safeguarding. They should have been the first point of call for any member of staff who had a safeguarding concern and they should have ensured that any safeguarding concerns were appropriately escalated, including to outside agencies.

12.29 The safeguarding team collectively fell short in every one of these roles.

12.30 Despite professed awareness within the safeguarding team of the case of Beverly Allitt and the Allitt Inquiry's recommendation to be alert to the possibility of malevolent intervention by health professionals as a cause of unexplained clinical events, the training delivered did not include information about the possibility of a staff member harming children. Whilst there were reportedly high levels of compliance with safeguarding training, there remained widespread ignorance amongst the clinical staff questioned by this Inquiry that a concern about a nurse possibly acting to harm babies was an issue of safeguarding. There were also staff who demonstrated by words and actions that they did not understand the fundamental principle that a concern that babies **may** have been harmed, or the **possibility** of a criminal offence, was sufficient to

initiate safeguarding measures.‡ Finally, amongst the paediatricians, there was a lack of familiarity with the SUDIC protocol, which required a multidisciplinary investigation in any case of unexpected child death, even where that was the neonatal death in hospital of a child who had never been home.

12.31 In respect of the deaths on the neonatal unit, the safeguarding team were not considered at all. As a result, they were informed about concerns about Letby long after others, including external consultants such as Dr Subhedar.

12.32 Despite the consultants raising with the executives concerns about deliberate harm, a LADO referral was not made by Ms Kelly, the Executive Lead for Safeguarding, until March 2018.

12.33 Ms Sindall (née Lewis), a nurse and health visitor, began working at the Countess in 2009 as a specialist safeguarding children's nurse (band 7), reporting to Ms Milne.

12.34 Ms Sindall's evidence was that there was "*a lot of pressure*" on the children's safeguarding team at the hospital, due to the size of the team in proportion to the workload.[26] She explained that "*every other month*" there were safeguarding peer review meetings designed to share learning from cases, but she stated: "[O]*ur workload was so heavy at times that I couldn't often attend.*"[27]

12.35 Ms Sindall was responsible for delivering safeguarding training, the content of which had been compiled by Ms Milne. The training was aimed at staff who had regular contact with children and families. Ms Sindall trained the neonatal and paediatric nurses, whilst Dr Isaac, the Named Doctor for Safeguarding, trained the paediatricians. In addition to 'in-person' training, the paediatricians and neonatal and paediatric nurses also had to complete online safeguarding training.§

12.36 Ms Sindall was clear that the Working Together guidance and the Countess's policies, namely the Safeguarding Policy and the Speak Out Safely Policy, set out that a concern about deliberate harm to a child "*would necessitate a referral to the LADO and that would then involve a strategy discussion about whether the police should be involved*", noting that "*you didn't need to wait for the outcome of an investigation*" prior to any referral. She confirmed that "*you didn't need evidence*" to raise, or escalate, a safeguarding concern.[28] This was an important point that had not been absorbed by any of the people dealing with the deaths on the neonatal unit. On a number of occasions, I heard from managers at different levels (Ms Rees, Ms Hodkinson, Ms Kelly, Mr Harvey) that there was no evidence.

12.37 Ms Sindall was aware of the Beverly Allitt case and the Allitt Inquiry's recommendation for heightened awareness amongst all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events. In evidence, she accepted the safeguarding training she delivered to staff on the neonatal unit did not contain information about a staff member causing deliberate harm. She reflected: "*Maybe we should have included a scenario that involved where a child had been harmed*

‡ The best example of this is probably the refusal by Ms Rees to remove Letby from the neonatal unit following Dr Brearey's request due to a lack of 'proof'.

§ In 2015/16, the CCG set a target that 80% of Group 3 staff had to complete the Group 3 safeguarding training. Completion of the training was monitored in staff appraisals.

by a professional." But she noted that training focused instead on the more likely scenario that a child was harmed by people within the family.[29] On questioning, she accepted that "*it's very hard to think that somebody in a position of care and that's trusted to provide that care and to -- to provide safe care would deliberately want to harm*" and that "*it's a natural thing for people to say 'surely not'*". Ms Sindall acknowledged that it was for this reason that safeguarding training about the possibility of deliberate harm was so important.[30]

12.38 In addition to in-person and online training on safeguarding, every clinical area in the hospital, including the neonatal unit, was required to have a safeguarding noticeboard. Communications about safeguarding initiatives were also sent out electronically. Ms Sindall stated there was a flowchart on the noticeboard of the neonatal unit outlining steps to take if a professional considered a child had been abused. Significantly, she could not recall whether the noticeboard contained any information related to situations regarding concerns about a member of staff causing deliberate harm.[31]

12.39 Ms Sindall confirmed the Countess's Safeguarding Policy also did not provide a step-by-step guide detailing what to do if someone had concerns about a staff member causing deliberate harm.[32] However, a key message of the training was to encourage staff to contact the safeguarding team if they had concerns, instead of deciding themselves whether the threshold for further action had been met. Ms Sindall's role involved responding to enquiries and concerns raised by any staff, but most typically she received enquiries from nursing staff. Ms Sindall visited the neonatal unit around once a week, usually prompted by a safeguarding concern regarding children being discharged from hospital to parents/families.[33] Ms Sindall's evidence was that, if concerns had been reported to her about a nurse harming babies, she would have recognised this as a safeguarding issue and triggered the safeguarding process.[34]

12.40 Ms Sindall acknowledged that no one raised concerns with her about the neonatal deaths or alerted her to suspicions of deliberate harm. In fact, despite visits to the neonatal unit, she was not even made aware that a nurse had been moved off the unit. Even when the RCPCH were commissioned to conduct a review into the increased mortality rate, she did not know that a number of the deaths were sudden and unexpected and/or unexplained.

12.41 Ms Sindall was not sure when she first became aware of the consultants' concerns about Letby, although the detail she gave suggests it was in April or May 2017. After Ms Milne had had a meeting with Ms Kelly, she told Ms Sindall that the Trust "*were about to call the police in relation to concerns that somebody was -- that a member of staff was involved in harm to the babies on the neonatal unit*".[35] Ms Sindall commented in her evidence:

> "[T]*he LADO should have been informed immediately … you would be able to pick up the phone, speak to the LADO and say: we are going to make a formal referral but this is the concern. And I'm fairly sure, knowing the LADOs that I have had contact with, that they would have been discussing the need to inform the police.*"[36]

12.42 The RCPCH in their written closing submissions accepted that their then current safeguarding competency framework for paediatricians did not refer to the LADO, noting that this was now being revised. This explains why none of the paediatricians suggested referral to the LADO. Ms Sindall could not explain why the senior managers and executives did not immediately contact the LADO in response to the consultants'

concerns, and was "*surprised*" that they did not.[37] None of the senior managers or executives explained the failure to contact the LADO in light of the consultants' concerns. This was a serious failure.

12.43 Once a possible connection had been made between the increase in neonatal deaths and a member of staff, the hospital safeguarding team should have been contacted. Primacy should have been given to keeping babies safe. Instead, time was spent on a 'wait and see/monitor and alert' policy and, after further deaths, trying to find a cause for the deaths other than deliberate harm. It does not seem to have been considered that such an approach did not preclude taking steps to keep babies safe. Safeguarding action could and should have been taken immediately. Investigations of other potential causes of increased mortality could have taken place at the same time. The concerns about Letby should have been taken to the LADO. Letby should and would have been excluded from the neonatal unit pending investigation. Mr Harvey's sequential approach was directly contrary to safeguarding principles. HR considerations trumped patient safety.

Dr Isaac

12.44 Dr Isaac was the Named Doctor for Safeguarding. That role is set out in the Working Together statutory guidance, which provides that named professionals have a key role in promoting good professional practice within their organisation and providing safeguarding advice and expertise to fellow professionals.[38] Dr Isaac failed to perform this role in relation to the concerns about Letby.

12.45 Dr Isaac was allocated one day a week for the Named Doctor for Safeguarding role; she considered that was sufficient time to fulfil her responsibilities.[39]

12.46 In evidence, Dr Isaac was referred to a 2015 Safeguarding PowerPoint presentation she had created with Ms Sindall. She explained the presentation was used to provide training to all hospital staff and a key message of the training was that safeguarding is everyone's business and staff should contact the safeguarding team if they had concerns.[40] Dr Isaac said that safeguarding professionals are taught to "*think the unthinkable*".[41]

12.47 Dr Isaac was responsible for the clinical and strategic aspect of safeguarding in the hospital and reported to Ms Kelly. Despite Ms Kelly being her line manager, Dr Isaac did not have one-to-one meetings with her and stated that there was no close working or supervising relationship. The pair did meet, however, at Safeguarding Strategy Board (SSB) meetings.[42]

Safeguarding Strategy Board

12.48 The SSB, chaired by Ms Kelly, reported to QSPEC. Other members of the board were Ms Millward, Dr Mittal and Dr Isaac. Its responsibilities included ensuring systems, processes and reporting mechanisms were in place to detect, prevent and respond to concerns about abuse or neglect, and ensuring that the hospital reported safeguarding concerns to external agencies. The Terms of Reference for the board also made provisions for emergency meetings to be called where necessary.[43]

12.49 Dr Isaac's view was that she would expect serious safeguarding matters to be discussed one to one before being brought to the board, but that she could not recall Ms Kelly ever informing her about any serious safeguarding issues.[44]

12.50 The SSB failed to play any role in detecting, preventing or responding to concerns about Letby. Between 23 July 2015 and November 2017, there were six meetings. There was no mention at any of the meetings during 2015 or 2016 of the increase in neonatal deaths or of consultants' concerns that Letby's presence on duty at the neonatal deaths needed investigation and action. Neither the increase in neonatal mortality nor the police investigation was mentioned in the papers for this board until November 2017.[45]

12.51 The November 2017 board meeting made reference to the 'Safeguarding Children Annual Report 2016–2017' by Ms Milne.¶ A section of the report was headed 'COCH Neonatal Unit Investigation'. The section does not contain any reference to the consultants' concerns about a staff member causing deliberate harm. This may be explained by the fact that the police were investigating (as was known publicly), but at that time the fact that a nurse was being investigated was not in the public domain and it was reasonable not to refer to the consultants' concerns.

12.52 I note that, at paragraph 6.4 of the 'Safeguarding Adults Annual Report 2016–2017' (also referred to in the November 2017 board meeting), there was reference to a rewritten policy for safeguarding concerns against staff working in adult care. The paragraph reads:

> "***6.4 Allegations against Staff regarding Safeguarding Concerns*** [emphasis in original]. *Currently we work closely with our DASM – Designated Adult Safeguarding Manager at the local authority, we also have our own local processes. We have re-written our local policy to provide guidance and continuity when addressing cause for concern and allegations against staff however we will now need to wait until the new 'persons in a position of trust' document overarching recommendations are in place and change ours accordingly. Recently ward staff have been invited and attended safeguarding adult strategy meetings with the Safeguarding Lead, this is positive for both the investigation as well as the staff in terms of increasing their knowledge and awareness of the safeguarding process.*"

12.53 This demonstrates that it was recognised at the Countess that staff were capable of harming adults. No question was raised by the SSB about the need for a policy for safeguarding concerns about staff working with children.

12.54 The failings in the Countess's approach to safeguarding, and in the oversight of the SSB, undermine CQC's findings in February 2016 that the Countess had safeguarding policies and procedures in place and that staff "*were aware of their roles and responsibilities, and knew how to raise matters of concern appropriately*".[46] I accept that some staff were aware of their roles and responsibilities, but it is not at all clear that they knew "*how to raise matters of concern appropriately*" in respect of members of staff and what steps CQC took in their inspection to reassure themselves that they did.

12.55 This is an example of the inadequacy of the way in which governance is scrutinised by CQC, as submitted by Family Group 1 in their closing statement.[47]

¶ The report was dated July 2017.

12.56 The most serious safeguarding issue that could arise in a hospital, that of a member of staff deliberately harming babies on the neonatal unit, was neither referred to the Designated Doctor for Safeguarding and Child Deaths, nor raised appropriately as a safeguarding issue, nor discussed at the SSB, despite the facts being known to the Chair of the board, Ms Kelly, certainly by May 2016.

Failure to escalate the concerns and make a safeguarding referral

12.57 Dr Isaac's evidence was that the hospital's Safeguarding Policy was in line with the Working Together 2015 guidance,[48] which provided that NHS organisations should have clear policies for dealing with allegations against people who work with children. Further, her view was that the evidential threshold in the hospital policy to escalate a concern was that an individual "*may*" have harmed a child or pose a risk to a child, and they had "*possibly*" committed a criminal offence. Suspicion was the threshold to escalate a safeguarding concern or make a referral – for example, to the LADO – not a higher "*balance of probabilities*" test.[49]

12.58 Whilst Dr Isaac understood the basic principles of safeguarding, that did not translate into action when faced with an actual concern. On 22 November 2016, Dr Brearey informed Dr Isaac "*about the increase in mortality rate going up to 13 babies from being 1 to 3* [per annum] *and that this nurse was on duty every time a baby died and they've had concerns*".[50]

12.59 Dr Isaac accepted she understood that Dr Brearey was concerned that a nurse was deliberately harming babies, and that she perceived he was "*sincere*" in his concerns. Notwithstanding this, her evidence was that "*at the time that wasn't regarded as safeguarding and I suspect that's why my colleagues haven't approached me as a safeguarding lead*".[51] Dr Isaac's evidence was that Dr Brearey had told her he had escalated it to the managers, but they had not responded to him.[52]

12.60 Dr Isaac made the following observations as to why she considered the consultants did not approach the safeguarding team about their concerns:

- It was not the "*typical safeguarding scenario*" of a child coming to the hospital with bruises or injuries.
- At the time, the issue was not as clear cut as it is now.
- The executives had already been informed of the consultants' concerns and Letby had been moved to a non-clinical role.
- "*A member of staff causing harm to babies and murdering babies was thought to be like more of a crime that would require police investigation.*"[53]

Despite giving evidence that she perceived Dr Brearey to be "*sincere*" in his concerns and that she was aware he was talking on behalf of the entire consultant body when he first expressed his concerns to her in November 2016, Dr Isaac did not make a safeguarding referral.[54]

12.61 Dr Isaac's evidence as to why she did not make a referral was as follows:

> "*I was waiting to see what would come out of the reports because you say you don't have to be sure to raise the alarm bells, which is correct, if you have suspicions, that's correct. But when you are making a referral you want to give a good quality referral.*
>
> *And a lot of people were saying at the time … 'This is just a coincidence, you can't blame a member of staff because of rise of mortality. You need to look into medical causes first. You need to look into competencies. There could be other possibilities.'*
>
> *But now, with the benefit of hindsight, we know that she was guilty but at the time we didn't.*"[55]

12.62 This evidence underlines Dr Isaac's unconscious raising of the bar from suspicion to the need to exclude all other possibilities before acting to protect children. The reason suspicion is enough to trigger safeguarding protocols is that it is imperative to protect children, here babies on the neonatal unit. A member of staff in a hospital is in no different a position from a teacher in a school. In that setting, suspicion leads to action, however unfair that may turn out to be to the teacher.

12.63 Dr Isaac gave evidence that she knew the grievance process had concluded and there was a possibility of Letby returning to the neonatal unit; however, she was not aware of a set date. She stated: "*If she were to be returned to the ward, I definitely would have escalated it.*"[56]

12.64 On 7 February 2017, almost three months after Dr Brearey had shared his concerns, Dr Isaac "*wrote a letter to Alison Kelly to express concerns about safeguarding the children*".[57] In the letter, Dr Isaac enquired about the outcome of the reviews into the neonatal deaths and wrote that further investigation may be warranted. She did not send the letter. It was her evidence that one of the reasons she did not send the letter was because there was a "*culture of fear*": "[T]*he Consultants were threatened to lose their jobs, they were told that a red line is drawn under this.*"[58]

12.65 Although the Working Together guidance makes clear proof or certainty of causing harm is not necessary to make a safeguarding referral to the local authority and there is no evidentiary threshold, Dr Isaac said "*I wanted more evidence to support me*" before she sent the letter, and she was also waiting for the outcome of the ongoing reviews.[59] Again, the error about evidence (see paragraph 12.57).

12.66 Dr Isaac accepted: "[I]*n retrospect now, with the benefit of hindsight … I do wish I had sent that letter sooner*[**] *and I wish I had escalated it as soon as Dr Brearey told me about this issue* [in November 2016]."[60] She agreed that drafting a letter to Ms Kelly was not an adequate response[61] and accepted that she should have ensured the matter was raised as a safeguarding issue, including referral to the LADO[62] and the police.[63]

12.67 An alternative route that was open to Dr Isaac, but which she did not take, was to escalate issues first to Dr Mittal, and subsequently to the LADO.

** Although she states that she wished she had sent the letter sooner, Dr Isaac confirmed that she did not send the letter at all.

Dr Mittal

12.68 In 2009, Dr Mittal had joined the Countess as a consultant paediatrician specialising in Community Paediatrics and Child Health. As part of his role, he became the Designated Doctor for Safeguarding and Child Deaths. His area was Cheshire West and Chester and Vale Royal, which included the Countess. He had four hours a week allocated for this role, which was funded by the ICB.

12.69 Dr Mittal explained that, if a safeguarding issue arose at the hospital, the first person to be approached was Dr Isaac, the Named Doctor for Safeguarding. However, he acknowledged that, because he was the Designated Doctor for Safeguarding and Child Deaths, he also had a responsibility for safeguarding issues at the hospital.

12.70 In September 2015, Dr Mittal was involved in an email exchange with Dr Gibbs regarding deaths on the neonatal unit. In the email dated 28 September 2015, Dr Gibbs had written: "[W]*e've had another neonatal death.*"[64] In evidence, Dr Mittal accepted that, in hindsight, the wording used by Dr Gibbs suggested there may have been a developing trend and he should have been more curious from this point and asked Dr Gibbs questions.[65] Despite being based on the same corridor as the other consultant paediatricians, Dr Mittal did not approach his fellow clinicians to ask about the increased number of deaths. He accepted that, "*in hindsight*", he "*should have explored these more*".[66]

12.71 Dr Mittal was aware that the neonatal unit had been downgraded in July 2016 and that this was due to an increase in the neonatal mortality rate. He stated in hindsight that this should have been a prompt for him to speak to the consultant paediatricians about what was going on with the deaths. His evidence was: "*I did not recognise the trend until I was called by the Royal College* [of Paediatrics and Child Health] *about that cluster of deaths.*"[67]

12.72 The dissemination version of the RCPCH report was published in February 2017. The confidential version of the report, produced in November 2016, was never shared with Dr Mittal. At the time, he was not aware there were two versions.[68]

12.73 In February 2017, Dr Isaac told Dr Mittal about the letter she had drafted to Ms Kelly regarding concerns. Although Dr Isaac did not share the details with him, Dr Mittal knew it related to safeguarding concerns and that Dr Isaac was fearful of the consequences if she sent the letter because there was "*tension going on between the paediatricians and the management because people were applying for jobs elsewhere at that time*".[69]

12.74 Dr Mittal said he told Dr Isaac that she was right to raise her concerns with Ms Kelly, but he did not follow up to see whether she had done so. Dr Mittal accepted in his oral evidence that, "*in hindsight*", he "*should have been more proactive*". He acknowledged, "*I should have intervened at that time*."[70] It is right to point out that there had been no deaths on the neonatal unit since Letby had been removed. This did not mean a referral to the LADO was unnecessary. In fact, by February 2017, Letby was still working in the hospital and the consultants still had concerns about her possible return to the neonatal unit. The need for a referral of the situation to the LADO persisted. Dr Mittal accepted in his evidence that he should have been thinking about formal action such as a LADO referral around February 2017.[71]

12.75 Subsequently, during a meeting at the hospital on 27 April 2017, which he attended at the request of Ms Hayley Frame, Independent Chair of the Pan-Cheshire CDOP, Dr Mittal learnt that the consultants had concerns about a staff member's involvement in neonatal deaths. Despite what he had heard at the meeting, he again failed to initiate any safeguarding action.[72]

12.76 When asked why he did not initiate any safeguarding action in April 2017, Dr Mittal answered it was because the police and Medical Director were involved by that stage and he considered: "[T]*his has now gone at a higher level. So I didn't even think at that time that I should be dealing with it at safeguarding level.*"[73] He agreed that he should have been thinking about safeguarding and taken safeguarding action.[74]

12.77 Despite his involvement with the CDOP and the fact he was notified of all the neonatal deaths, he failed to show any professional curiosity and failed to initiate safeguarding procedures.

12.78 Working Together stated that "*designated professionals, as clinical experts and strategic leaders, are a vital source of … advice and support to other health professionals*".[75] Dr Mittal failed to provide that advice and support. He accepted in his evidence that he had a responsibility to ensure that staff at the Countess understood that the SUDIC process should be followed for inpatient neonatal deaths.[76] As a matter of fact, this was not understood.

12.79 Dr Mittal said that none of his colleagues at the hospital asked him whether the SUDIC protocol applied to any of the deaths they had dealt with, presumably due to the widespread misunderstanding that it was not applicable in the case of neonatal deaths in hospital.[77] Dr Mittal, likewise, took no steps to enquire of his colleagues whether the SUDIC protocol was being correctly followed, despite learning of neonatal deaths through the CDOP.

Findings

12.80 The failures in safeguarding occurred at every level of the hospital: nurses, doctors and executives failed to identify concerns about Letby as being an issue of safeguarding. All the Countess's executives and senior managers failed to follow safeguarding processes. However, particular opprobrium attaches to Ms Kelly, for her repeated and serious failures to ensure appropriate safeguarding responses were initiated. As the Executive Lead for Safeguarding, she should have ensured that the concern about Letby harming babies was referred to the LADO and indeed to the police. She did not refer the matter until March 2018, and when she did, the referral contained inaccuracies and was misleading.[78]

12.81 Although Mr Harvey[79] and Mr Chambers[80] both said they would have looked to Ms Kelly for advice on whether the circumstances raised a safeguarding issue, this does not absolve them of their own responsibility for failing to initiate safeguarding procedures. Mr Chambers' accountability was affirmed in the Countess's Safeguarding Policy dated September 2015: "*The Director of Nursing … is the Executive Lead for the Trust with the responsibility of Safeguarding Children, acting for the Chief Executive who maintains accountability*."[81] In relation to Mr Harvey, the 'Safeguarding Children Annual Report

2015–2016' noted that both "*the Director of Nursing and the Medical Director will be informed as a matter of urgency*" where there has been a referral to the LADO.[82] As Working Together emphasises, safeguarding engages individual responsibility:

> "*This statutory guidance should be read and followed by … senior managers within organisations who commission and provide services for children and families, including … professionals from health services*
>
> …
>
> *All relevant professionals should read and follow this guidance so that they can respond to individual children's needs appropriately.*"[83]

Pan-Cheshire CDOP

12.82 The Pan-Cheshire CDOP covers Cheshire East, Cheshire West and Chester, Halton, and Warrington. In 2015/16, the panel had the following members of material relevance to the Inquiry:

a. Ms Hayley Frame – Chair

b. Dr Mittal – Designated Doctor for Safeguarding and Child Deaths for the ICB

c. Ms Sharon Dodd – Paediatric Liaison and CDOP Nurse Representative, Cheshire and Wirral Partnership NHS Foundation Trust

d. Detective Superintendent Nigel Wenham (later Detective Chief Superintendent) – Deputy Head of the Public Protection Directorate, Cheshire Constabulary.††

12.83 DCS Wenham explained in evidence that there is a police representative on all CDOPs. Prior to every Pan-Cheshire CDOP meeting, members were provided with an agenda that included which children would be discussed. One of the roles of the police member was to search the police database for any relevant information about the child.[84]

12.84 Ms Hayley Frame was appointed as the Independent Chair of the Pan-Cheshire CDOP in 2015. She had qualified as a social worker in 1995 and worked in local authority children's social care for 13 years, covering matters relating to child protection and safeguarding. Following her appointment in 2015, she remained the Chair of the Pan-Cheshire CDOP for two years. The main responsibility of her role was to chair the CDOP meetings. Outside of the meetings, Ms Hayley Frame spent approximately one day a month on the role.[85]

12.85 Ms Hayley Frame gave evidence that, when she was appointed as Chair of the Pan-Cheshire CDOP in 2015, "*there was a significant amount of work to do to get the CDOP to be fit for purpose*".[86] This included the fact that there was a "*very large backlog of child deaths that hadn't been through the process*".[87] Thus, instead of having quarterly meetings, she increased the frequency to once every two months to reduce the backlog.[88]

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†† Nigel Wenham was promoted from Detective Superintendent (DS) to Detective Chief Superintendent (DCS) in December 2016 and the appropriate rank will be used in this chapter depending on the context.

12.86 In addition to the backlog, Ms Hayley Frame outlined several issues that needed addressing, including the lack of compliance with the SUDIC/rapid response process[89] and the quality of information being provided to the panels.[90] Ms Hayley Frame had identified that there was "*minimal liaison*" between the Pan-Cheshire CDOP and neighbouring panels in the NHS North West region, noting that the Pan-Cheshire CDOP was "*only notified of deaths of children whose parents were resident in that area*".[91] This differed from her previous experience in Nottingham, where the CDOP would be notified of all deaths in the area, regardless of the home address. However, having taken on the role of Chair, she considered that liaison with neighbouring panels was not an immediate priority. This was a reasonable decision – addressing the backlog was an understandable priority – but it was the lack of liaison with neighbouring panels that most hindered the Pan-Cheshire CDOP's ability to identify the trend of an increased number of unexpected and unexplained neonatal deaths at the Countess. Of the seven deaths that occurred on the neonatal unit and featured on the indictment, only Baby A, who died in June 2015, and Baby I, who died in October 2015, fell within the Pan-Cheshire CDOP's catchment area. The families of Baby C and Baby D (who died in June 2015) and Baby E (who died in August 2015) all lived outside the area, and their forms were sent to the CDOPs in the appropriate areas. The family of Baby O and Baby P (who died in June 2016) also lived outside the catchment area. Whilst Dr Mittal and Ms Sharon Dodd saw all the CDOP notification forms that had originated from the Countess, Ms Hayley Frame, as Chair of the Pan-Cheshire CDOP, had no awareness of the other deaths that had occurred at the hospital around the time of the deaths of Baby A and Baby I.

12.87 Ms Hayley Frame's evidence was that, during her time as Chair, no trends or patterns were identified in relation to child deaths. She attributed this partly to the backlog: "[I]*t was very difficult in terms of like identifying trends because we were dealing with a backlog as well so we weren't reviewing the deaths in a timely way. So that obviously skews the data as well.*"[92] She was clear that the SUDIC and rapid response meeting process applied to babies who were born in hospitals and died on the neonatal unit: "[i]*f death was unexpected, then the same process applies*" as if the death occurred in the community.[93]

12.88 Ms Sharon Dodd was a qualified nurse, midwife and health visitor working for the safeguarding department at Cheshire and Wirral Partnership NHS Foundation Trust. As part of her role, she acted as the specialist nurse on the Pan-Cheshire CDOP. In large part, her role involved ensuring that information about each child death that had occurred at the Countess was properly communicated to the correct CDOP, depending on the home address of the deceased child.

12.89 In 2015/16, if a death occurred on the neonatal unit, a notification, referred to as 'Form A', would typically be received on paper by either Ms Sharon Dodd or Dr Mittal.‡‡ Occasionally, a clinician would call Ms Sharon Dodd to notify her about the death and she would complete a paper form herself (and the caller would later send their own form).§§ Ms Sharon Dodd processed the Form As and would forward them to the relevant CDOP depending on where the child lived. She explained that her role was to be a "*conduit to inform community practitioners, the LSCB and the designated nurses and my senior managers*" about the deaths.[94]

‡‡ The forms were anonymised with numbers and not the child's name.

§§ Today, the CDOP forms are electronic.

12.90 Following notification of the death, 'Form B' would be completed, setting out the relevant circumstances of the death. This form could be completed by health professionals, police, social services or educational services. Ms Sharon Dodd's role included managing the completion of Form Bs by health professionals. By agreement at the Countess,¶¶ and in keeping with common practice, rather than filling out Form B, paediatricians would forward documents to Ms Sharon Dodd, such as the post-mortem referral letter or discharge letter which contained all the relevant information, thereby avoiding duplication of information and reducing the number of forms that clinicians needed to complete.[95] Ms Sharon Dodd ensured that the Form Bs were complete and forwarded them on to the relevant CDOP, although she emphasised that she did not analyse the content of the forms. Once the panel had considered a case, a final 'Form C' would be completed.

12.91 Ms Sharon Dodd kept a spreadsheet log of all the Form As and Form Bs she had received. Between June 2015 and June 2016, she became aware of 19 neonatal deaths: 13 of those deaths had occurred on the Countess's neonatal unit.[96] Ms Hayley Frame stated she was not aware of the spreadsheet kept by Ms Sharon Dodd, or its contents.[97]

12.92 Ms Sharon Dodd had never known so many deaths on a neonatal unit before, and accepted that her spreadsheet showed a pattern of 13 neonatal deaths at the Countess.[98] Asked why she did not act on the unusual number of neonatal deaths, she stated this was because she had not been alerted to anything unusual about the deaths and thought the babies that had died were sick. However, she accepted that "*with the benefit of hindsight you can look back and say yes, this was very alarming*".[99]

12.93 Despite being present at a Pan-Cheshire CDOP meeting on 24 March 2017, when a redacted version of the RCPCH report was presented and a discussion took place regarding the deaths at the Countess, Ms Sharon Dodd remained unaware of the concerns about Letby. She stated: "*I wasn't aware about the allegations about Lucy Letby for quite some time. In fact, it was when the media were at the hospital, that was the first time I heard her name ever mentioned.*"[100] Ms Sharon Dodd confirmed this was after the police were involved.

12.94 There were errors in respect of some of the deaths of babies that featured on the indictment. Baby A's death was categorised as 'No.8 Perinatal/neonatal event'. Ms Hayley Frame confirmed that the death should have been categorised as 'No.10 Sudden, unexpected, unexplained death'.[101]

12.95 In relation to Baby I, Form C, recording the panel's decision, described the death as 'Sudden'. Notwithstanding this, Baby I's death was categorised as 'No.8 Perinatal/neonatal event'. Ms Hayley Frame said that the death was "*wrongly categorised*".[102] She confirmed that 'No.10 Sudden, unexpected, unexplained death' should have been selected and the SUDIC process should have been initiated. She explained that the panel categorised the death as No.8 because Baby I's post-mortem had a cause of death.

12.96 Whilst the geographic approach of the panels meant that the Pan-Cheshire CDOP was not aware of all the neonatal deaths that occurred at the hospital, had the deaths they considered been correctly categorised as 'Sudden, unexpected, unexplained death', this

¶¶ As set out in an email exchange of 28 September 2015 between Dr Gibbs and Dr Mittal: INQ0103110/1.

should have led to further questions being asked of Dr Mittal regarding deaths at the neonatal unit, and importantly it should have led to questions being asked as to why the SUDIC process was not being used. I am informed that, since these events occurred, changes have been made for reporting deaths to the Pan-Cheshire CDOP. The panel now reviews all deaths in the area irrespective of place of residence and reports these in its annual report. It also sees the minutes of perinatal morbidity and mortality meetings. This is to be welcomed. All CDOPs should review their practices to ensure there are no gaps.

12.97 As I said earlier, Dr Mittal sat on the Pan-Cheshire CDOP. He acted as a liaison between the hospital and all the CDOPs who were notified in the case of any child death. He and Ms Sharon Dodd received all the Form As, which notified panels about a child death. Dr Mittal gave evidence that he "*knew that the number of deaths* [were] *more because of the notification forms*".[103] He commented that, in 2015 and 2016, "*the number of deaths in* [the] *Countess were much more than what we would normally expect in a year*".[104] Dr Mittal said that he and Ms Sharon Dodd discussed that the numbers of deaths were higher than normal; however, the conversation did not go any further than that.[105] No action was taken.

12.98 Dr Mittal's evidence was that, although he had noticed there were more child deaths, he had not noticed an increased neonatal mortality rate. He acknowledged: "[I]*n hindsight I should have but I did not notice at that time.*"[106] The reason he gave was that "*the system was not very structured*".[107] He observed the following:

a. Although he received the Form As, he did not record them on a system.

b. Ms Sharon Dodd, who was based in the Cheshire and Wirral Partnership NHS Foundation Trust office, recorded the Form As and Form Bs on a spreadsheet, rather than a database.

c. Dr Mittal could not access this spreadsheet at the Countess.[108]

12.99 Dr Mittal should also have asked questions as to whether consultants had concerns about the deaths, enquired about the use of the SUDIC protocol, and communicated the increased mortality rates and concerns of the consultant paediatricians to the CDOP.

12.100 Ms Hayley Frame, as the Chair of the Pan-Cheshire CDOP, first became aware of the increased mortality rate in September 2016, after the panel reviewed Baby I's death and it was pointed out that Baby I was subject to a review by the RCPCH. Ms Hayley Frame's evidence was that, at the time of the RCPCH review, "*we didn't know we had anything to be worried about*".[109]

12.101 Ms Hayley Frame confirmed she was not interviewed by the RCPCH and was not spoken to directly by the RCPCH at any time. She considered she should have been. In her view, "[T]*he CDOP and the wider LSCB should have been part of the Terms of Reference. It's -- the fact that that review was done completely in isolation and not in a wider partnership arrangement doesn't make sense to me.*"[110]

12.102 A recorded action from the September 2016 meeting was: "*Item to be added to the November meeting asking if the panel consider that unexpected deaths in Hospital should be referred for RR* [rapid response] *meetings.*"[111] Dr Mittal's evidence was that the

wording used in the minutes did not reflect the position that it was clear that the SUDIC process applied to inpatient neonatal deaths, and the discussion was about raising awareness of this.[112]

12.103 At the meeting on 20 November 2016 (which Dr Mittal attended), the recorded discussion was as follows:

> "*Should a rapid response meeting be held each time there is a sudden unexpected death within a hospital. The meeting felt that the response should be on a case-by-case basis and the safeguarding doctor should be involved in the discussion with the designated doctor and a rapid response should be arranged if deemed appropriate. The meeting felt this process should be reflected in our procedures with clarification of best practice.*
>
> *Action: Ensure that … when the Pan Cheshire procedures are reviewed sudden unexpected death in hospitals are identified.*
>
> *Action: A letter to be sent to hospitals reminding them of the procedure and a requirement for a discussion between key professionals needs to take place.*"[113]

12.104 The final RCPCH report was received by the Countess in November 2016. Section 4.4.25 of the report read:

> "*The RCPCH Review Team was concerned that the CDOP did not appear to be alert to the cluster of neonatal deaths and for at least some there should have been a Rapid Response Meeting within 5 working days of notification.*
>
> …
>
> *Recommendation: The CDOP should consider whether its processes could have detected the cluster of deaths and initiated external review more swiftly.*"[114]

12.105 Ms Hayley Frame first saw the dissemination RCPCH report in February 2017, almost three months after the final report was received by the Trust. Ms Hayley Frame's evidence was that it was "*hugely important*" that the CDOP received this recommendation as soon as possible.[115] Ms Hayley Frame's evidence was that no one at the RCPCH spoke to her about the recommendation. She thought they should have done.

12.106 With regard to the RCPCH review, Ms Hayley Frame accepted: "[W]*e perhaps should have shown more curiosity in terms of who are the children that are subject to this review and we didn't ask those questions.*"[116] When Ms Hayley Frame learnt that the SUDIC process was not being followed by the Countess, she did not speak to Dr Mittal about any of the deaths. She reflected: "[W]*hen I think back that probably was quite passive.*"[117]

12.107 The Pan-Cheshire CDOP had been provided with a redacted version of the RCPCH report (which made no reference to Letby). The panel's meeting on 24 March 2017 discussed its failure to identify trends, considering that this was partly due to the fact the panel only reviewed the deaths of children that lived within a certain geographical area. Further, there was discussion of the failure of the Countess to systematically follow the rapid response/SUDIC process. According to Ms Sharon Dodd, she did not contemplate deliberate harm in this meeting, and no one raised the issue of Letby or concerns about a healthcare professional. The minutes recorded:

> "*The panel discussed SUDI deaths within hospital and whether it was felt that deaths are not always treated with the same concern. It was agreed that a discussion between professionals should always occur and if there was a concern over the death the SUDI protocol should be followed. The panel is aware that on a number of occasions the rapid response process is not followed.* [Ms Gill Frame][***] *suggested that the SUDI process for hospital deaths should be identified within the guidelines.*"[118]

12.108 It is clear that even the CDOP's collective understanding of SUDIC was wrong. The use of the SUDIC process was not dependent on whether there was a "*concern*" and was not down to the discretion of professionals. It was a mandatory process, to be used where the death was sudden and unexpected. Ms Sharon Dodd gave evidence that, at the time "*we were concerned that the SUDIC wasn't followed because of lack of knowledge and lack of education primarily*". She said: "[I]*t was after that that we did some training around use of the SUDIC protocol.*"[119]

12.109 Ms Hayley Frame and DCS Wenham both referred to the significance of the backlog and the inherent delay in considering a death. As the CDOP reviewed deaths after all other processes and reviews were complete, it was not unusual for child deaths to be reviewed by the panel 12 or more months after the death. In the view of DCS Wenham, steps were needed to "*try and improve the timeliness*".[120] DCS Wenham also considered that the fact the panel reviewed a large volume of deaths, between 10 to 20 deaths per meeting, and the cases were listed in isolation, without any system to identify trends on the forms, meant "*there* […were] *gaps in the system in terms of CDOP's ability to identify repeats*" or patterns in the forms.[121]

12.110 The existence of a backlog, and the distribution of cases to panels according to the place of residence of the child, no doubt reduced the CDOP's ability to identify a pattern at the hospital. However, Dr Mittal and Ms Sharon Dodd had both been notified of every child death that occurred on the neonatal unit. They both sat on the Pan-Cheshire CDOP. Ms Hayley Frame accepted that the deaths of Baby A and Baby I should have been categorised as 'Sudden, unexpected, unexplained death'. This, in turn, should have caused the panel to collectively query why the SUDIC process had not been followed and to question Dr Mittal about occurrences and procedures at the Countess. Had such inquiries been made, the extent of the deaths at the hospital would have been exposed and should have been subjected to scrutiny.

12.111 Whilst the Pan-Cheshire CDOP did not identify the concerning trend of unexpected and unexplained deaths at the Countess, it was at the Pan-Cheshire CDOP meeting on 24 March 2017 that the police were first alerted to a potential problem at the neonatal

*** Ms Gill Frame was the Independent Chair of Cheshire West and Chester Local Safeguarding Children Board.

unit. DCS Wenham became aware of the increased mortality rate at the Countess when he read the redacted RCPCH report at the meeting. This 'for dissemination' version of the report made no reference to Letby or concerns about a nurse,††† but it did refer to increased mortality.‡‡‡ DCS Wenham "*left that meeting with some concerns*".[122] His evidence was that, if he had read the unredacted report with the section about the findings about a nurse, then his "*concerns possibly would have been even more heightened and increased*".[123] The CDOP's role was to consider child deaths following all other investigations and identify trends. Given their role, there was no justification for giving them a redacted version of the RCPCH report and thus concealing from the panel that the increased mortality rate at the hospital was possibly linked to the acts of a nurse.

12.112 On 19 April 2017, Ms Debbie Dodd (Mr Harvey's Personal Assistant) emailed Ms Hayley Frame and asked if Mr Harvey could speak with her. Mr Harvey and Ms Hayley Frame had a phone conversation on 20 April 2017. Ms Hayley Frame's evidence was that the call was brief and the reason Mr Harvey contacted her was based on the RCPCH's observation that the SUDIC/rapid response protocol for unexpected deaths was not always followed and that the hospital "*hadn't raised any concerns with the CDOP around the cluster of deaths in a timely way and that they would do so going forward*".[124]

12.113 On 27 April 2017 at the hospital, Ms Hayley Frame and DCS Wenham met Mr Harvey as well as Dr Jayaram and Dr Holt. Dr Mittal was also there at Ms Hayley Frame's request.[125]

12.114 According to Ms Hayley Frame, the beginning of the meeting focused on the investigations into the deaths. However, at some point, the meeting "*shifted*" when they began to discuss "*staff rotas and that there was one member of staff who was on shift during each collapse*". Ms Hayley Frame recalled thinking, "*What, what are we being told here? This, this is gravely concerning.*"[126] This was the first time she became aware there were suspicions a staff member was involved in the deaths.

12.115 Ms Hayley Frame stated it became "*clear that the reviews that had taken place so far hadn't ruled out anything untoward*". Ms Hayley Frame remarked it was "*clear coming out of that meeting that there was something very worrying and Nigel* [Wenham] *had the same view*". She said in evidence that, during the meeting, DCS Wenham had said this was a matter for his officers.[127]

12.116 In the meeting, Ms Hayley Frame was not provided with an explanation as to why she had not been told about the suspicions until this point. Her evidence was that she should have been informed about the concerns when they were raised in June 2016: "*The Child Death Overview Panel needed -- should have been notified of all of the deaths and should have been notified of the concerns.*" Additionally, she asserted: "[T]*he police at the time, the local authority should have been informed so that their Local Authority Designated Officer would be involved.*"[128] Ms Hayley Frame was right about this.

12.117 The paediatricians' concerns were not shared with the Pan-Cheshire CDOP or any other panels. Ms Sharon Dodd said: "*At the time there was nothing to indicate to us that there was a concern and certainly nobody ever said to me that there was anything to be*

††† DCS Wenham confirmed this version did not contain any references to an individual nurse.

‡‡‡ Ms Sharon Dodd gave oral evidence that there were 13 deaths on the Countess's neonatal unit between June 2015 and June 2016.

worried about on the neonatal unit."[129] Ms Sharon Dodd, whilst acknowledging that she was not sure whether Dr Mittal was aware of the concerns at the time, said it was his responsibility to relay those types of concerns to the CDOP.[130] This accorded with what was set out in the RCPCH report of October 2016, which noted: "*When an unexpected paediatric death occurs the paediatrician on call contacts the senior investigating officer on site. For neonates the Designated Doctor for Unexpected Child Death is notified directly and he is responsible for advising the Pan-Cheshire CDOP administration of all deaths, whether expected or unexpected.*"[131]

SUDIC protocol

12.118 The SUDIC process is a multi-agency/joint agency response (JAR) to a sudden and unexpected child death. The SUDIC guidelines apply, irrespective of where a child dies, whether that be in the community or in the hospital. Where there is uncertainty over whether a death is unexpected, the designated paediatrician responsible for unexpected deaths in childhood (in this case, Dr Mittal) should be consulted. The Designated Doctor is responsible for notifying all the other agencies in the JAR of an unexpected death in childhood. This includes the coroner, the police and the local authority.[132] The timescale for notification is in the first two to four hours after the death.[133] The agencies would then meet to discuss the death.

12.119 The protocol applies to sudden and unexpected deaths, not all deaths. Some of the deaths in the Countess in 2015 and 2016 were not sudden and 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.

12.120 The Working Together guidance contained a section headed 'Action by professionals when a child dies unexpectedly'.[134] This included the following definition of an unexpected death of a child: "[T]*he death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which* [led] *to the death.*"[135]

12.121 The April 2015 version of the Pan-Cheshire Guidelines for the Management of Sudden Unexpected Death In Infants and Children (SUDIC) (the Pan-Cheshire Guidelines) expressly stated:

> "*This guidance should be used for the sudden and unexpected death of a child under the age of 18 years irrespective of place of death:*
>
> - *At home or in the community*
> - *In the hospital Emergency Department* ***or in the Ward*** [emphasis added]."[136]

12.122 Identical language was used in the July 2015 version of this document, and both versions of the Pan-Cheshire Guidelines contained flowcharts setting out the pathway after a "*Child Death in Hospital/Community*".[137]

12.123 The Countess's Safeguarding Policy, dated September 2015, gave the following definition of SUDIC: "*The sudden and unexpected death (unexpected in 24 hours prior to death) of a child under the age of 24 months, irrespective of the place of death*." It stated: "*A SUDIC should be managed in accordance with the SUDIC guidelines.*"[138]

12.124 The predecessor to the Countess's Safeguarding Policy, dated October 2013, used the same definition.

12.125 In 2015/16, the Working Together guidance indicated that, in the event of the unexpected death of a child, or where professionals were uncertain about whether the death was unexpected, a certain sequence should be followed:

> "[T]*he consultant clinician … should inform the local designated paediatrician with responsibility for unexpected deaths* [Dr Mittal] *at the same time as informing the coroner and the police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. The paediatrician should initiate an immediate information sharing and planning discussion between lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it.*"[139]

12.126 The Pan-Cheshire Guidelines (April and July 2015) stated: "*Investigation of a SUDIC case is a multi-agency task and all the professionals who are involved in the case are inter-dependent for sharing of information with the proficient level of expertise.*"[140] This included police and local authority involvement.[141] The Pan-Cheshire Guidelines also anticipated discussion with the coroner and the family.[142]

12.127 In the case of Baby A, and all subsequent sudden and unexpected neonatal deaths, there should have been a multi-agency meeting within 72 hours where possible and no later than five days after the child's death. This would have been chaired by a senior investigating police officer. The purpose of such a meeting would have included gathering and sharing information to identify the cause of death and/or those factors that may have contributed to the death and identifying any risk factors or suspicious circumstances. NHS England should also have been notified of the death.[143]

12.128 Importantly, under the July 2015 version of the Pan-Cheshire Guidelines (the relevant version), a final multidisciplinary case discussion should also have been held as soon as the final post-mortem results were available. In Baby A's case, that would have meant a multidisciplinary meeting with police attendance in late December 2015 or early January 2016.[§§§] Had the case discussion taken place and included the later deaths, it may well have meant that concerns about Letby would have been raised, discussed and investigated at a much earlier stage.

12.129 None of this happened. The overwhelming preponderance of the evidence heard by the Inquiry from the safeguarding team and the consultant paediatricians was that it was not understood that SUDIC processes applied to the sudden and unexpected death of a baby in hospital where the baby had never left hospital. As a result, the SUDIC protocol was never applied. This misunderstanding, widespread across the NHS, was acknowledged by the RCPCH in their written closing submissions as prevalent amongst hospital paediatricians.[144] The RCPCH accepted Dr Garstang's views that the 2016 SUDIC guidance failed to make it clear that the guidance was applicable to all sudden and unexpected child deaths, including neonatal deaths in hospital.

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§§§ As set out in the closing submissions of Family Group 1 (P. Skelton KC): **Written Closing Submissions on Behalf of Family Group 14 March 2025/para 91b**.

12.130 Several witnesses accepted in their oral evidence that the SUDIC process should have been used for inpatient neonatal deaths, including: Dr Jayaram,[145] Dr Holt (although she considered that the way in which the policy was written leant more towards deaths in the community),[146] Dr Mittal,[147] Ms Sharon Dodd[148] and Dr Saladi (although he appeared to misunderstand what the SUDIC entailed, believing that it was followed if there was a discussion with the coroner).[149]

12.131 Dr ZA accepted that the SUDIC process was applicable to hospital deaths but explained that this was not the practice and culture at the time.[150] Dr Brearey said he understood the SUDIC guidelines as "*predominantly*" written for children or babies who had died unexpectedly in a community home setting rather than a hospital setting, and that death on the neonatal unit was even more detached from this.[151] Dr McGuigan said he could not think of any examples of the sudden unexpected death of an inpatient that had led to a JAR, but recalled training he had undertaken as a registrar which made clear that it should.[152] Dr Rackham, Clinical Lead at Arrowe Park Hospital at the time, said: "*Our experience was that that policy existed but that it wasn't … always enacted for babies who die in a hospital but in certain cases it would be.*"[153] Dr Gibbs said that, in 2015/16, he did not understand that it applied.[154] Dr Newby said she did not understand that SUDIC processes applied to inpatient neonatal deaths.[155]

12.132 Dr Garstang gave evidence about the value of police involvement in the SUDIC process. She pointed to the fact that specialist officers deal with these cases and good relationships are built up so "*if you do have soft concerns about something, you're not having to pick up the phone to somebody you have no relationship with or you don't know*".[156] This is a reassuring point for those who may worry about a heavy-handed police response.

Failures to apply SUDIC

12.133 I accept the criticisms made in respect of the failure to apply SUDIC processes by those representing the parents of the babies.

12.134 The repeated failure to apply SUDIC to the deaths in the neonatal unit at the Countess is indicative of wider systemic failures:

a. At a national level, training on SUDIC and communication/education about the applicability of SUDIC processes were inadequate.

b. At a local level, training on SUDIC and communication/education about the applicability of SUDIC processes were inadequate.

c. Healthcare professionals, particularly doctors, were not aware of the SUDIC policies and processes that applied.

12.135 In her evidence, Dr Camilla Kingdon, former President of the RCPCH, explained that, in the Level 3 unit in which she works, when a baby dies the notion of deliberate harm is not something 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 change that has occurred in schools and social

care. The evidence also points towards a lack of training, communication and education at a national level on the applicability of SUDIC processes to inpatient neonatal deaths. Dr Kingdon gave evidence that: "[U]*p until very recently the teaching and our curriculum has not highlighted Sudden Death in Infancy and Childhood well enough. That has been remedied because we have an outcomes-based curriculum which is very easy to update, so that has been updated.*"[157] Whilst that was encouraging, Dr Mittal asserted that the non-use of the SUDIC process for hospital deaths remains a national problem.[158]

12.136 At a local level, training on SUDIC and communication/education about the applicability of SUDIC processes were inadequate. It was apparent that many clinicians did not properly appreciate that SUDIC processes should have applied to inpatient neonatal deaths and failed to familiarise themselves with SUDIC policies and processes. This was contrary to both the Pan-Cheshire Guidelines, which expressly stated that "[i]*t is essential that every professional involved in a … (SUDIC) case must be fully aware of the guidelines and should keep meticulous records*",[159] and the Countess's Safeguarding Policy (see paragraph 12.14), which stated: "***All Trust employees must comply with this generic policy*** [emphasis in original]."[160]

12.137 Dr Gibbs' evidence was that he did not remember his attention being drawn at the time to the section of Working Together that dealt with SUDIC. It was telling that he referred to the "*enormous number of guidelines in all different aspects of our specialty*".[161] That is precisely why there needed to be training and education on SUDIC, delivered in the Countess (either by Dr Mittal or under his direction). The length and proliferation of policies did not aid doctors in understanding key safeguarding principles. To the contrary, an allied concern, raised by the RCPCH in their closing submissions, was the length of forms requiring completion in the case of a SUDIC referral, described as "*likely to take a day's work if filled in*".[162] The RCPCH consider that the length of these forms also needs to be reviewed. I agree.

12.138 Dr Mittal's evidence was that, at the time, there was no Named Doctor for Child Death at the hospital. It is the role of the Named Doctor to promote good professional practice and ensure safeguarding training is in place.[163] Dr Mittal was the Designated Doctor for Safeguarding and Child Deaths but was not employed by the Countess in this role; rather, he was employed by the CCG (now the ICB) to provide advice more widely, including to NHS England and to other health professionals. He said that he was delivering ad hoc training to paediatricians and consultants in the hospital but could not remember when such training was held. He accepted personal responsibility for not ensuring that this took place and for the fact that it was not made clear that the SUDIC process applied in hospitals, but emphasised how little time and funding he had for this aspect of his work.[164]

12.139 The key safeguarding messages for those working with children and babies in hospitals are these. Child safety comes first. This is everyone's responsibility. Where there are genuine concerns that harm is being caused by a member of staff (or anyone else), this must be shared with colleagues and those responsible for safeguarding. Proof or certainty of causing harm is not necessary to make a safeguarding referral to the local authority. Taking steps to keep children and babies safe from harm pending investigation is the priority. Multi-agency discussion and/or investigation is essential. When concerns are raised, managers and executives must act and they should do so promptly. Where a child dies unexpectedly the SUDIC guidance must be followed.

12.140 A review of the SUDIC guidance is long overdue. DHSC have now 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 in 2026/27 and work to review the guidelines is expected to commence in the early autumn of 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.

Endnotes

1 Children Act 2004, sections 10(1)-10(2) (https://www.legislation.gov.uk/ukpga/2004/31/section/10)

2 Children Act 2004, section 11(1) (https://www.legislation.gov.uk/ukpga/2004/31/section/11)

3 INQ0013235/8/para 12

4 INQ0013235/8/para 12

5 INQ0013235/8/para 12

6 INQ0013235/8/para 13

7 INQ0013235/9/para 14

8 INQ0013235/9/para 16

9 INQ0013235/9/para 20; Dr Joanna Garstang 26 September 2024 132/5-13

10 INQ0013235/17/para 24

11 INQ0013235/54/para 4

12 INQ0107001/6/para 5.4

13 Dr Joanna Garstang 26 September 2024 133/23 to 134/5

14 INQ0009485/3

15 INQ0009505/3

16 INQ0009485/30; INQ0009505/30

17 INQ0009485/30; INQ0009505/30

18 INQ0009505/32

19 INQ0014171/9

20 INQ0014171/9

21 INQ0108329/1

22 INQ0108329/15

23 INQ0010095/11

24 INQ0017823/16/para 71

25 Dr Joanna Garstang 26 September 2024 185/14 to 186/18

26 Paula Sindall 18 November 2024 133/4-5

27 Paula Sindall 18 November 2024 146/7-8

28 Paula Sindall 18 November 2024 149/11-24

29 Paula Sindall 18 November 2024 155/16 to 156/2

30 Paula Sindall 18 November 2024 180/24 to 181/9

31 Paula Sindall 18 November 2024 138/20 to 139/13

32 Paula Sindall 18 November 2024 157/20-24

33 Paula Sindall 18 November 2024 136/10 to 137/1
34 Paula Sindall 18 November 2024 154/13-17
35 Paula Sindall 18 November 2024 175/20-22
36 Paula Sindall 18 November 2024 167/10-18
37 Paula Sindall 18 November 2024 166/7-12
38 INQ0013235/53; INQ0013235/57
39 Dr Howyada Isaac 18 November 2024 186/15-19
40 Dr Howyada Isaac 18 November 2024 200/14 to 201/21; INQ0108344/1 and 74
41 Dr Howyada Isaac 18 November 2024 203/21-22
42 Dr Howyada Isaac 18 November 2024 188/20-21
43 INQ0102620/17-20
44 Dr Howyada Isaac 18 November 2024 188/22 to 189/1
45 INQ0063741/2; INQ0004715/19
46 INQ0017433/110
47 Written Closing Submissions on Behalf of Family Group 1 4 March 2025 48/para 174
48 INQ0013235/54
49 Dr Howyada Isaac 18 November 2024 191/9 to 199/3
50 Dr Howyada Isaac 18 November 2024 211/4-7
51 Dr Howyada Isaac 18 November 2024 211/25 to 212/2
52 Dr Howyada Isaac 18 November 2024 211/15 to 214/25
53 Dr Howyada Isaac 18 November 2024 212/3-15 and 215/2-25
54 Dr Howyada Isaac 18 November 2024 214/19
55 Dr Howyada Isaac 18 November 2024 213/12-23
56 Dr Howyada Isaac 18 November 2024 213/7-8
57 Dr Howyada Isaac 18 November 2024 215/19-21; INQ0102620/22
58 Dr Howyada Isaac 18 November 2024 221/3-6
59 Dr Howyada Isaac 18 November 2024 221/9
60 Dr Howyada Isaac 18 November 2024 216/9-12 and 215/22
61 Dr Howyada Isaac 18 November 2024 219/6-13
62 Dr Howyada Isaac 18 November 2024 222/5 to 223/5
63 Dr Howyada Isaac 18 November 2024 226/17-19
64 INQ0103110/1
65 Dr Rajiv Mittal 20 November 2024 106/14-24
66 Dr Rajiv Mittal 20 November 2024 104/25 to 105/19
67 Dr Rajiv Mittal 20 November 2024 103/21-23

68 Dr Rajiv Mittal 20 November 2024 122/17-20
69 Dr Rajiv Mittal 20 November 2024 117/15-17
70 Dr Rajiv Mittal 20 November 2024 120/6-8 and 120/23-24
71 Dr Rajiv Mittal 20 November 2024 134/15-25
72 Dr Rajiv Mittal 20 November 2024 131/15 to 135/8; INQ0005461/1-8
73 Dr Rajiv Mittal 20 November 2024 135/4-6
74 Dr Rajiv Mittal 20 November 2024 134/3-9
75 INQ0013235/57
76 Dr Rajiv Mittal 20 November 2024 92/2-8
77 Dr Rajiv Mittal 20 November 2024 87/8-20
78 Alison Kelly 25 November 2024 31/18 to 37/16; INQ0013064/1-3
79 Ian Harvey 28 November 2024 88/6-20
80 Tony Chambers 27 November 2024 203/5-7
81 INQ0003250/14
82 INQ0004505/6
83 INQ0013235/7/paras 6-7
84 DCS Nigel Wenham 20 November 2024 201/3-21
85 Hayley Frame 18 November 2024 66/7 to 68/8
86 Hayley Frame 18 November 2024 69/25 to 70/1
87 Hayley Frame 18 November 2024 67/12-13
88 Hayley Frame 18 November 2024 67/15-17
89 Hayley Frame 18 November 2024 70/3 to 72/6
90 Hayley Frame 18 November 2024 70/19-22
91 Hayley Frame 18 November 2024 69/10-15
92 Hayley Frame 18 November 2024 73/8-12
93 Hayley Frame 18 November 2024 72/1-6
94 Sharon Dodd 18 November 2024 18/19-20
95 Sharon Dodd 18 November 2024 22/14 to 24/3
96 Sharon Dodd 18 November 2024 27/6-19
97 Hayley Frame 18 November 2024 77/25 to 78/9
98 Sharon Dodd 18 November 2024 29/14-22
99 Sharon Dodd 18 November 2024 29/21-22
100 Sharon Dodd 18 November 2024 50/5-8
101 Hayley Frame 18 November 2024 116/5 to 118/12
102 Hayley Frame 18 November 2024 94/20

103 Dr Rajiv Mittal 20 November 2024 105/11-12
104 Dr Rajiv Mittal 20 November 2024 102/16-18
105 Sharon Dodd 18 November 2024 60/24 to 61/7
106 Dr Rajiv Mittal 20 November 2024 102/21-22
107 Dr Rajiv Mittal 20 November 2024 103/9
108 Dr Rajiv Mittal 20 November 2024 102/19 to 103/23
109 Hayley Frame 18 November 2024 81/15-16
110 Hayley Frame 18 November 2024 80/24 to 81/6
111 INQ00178115/2
112 Dr Rajiv Mittal 20 November 2024 97/2-10
113 INQ0017817/2
114 INQ0001954/20
115 Hayley Frame 18 November 2024 107/21-24
116 Hayley Frame 18 November 2024 83/20-23
117 Hayley Frame 18 November 2024 105/11
118 INQ0012008/3
119 Sharon Dodd 18 November 2024 51/25 to 52/4
120 DCS Nigel Wenham 20 November 2024 142/1
121 DCS Nigel Wenham 20 November 2024 202/17-19
122 DCS Nigel Wenham 20 November 2024 146/2-3
123 DCS Nigel Wenham 20 November 2024 147/4-6
124 Hayley Frame 18 November 2024 122/6-8
125 Dr Rajiv Mittal 20 November 2024 131/2-14; INQ0005461/1
126 Hayley Frame 18 November 2024 123/24 to 124/4
127 Hayley Frame 18 November 2024 124/9 to 125/2
128 Hayley Frame 18 November 2024 119/11-13 and 17-20
129 Sharon Dodd 18 November 2024 29/23 to 30/1
130 Sharon Dodd 18 November 2024 43/15 to 44/12
131 INQ0009618/21
132 Dr Joanna Garstang 26 September 2024 146/23 to 147/11 and 149/21 to 150/9
133 Dr Joanna Garstang 26 September 2024 151/10-14
134 INQ0013235/85
135 INQ0013235/85/para 12
136 INQ0014580/3/para 1.4
137 INQ0014580/10; INQ0014582/9

138 INQ0003250/33

139 INQ0013235/85/para 15

140 INQ0014582/4/para 1.9

141 INQ0014580/9-10; INQ0014582/9. See in particular the flowcharts.

142 INQ0014582/10/paras 2.3.1-2.3.11; INQ0013235/85/para 15; INQ0013235/86/para 17

143 INQ0014582/10/paras 2.3.1-2.3.10; INQ0013235/87/para 19

144 Written Closing Submissions on Behalf of the Royal College of Paediatrics and Child Health 26 February 2025 42/para 92

145 Dr Ravi Jayaram 13 November 2024 9/3 to 10/25 and 11/19-21

146 Dr Susie Holt 3 October 2024 140/12-25

147 Dr Rajiv Mittal 20 November 2024 86/6 to 87/16

148 Sharon Dodd 18 November 2024 45/15-21

149 Dr Murthy Saladi 3 October 2024 55/7 to 56/19

150 Dr ZA 7 October 2024 15/1-4

151 Dr Stephen Brearey 19 November 2024 3/15-19

152 Dr Michael McGuigan 8 October 2024 83/14 to 85/3

153 Dr Oliver Rackham 26 November 2024 253/20-23

154 Dr John Gibbs 1 October 2024 32/13 to 33/7

155 Dr Elizabeth Newby 3 October 2024 15/12-19

156 Dr Joanna Garstang 26 September 2024 169/11-23

157 Dr Camilla Kingdon 12 December 2024 173/19-24

158 Dr Rajiv Mittal 20 November 2024 84/18 to 85/13

159 INQ0014580/3/para 1.5; INQ0014582/3/para 1.5

160 INQ0003250/14

161 Dr John Gibbs 1 October 2024 32/3-5

162 Written Closing Submissions on Behalf of the Royal College of Paediatrics and Child Health 26 February 2024 39/para 87

163 INQ00013235/57/para 17

164 Dr Rajiv Mittal 20 November 2024 89/11 to 92/8

Chapter 13. Why was action not taken sooner?

13.1 Among the questions to be answered by this Inquiry are: should suspicions have been raised earlier? And, what were the responses to concerns raised about Letby from those with management responsibilities within the Trust?

13.2 In this chapter I consider the actions and decisions of doctors and managers from mid-June 2015 to mid-June 2016.

Unthinkable

13.3 I start by acknowledging that the idea that anyone would deliberately harm and even kill tiny babies is repugnant. That a nurse would do so is often said to be unthinkable.

13.4 Because it is too hard to accept, declaring something unthinkable avoids having to confront it. We know that sometimes, albeit very rarely, nurses and doctors deliberately harm and kill patients, including very young children and very elderly people. The case of Harold Shipman, a well-regarded GP who murdered approximately 250 elderly patients, is probably the most well known. The case of Beverly Allitt, a nurse at Grantham and Kesteven General Hospital who killed patients (including children) by poisoning them with insulin, is another. Some years after her trial she admitted the offences. There are others: in May 2015, very shortly before the first deaths at the Countess, Victorino Chua, a nurse at Stepping Hill Hospital, was convicted of two offences of murder, also by insulin poisoning. Before he was arrested, another nurse had been arrested and held on remand in custody for six weeks. She was released and no further proceedings were taken against her. Stepping Hill Hospital is about 35 miles from the Countess. The case was clearly known about at the Countess. It was mentioned by a number of witnesses (Mr Harvey[1] and Dr Gibbs[2] in particular) as an example of a mistake made in circumstances where a nurse was on duty at the time of deaths and, for a while, was wrongly accused. This undoubtedly featured in the thinking of doctors and managers. Mr Harvey seems to have regarded the case of Stepping Hill Hospital as a counter-balance to the Allitt case. Being alert to the possibility of a mistaken link being made between deaths and the presence on shift of a nurse was reasonable, but the injustice done to the first nurse did not negate the fact that a nurse, Victorino Chua, had murdered patients, just as Allitt had done. Nurses do kill. It is not unthinkable. All doctors, nurses and managers should know that.

13.5 For most of 2015, the fact that someone was or might be harming babies did not cross anyone's mind. It is likely that all considered such a situation as unthinkable, not because they did not know about the cases I have referred to (at least the case of Victorino Chua) but because those cases occurred somewhere else. They did not involve

a person or people known to the nurses and doctors at the Countess. As Ms Kelly put it: "*I suppose we found it quite -- we found it quite difficult to kind of comprehend, really … The last thing on my mind is that one of my nurses is -- is deliberately harming children or babies or adults.*"[3]

13.6 She was not alone in thinking like that. Many witnesses, both doctors and nurses, described it as unthinkable. Professor Mary Dixon-Woods, Professor of Healthcare Improvement Studies at the University of Cambridge, made the point in her report that it is harder to raise concerns about someone who is known.[4] That was the case at the Countess. Letby was known, liked by many, and her manager considered her an excellent nurse.

13.7 Raising concerns is easier when there is objective evidence of deliberate harm. The insulin results in respect of Baby F and Baby L were clear, objective evidence of wrongdoing, the first in August 2015. As I have set out in Chapter 5 in respect of Baby F, the consultant considered it not just unthinkable but fantastical and so took no action, Baby F having apparently recovered. In respect of Baby L, later, the significance of the test results was overlooked by Dr U (see Chapter 8). Had either of these results been raised with managers it is likely that, whatever the reputational risk, contacting the police would have been unavoidable. Mr Harvey was very firm in evidence about the difference that information would have made to him.[5]

13.8 The fact of numerous deaths was, in itself, a matter of concern. But to move from a concern about that to a concern about deliberate harm requires a significant shift. The absence of hard evidence makes it even more difficult to consider still less to conclude there may be someone deliberately harming babies. Professor Dixon-Woods spoke about this in her report and in evidence. Her expert evidence reflects precisely what happened at the Countess.[6]

Emerging concerns

13.9 The fact that Letby was usually on shift when babies collapsed and died unexpectedly was obvious to Dr Brearey and Ms Powell but it is to be remembered that no one ever said they had seen Letby doing anything untoward to a baby. Ms Powell considered her an excellent nurse who did a lot of shifts and so was more likely to be present at deaths. She also mentioned repeatedly that Letby was well qualified.[7] In fact, she was one of the more junior nurses on the neonatal unit at band 5. Evidence of her failings and worrying behaviour was not shared and so these were not part of the picture being pieced together by Dr Brearey.

13.10 Dr Brearey was concerned about the number of deaths on the neonatal unit from June 2015. In a unit where the annual rate of deaths was between one and three, the occurrence of three deaths in a fortnight was unheard of and did cause concern. Dr Brearey has spent most of the last ten years or so reliving many of the events about which he gave evidence. It is not easy to unknow the fact that Letby was convicted of murdering seven babies and of attempting to murder another seven babies (eight offences). Knowing those shocking facts is likely to colour his (and others') views of what he did or did not know and think in 2015.

13.11 Maintaining focus on what was said and done at the time, there is no evidence that during June, July or August 2015 he had any thought that anyone might have deliberately harmed a baby. In his evidence in November 2024, he spoke of having a nagging concern; that arose from the fact that Letby was on shift when each of the babies died.[8] These were, using Professor Dixon-Woods' words, emerging concerns, which are harder to voice.[9] I have set out elsewhere Dr Brearey's detailed approach to the deaths, his investigations and conclusions. I bear in mind that in 2015 there were, on the face of it, medically plausible explanations at post-mortem for Baby C and Baby D, and the post-mortem for Baby A was still awaited. There was no obvious medical or other common denominator (such as infection) to link the deaths. Because it was thought, wrongly, that Baby E's death had been caused by necrotising enterocolitis (NEC), there was no post-mortem.

13.12 It would have been better had the collapse of Baby B been considered alongside the deaths of Baby A, Baby C and Baby D, and had more attention been paid by Dr Brearey to the concerns about rashes/skin mottling, but those observations are made with the benefit of hindsight. Some doctors would have looked at Baby A and Baby B together, given that they were twins, but some (reasonably) would not have. The same applies to the rashes/skin mottling. Mr Harvey was also to observe later, correctly, that there were post-mortems that explained the deaths as natural. Neither he nor Dr Brearey had at that time any reason to believe that the findings of the post-mortems may not correctly explain the deaths. The difference between them was that, as the position changed, Mr Harvey remained fixed in his thinking, whereas Dr Brearey kept questioning himself and the findings, looking for explanations and, in due course, challenging the effect of the post-mortem findings, particularly where the cause of death appeared natural but did not explain the collapse.

13.13 The death of Baby I in October 2015 caused a shift in the attitude of some of the consultant paediatricians. Corridor conversations about Letby began between Dr Brearey, Dr Jayaram and other consultants in light of their concerns about the circumstances of Baby I's collapses and death. At that time, Dr Gibbs said that he did not think Letby was deliberately harming babies; he disagreed with Dr Brearey, but that changed over time.[10] Dr Gibbs exemplified the struggles the paediatricians had in acknowledging, even to themselves, that a nurse might deliberately be harming babies. He had been concerned about the cause of Baby C's death but eventually accepted the pathologist's view, notwithstanding his own views, which he had shared with Mother C.[11] Later than Dr Brearey and Dr Jayaram, he too was satisfied that Letby was responsible for the deaths. This interaction between the doctors, all of whom were trying to do the right thing, underlines how hard it is for each individual to be confident that their suspicion is even worthy of action. They all shied away from the shocking reality. Dr Jayaram internalised his concerns about seeing Letby doing nothing to help Baby K in February 2016. Dr Gibbs said that he believed it was after he read the Thematic Review and realised how many deaths there were that he began to have suspicions about Letby.

Thematic Review

13.14 The Thematic Review, completed in March 2016, should have led to questions from those who read it.[12] Some of them asked why the review did not make explicit in the main text that the same nurse had been on duty on every occasion an unexpected collapse and death had occurred. Instead, that information could only be found by

reading the appendix. The evidence shows that people did not read the appendix. Another question is: why did the review not say that any sudden and unexplained collapse of a neonate is of itself a cause for concern, and there were several? As Dr Hawdon, a consultant neonatologist and Medical Director at the Royal Free Hospital, said in evidence (see Chapter 21): "[F]*or a clinician to be told that a number of deaths are unexpected and unexplained is a message in itself.*"[13] Dr Alan Fletcher, the former National Medical Examiner for England and Wales, agreed with that in evidence: "[T]*he Sudden and Unexpected Death of a baby in a neonatal unit is an outstanding and remarkable matter. So in* [and] *of itself I would expect that occurrence to generate … a heightened sense of concern about what happened, what led up to it, what the response was, and why it happened.*"[14] The phrase 'heightened sense of concern' describes well the response to the sudden and unexpected death of a baby in a neonatal unit. Mr Harvey seemed surprised by this when Dr Hawdon emailed him to that effect in answer to his direct question in April 2017.[15] Had Mr Harvey asked the paediatricians the same question at any point, they would have given the same answer as Dr Hawdon.

13.15 In my view, even in March 2016 the review writers were not **confident** that Letby was harming babies, but they saw the association and had concerns about the number of deaths, the timing of the deaths and the sudden and unexpected nature of the collapses. No one was confident enough to say directly that they thought she was or even might be responsible (deliberately or otherwise). That was not due to anything the managers had said at that point – for nothing much had been said – but because of the enormous consequences for everyone if they were wrong. This was, as Professor Dixon-Woods described, a barrier to raising concerns.[16] As I have said elsewhere, the consequences would be graver if they were right, but self-doubt and hesitation prevailed. The writers set out, accurately, what was known. The review was provided to senior managers, seeking assistance and a way forward (see Chapter 6).

Conclusions

Senior nurses

13.16 The evidence makes it clear that for the senior nurses, the idea that Letby might be harming babies deliberately was and remained unthinkable from 2015 onwards. I have dealt with Ms Kelly's position in detail. Ms Powell was steadfast in her defence of Letby. The nursing voice was loud and prevailed in the meeting on 11 May 2016, in the RCPCH report and with the senior managers (see Chapter 19).

13.17 Whether the senior nurses believed Letby was harming babies was not the issue. The question was: were there suspicions, genuinely held, that she was or may be doing so? Ms Powell considered it was "*all nonsense*".[17]

The consultants

13.18 I have no doubt that the consultants' concerns were held in good faith and were based on their clinical judgement. It is clear that they did not know what Letby was doing to harm babies (the two cases of insulin poisoning having been missed). This undermined their confidence and contributed to Dr Brearey being shouted down by the forthright and determined views of the senior nurses at the meeting on 11 May 2016. Dr Gibbs[18] and Dr Brearey both acknowledged that they were influenced by the nurses' views.[19]

These were not the arrogant, all-knowing consultants who so often appear in reviews of hospitals. They, like all their consultant colleagues, were worried about the babies and fearful of the consequences, for all concerned, of their own views. Later, in late June 2016 – after the unexpected and unexplained deaths of Baby O and Baby P and the situation had become extreme – Dr Brearey did not back down, and was supported by his fellow consultants. His change of approach was not welcomed by the managers (see Chapter 11).

The managers

13.19 I am satisfied that from the outset the senior managers, first Ms Kelly and Mr Harvey and, in late June 2016, Mr Chambers, dismissed the idea that Letby was deliberately harming babies. They did not believe it. This is what Professor Dixon-Woods described as the "*credibility gap*".[20] But, as is clear from the previous chapter, whether the senior managers believed Letby was harming babies or not was irrelevant to their duties and responsibilities to take safeguarding action. It is striking that on 29 June 2016, Ms Kelly and Mr Harvey both believed that the doctors' concerns meant that the police should be called, but by the end of that day they had accepted Mr Chambers' view that other steps should be taken first, even though they both knew more about the detail of the concerns than he did. As Mr Harvey said in evidence, he regrets that they did not go to the police in June 2016.[21]

13.20 Mr Harvey said in evidence that he believed the doctors' concerns were genuine but not justified. Neither he nor Mr Chambers was in a position at any stage to decide the concerns were not justified. Mr Chambers' remark during his first meeting with the consultants expressing their concerns to him – "*that would be convenient*" – was offensive and suggests that he considered the concerns were not being raised in good faith.[22] He could not remember saying that, but it fits his later actions.

13.21 A criticism of the doctors from the managers was that they had not called the police – the point being, presumably, that if their concerns were genuine they would have done so. The managers never considered whether the reason the doctors had not done so was because this was so serious that it needed to be dealt with at the most senior level of the hospital, exactly as Mr Harvey himself thought. That the consultants may have doubted themselves did not occur to the managers either. The managers did not, however, doubt themselves. The difference between them and the paediatricians was stark.

In summary

13.22 The blood test results of Baby F in August 2015 should have been brought to the attention of the Medical Director. Had Dr ZA raised these results with Dr Brearey and Dr Jayaram, it is highly probable that they would have raised them immediately with Mr Harvey and Ms Kelly. The executives (if necessary after informing Mr Chambers) should have called the police.

13.23 Dr Jayaram should have informed the Safeguarding Lead (Ms Kelly) or the Medical Director (Mr Harvey) about Baby K. Given that they ignored his concerns when he raised them in 2017, I cannot say that this would have led to protective action. It should have been done.

13.24 The insulin results of Baby L in April 2016 should not have been overlooked. They should have been brought to the attention of the Medical Director and the police should have been called.

13.25 In light of the serious concerns arising out of the Thematic Review and expressed at the meeting of 11 May 2016, the decision to watch and monitor for three months was wrong. Had urgent action to protect babies been taken after the meeting of 11 May, as it should have been, necessary advice would have been taken and Letby would have been moved off the unit pending investigations, other safeguarding action and referral to the police. Instead, six weeks after the 11 May meeting, Baby O and Baby P died.

Endnotes

1 Ian Harvey 28 November 2024 92/24 to 93/4

2 Dr John Gibbs 1 October 2024 82/15-24

3 Alison Kelly 25 November 2024 137/12-17

4 Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/20

5 Ian Harvey 28 November 2024 93/14-16 and 196/16 to 197/10

6 Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/9

7 INQ0003243/1

8 Dr Stephen Brearey 19 November 2024 59/20-22

9 Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/9

10 Dr John Gibbs 1 October 2024 125/1-21

11 Dr John Gibbs 1 October 2024 200/7-11

12 INQ0003251

13 Dr Jane Hawdon 12 November 2024 74/18-20

14 Dr Alan Fletcher 12 December 2024 44/15-20

15 INQ0003124/2

16 Prof. Mary Dixon-Woods 26 September 2024 87/5 to 88/5

17 Nurse T 14 October 2024 22/23-25

18 Dr John Gibbs 1 October 2024 93/12-17

19 Dr Stephen Brearey 19 November 2024 113/17-20 and 253/3 to 254/5

20 Prof. Mary Dixon-Woods 26 September 2024 9/11 to 10/16

21 Mr Ian Harvey 29 November 2024 103/21-22

22 Dr Stephen Brearey 19 November 2024 140/9-10

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