# Thirlwall Inquiry

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

## Volume II-II

September 2026

HC 597-II (II)

# Thirlwall Inquiry

## 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

Ordered by the House of Commons to be printed
15 September 2026

**Volume II-II**

HC 597-II (II)

This publication is available at **www.gov.uk/official-documents**.

Any enquiries regarding this publication should be sent to us at **contact@thirlwallinquiry.co.uk**

ISBN 978-1-5286-5451-7
E03297534 09/2026

Printed on paper containing 40% recycled fibre content minimum.

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office.

# Contents

## Volume II-II

## Part One continued

# Chapter 24. Referral of deaths to the coroner

## Background

24.1 The Coroners and Justice Act 2009 provides the statutory framework for the powers and duties of coroners.[1] So far as relevant to the Inquiry, the Act provides:

> Section 1: On report of a death, if there is a reason to suspect a violent or unnatural death, or the cause of death is unknown, a senior coroner must conduct an investigation.
>
> Section 4: Where preliminary inquiries satisfy the coroner that the death was naturally occurring and non-violent, the coroner is required to discontinue the investigation and his involvement will come to an end.
>
> Section 5: The purpose of an investigation is to ascertain who the deceased was; how, when and where the deceased came by his or her death; and the particulars (if any) required to be registered concerning the death.

Section 6: Otherwise, the coroner must hold an inquest.

24.2 A senior coroner has the power to request a post-mortem examination if an investigation is already under way, or for the purpose of deciding whether the death is one where the coroner has a duty to conduct an investigation.[2]

24.3 Mr Nicholas Rheinberg was the Senior Coroner for Cheshire from July 1999 until his retirement on 10 March 2017.

24.4 Mr Rheinberg had published local guidance titled 'Reporting Deaths to the Coroner', which required all child deaths in the area to be reported, irrespective of the circumstance of death.[3]

## Sequence of referrals, 8 June 2015 to 27 June 2016

24.5 The death of Baby A was reported to the coroner by Dr Saladi on 8 June 2015[4] (see Chapter 3). No medical cause of death was given in the reporting form.

24.6 A coronial investigation was commenced into Baby A's death on 22 June 2015.[5] The inquest was opened on 23 December 2015, following receipt of the post-mortem report of

Dr Shukla dated 18 December 2015, which gave the cause of death as 'unascertained'.[6] The evidence that the Inquiry heard about preparation for the inquest, and about the inquest itself, is set out below.

24.7 On 15 June 2015, the death of Baby C was reported to the coroner by Dr Gibbs (see Chapter 3). No cause of death was given in the reporting form. An investigation was commenced on 16 June 2015.[7] On 14 August 2015, Dr Gibbs spoke with Dr Kokai, who had performed the post-mortem on Baby C. Dr Kokai's view was that Baby C had died from myocardial ischaemia, which led to Baby C's collapse and unsuccessful resuscitation. Dr Gibbs described his view to the Inquiry, following his conversation with Dr Kokai, as follows:

> "*I was satisfied that the death had been partly explained …*
>
> *… because of the unusual nature of the resuscitation … I 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?' So you keep going back one more step. But with Baby C being an at-risk baby, very small, growth retarded, difficulties with perfusion from the placenta, the afterbirth, before the baby was born possibly that might have explained why the heart … had suffered this insult. But it didn't quite fit together.*"[8]

24.8 Speaking more generally about the impact of the post-mortem reports for the babies featured on the indictment, Dr Gibbs said that the fact that the post-mortems performed had not revealed any suggestion of deliberate harm contributed to his "*dithering*" when deciding whether or not to act upon his concerns.[9] Dr Gibbs added:

"[M]*ost of the babies had an explanation for their deaths from the ones that had had the postmortem …*

*So because we had explanations for all the deaths … I wasn't sure that harm had happened to these babies … They were not completely unexplained; some*

*of them had postmortems that seemed to explain the death but they didn't explain it adequately when we looked back at it."*[10]

24.9 The coronial investigation into Baby C's death was discontinued on 26 November 2015, following receipt of the post-mortem report of Dr Kokai.

24.10 In oral evidence, Mr Rheinberg said that he would normally hope that a difference in opinion between a clinician and pathologist as to cause of death would be made clear in any post-mortem report.[11] He agreed that, where the difference in opinion was between a specified natural cause of death or an 'unascertained' cause of death, this would be relevant and important information to provide to the coroner and would have been a reason to hold an inquest into the death of Baby C.[12] At the time, Dr Gibbs did not mention his view that "*it didn't quite fit together*" to Dr Kokai and deferred to his view about the cause of death.[13]

24.11 Baby D's death was reported to the coroner by Dr Newby on 22 June 2015[14] (see Chapter 3). In the report, Dr Newby offered no cause of death. Dr Newby did, however, inform the coroner that there had been a cluster of neonatal deaths at the hospital – the

'additional information' section of the reporting form recorded: "*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.*"[15]

24.12 In oral evidence, Mr Rheinberg said that his team would have discussed the cluster of three deaths in June 2015. He explained: "*It was worrying. But as … the results came … out they all seemed to be explicable*."[16] Baby A's death was not explained. Baby C's death was, on the face of it, explained in November 2015.

24.13 As with Baby A and Baby C, an investigation was commenced into the death of Baby D. The report of the post-mortem conducted by Dr McPartland found a natural cause of death. The view of Mr Alan Moore, Assistant Coroner for Cheshire, was that the investigation should be discontinued. After representations from Baby D's family, however, an inquest was opened on 8 January 2016. Mr Rheinberg described the effect of the representations in his oral evidence:

> "*I think I had received a letter from Baby D's parents direct, giving a number of details relating to what they saw as*

*mismanagement in relation to the death and I decided that this did need further investigation, and although a natural cause of death had been given, and so in normal circumstances a discontinuance would be the only course of action appropriate, in these particular circumstances I decided to accede to the request made*."[17]

24.14 The inquest into Baby D's death was scheduled to be heard on 25 May 2017 but was adjourned due to the coroner being informed that a police investigation was to be carried out into neonatal deaths at the hospital. The coronial investigation was subsequently suspended on 27 November 2020.[18] The inquest of Baby D (as well as Baby C, Baby E, Baby I, Baby O and Baby P) was reopened on 4 February 2026 and adjourned again.

24.15 The death of Baby E was reported to the coroner on 4 August 2015 (see Chapter 5). A cause of death was proposed by the consultant paediatrician Dr ZA – namely, necrotising enterocolitis and prematurity. She explained her view to the assistant coroner, who accepted it. Dr ZA accepted in oral evidence that she had not realised the significance of the X-ray of Baby E, which did

not show signs of necrotising enterocolitis; she agreed that a post-mortem should have been performed.[19] Instead, there was no post-mortem and no investigation.

24.16 Baby I's death was reported to the coroner on 23 October 2015 by Dr Gibbs[20] (see Chapter 6). No cause of death was offered. An investigation was opened by Dr Janet Napier, Assistant Coroner, on 28 October 2015. The post-mortem was performed by Dr Kokai, who concluded that there was a natural cause of death. The investigation was discontinued on 12 February 2016.

24.17 The deaths of Baby O and Baby P were reported to the coroner by Dr V, on 27 June 2016.[21] No cause of death was offered. Investigations were opened by the assistant coroner, Mr Moore, on 30 June 2016.[22] Post-mortems were conducted by Dr Kokai, who concluded there were natural causes of death in both cases.

24.18 None of the forms reporting deaths of babies on the indictment to the coroner mentioned suspicion or concern about deliberate harm, or the association between neonatal mortality and a specific nurse. Whilst there is no obvious place on the form to enter such information, the coroner should have been

informed by telephone about the concerns. By the time of the deaths of Baby O and Baby P, the failure to alert the coroner was inexcusable.

24.19 Ultimately, however, and on behalf of the Countess, Mr Cross and later Mr Harvey were responsible for liaising directly with the coroner about deaths on the neonatal unit. They bear principal responsibility for the failure to make it clear to the coroner that there were suspicions and concerns about deliberate harm being caused on the unit. They should have communicated this long before the inquest hearing in the case of Baby A.

## Communications between the Countess and the coroner, 2016

24.20 The inquest into the death of Baby A was opened on 23 December 2015. The hearing of the inquest was initially set for 23 March 2016, to allow for the preparation of witness evidence.

24.21 On 28 January 2016, Ms Yvonne Williams, Coroner's Officer, wrote to the hospital saying that Mr Rheinberg believed the hospital should consider completing a Serious Untoward Incident report.[23]

24.22 On 29 January 2016, Mother A and B wrote to Ms Yvonne Williams, explaining issues with Baby A's care. In evidence she explained that she felt she had no answers: "*I was brought into the room when it was too late. So I was trying to get some answers as to what had led for, in one of the nurse's own words, a perfectly well pre-term baby to suddenly die*." She asked five questions:

a. Why was the long line not put in straight away?

b. How many times was Baby A's monitor allowed to beep without being checked and how long was it before medical staff attended to Baby A?

c. Why was a more senior doctor not called to assist with the insertion of the long line?

d. Why were Parents A and B allowed to believe Baby A's initial post-mortem showed nothing when in actual fact Baby A had a condition?

e. Why were Parents A and B not informed that the long line had been put through Baby A's liver?

> The email was forwarded to Dr Jayaram, who answered each of the questions. Mother A and B said she had found his explanation about the crossed pulmonary artery reassuring. Dr Jayaram had explained that the rare variant should not cause any problems with the function of the heart and lungs, "*and the* [post-mortem report] *suggests that there was no issue with the heart and lungs*" arising from that variant. He also explained, in the context of the long line, that he would not normally expect paediatricians to keep parents informed at every stage of the procedure. Mother A and B made the points in evidence that she had not seen her babies when they were born because they were delivered under general anaesthetic, she had not been allowed to go and see Baby A because of the lines, and she felt that the cause of the delay should have been explained to her. I agree with her.[24]

24.23 On 23 February 2016, Ms Harper-Lea wrote to Mr Harvey and Ms Kelly, passing on Mr Rheinberg's view that the Countess should consider completing a Serious Untoward Incident report. Mr Harvey replied the same day, referring to the recent Thematic Review: "*I believe that* [Dr Brearey's] *review is equivalent of a SUI* [Serious Untoward

Incident] – *but we can make a final decision when we see the report*."[25] Mr Harvey had received the draft Thematic Review from Dr Brearey on 15 February 2016.[26] The updated version was sent to him and to Ms Kelly on 21 March 2016.[27] Although Mr Harvey had described it as the equivalent of a Serious Untoward Incident report, he did not discuss it with Ms Kelly until 11 April 2016 (see Chapter 9).

24.24 The inquest was not ready for hearing on 23 March 2016, because the Countess had not provided the required evidence.[28] The hearing was put back to 10 October 2016.

24.25 Mr Rheinberg said that it was after notification of the deaths of Baby O and Baby P in June 2016 that he first became concerned about neonatal mortality at the hospital.[29] He had already been notified of deaths on the unit during 2015 and during 2016. In oral evidence, Mr Rheinberg described talking with Ms Christine Hurst, Coroner's Officer, "*about our concerns about … this being yet another unexpected death of an infant or infants at the Countess of Chester Hospital*".[30] Mr Rheinberg expanded in his witness statement:

> "*We were both concerned about the number of neonatal deaths that had occurred at* [the Countess] *in a comparatively short period of time and the deaths of the two triplets focused our concern. For my part I wondered whether there was some underlying problem with the standard and quality of care at the hospital although there had been no indication previously to show that this might be the case*."[31]

24.26 Mr Rheinberg says in his statement that it was at about the same time as these concerns arose that he learnt that the Countess had commissioned the RCPCH to carry out a review, and that: "*This was something of a comfort as I hoped that if there were deficiencies within the department, I anticipated that these would be revealed*."[32]

24.27 Consistent with Mr Rheinberg's recollection that he became aware of the hospital commissioning a report by the RCPCH, Mr Moore gave evidence to the Inquiry that he received a telephone call in early July 2016 from Mr Cross, intended for Mr Rheinberg, who was unavailable at the time.[33] Mr Moore said that Mr Cross:

> "*indicated that the Countess of Chester Hospital had experienced a number of neonatal deaths … in recent times and that the Trust had therefore commissioned an independent review by the Royal College of Paediatrics and Child Health. He said the review would look at the neonatal unit and he said, 'We will send a copy of the report once it's available through to Mr Rheinberg'*."[34]

24.28 In a supplementary statement to the Inquiry, Mr Cross stated that he "*liaised with the Coroner on a regular basis and it is my strong recollection that on 8 July 2016 I called him and updated the Assistant Coroner in respect of everything I was aware of about the current position, including the suspicions relating to Lucy Letby*".[35] Mr Moore's evidence was that Mr Cross did not raise the consultants' concerns that a member of staff may be responsible for the deaths. When asked what he would have done if that information had been shared with him, Mr Moore replied: "*I would have explored exactly what the concerns were that Mr Cross or the Trust or both had and, if necessary, would have spoken with the police*."[36]

24.29 There was a clear failure by the Countess, through Mr Cross, to discharge the duty of candour to the coroner. Mr Cross was the point of contact and knew about the paediatricians' suspicions and concerns.

24.30 On 4 August 2016, the solicitors acting for Parents A and B wrote to Mr Rheinberg, expressing their frustration at the current duration of the coronial investigation and seeking a date for the inquest.[37] On 11 August 2016, Mr Rheinberg replied in the following terms: "*I share your frustration and that of your clients. Of particular importance to the inquest is the Serious Untoward Incident report which although promised has yet to be completed. In addition two critical statements are outstanding*."[38]

24.31 There was no Serious Untoward Incident report into the death of Baby A. There was, however, the Thematic Review that Mr Harvey had described as the equivalent of a Serious Untoward Incident report.

24.32 On the same day, Mr Rheinberg wrote to Mr Cross:

> "*My Officer has been chasing up missing statements in relation to the above Inquest together with a copy of the*

> *Serious Untoward Incident review. Of late I understand that enquiries have been ignored and bearing in mind the fact that it is now over a year ago since this poor infant died I am prepared to wait no longer*."[39]

24.33 Mr Rheinberg required from Mr Cross witness statements from two further junior doctors involved in Baby A's care as well as a copy of any root cause analysis or Serious Untoward Incident report.

24.34 Mr Cross replied the next day, explaining that: the statements of three junior doctors – Dr Teresa MacCarrick (a paediatric specialty trainee), Dr Harkness and Dr Ogden – had now been sent; that a copy of an obstetric secondary review undertaken would also be sent; and that he had asked Mr Harvey to let him know of any other reviews that had been undertaken.[40]

24.35 On 19 August 2016, Mr Joshua Swash, a band 3 legal services assistant at the Countess, sent to the coroner's office a copy of the obstetric secondary review and a version of the Thematic Review in which the details of babies other than Baby A had been removed.[41] The version of the Thematic Review provided to the coroner identified

within its listed themes: (a) that babies had suddenly and unexpectedly deteriorated, with no clear cause on post-mortem; and (b) that six out of the nine babies who had died had arrests between midnight and 4am.[42]

24.36 The coroner was also sent the first page from Dr Brearey's 1 July 2015 'Summary of cases'.[43] Whereas the original document had contained discussion of the deaths of Baby A, Baby C and Baby D, the single page sent to the coroner related to Baby A alone. Six weeks later, that single page only was sent, on 28 September 2016, by the coroner's office to the solicitors for Baby A's parents.

24.37 The solicitors for Baby A's parents wrote to Mr Rheinberg on 28 September 2016, to express their disappointment in the document received:

> "*We were of the understanding that a full investigation was taking place at the Trust regarding* [Baby A's] *death, which would result in a report, detailing the chronology of events, the issues involved, whether any errors were made, whether such errors could have caused or contributed to* [Baby A's] *death, and the lessons learned. We were told in August 2016, that this*

*investigation was on-going and we would be provided with the Serious Untoward Incident Report.*

*We therefore expected to receive, prior to the Inquest hearing, a fairly lengthy and comprehensive document, dated August or September 2016.*

*We are therefore very surprised that the Trust has now provided such a short document, describing only the most superficial investigation, and one that bears the date 1st July 2015. Clearly this document is not the result of the major and detailed investigation we were told was still on-going only a few weeks ago.*"[44]

24.38 The solicitors requested an adjournment of the inquest hearing if a further, fuller report was not received by 3 October 2016.

24.39 Mr Rheinberg replied on 3 October 2016, expressing his disappointment with the documents provided by the Countess but declining to adjourn the inquest:

"*I too was disappointed with the brevity* [of] *the report which I received. However, I have no power to order a hospital to*

*conduct an investigation and still less give directions as to the nature and extent of any investigation that is undertaken*."[45]

24.40 Mr Rheinberg made no reference, in his letter, to the Thematic Review, which his office had received along with Dr Brearey's 2015 summary of Baby A's case on 19 August 2016. This was a significant omission. It was the Thematic Review that was being presented as the equivalent of a Serious Untoward Incident report. Mr Rheinberg seems to have been unaware that it had been received. This was a serious failing of the administration of the coroner's office. As a result, important evidence was not provided to the parents or their lawyer. When asked by the Inquiry whether there was any reason not to send the Thematic Review to the parents, Mr Rheinberg answered "*absolutely not*".[46] He also said the Thematic Review "*almost certainly*" was not in front of him at the inquest.[47] It should have been before Mr Rheinberg well before and during the inquest.

24.41 In their written closing submissions, Family Group 1 said: "*Certainly Parents A and B were not provided with the Thematic Review*."[48] I am satisfied that had their solicitors received

it they would have forwarded it to Parents A and B. It is at the very least possible that, had that been done, Parents A and B, and/or their solicitor, would have taken the time to read it carefully and to note the various themes, and, importantly, ask questions about them.

24.42 On 6 October 2016, Mr Cross sent Mr Rheinberg an email notifying him that he had told Mr Moore that the RCPCH would be conducting a review of the neonatal deaths; that this review had occurred in September 2016; and that the Trust was awaiting the report.* [49] Mr Cross informed Mr Rheinberg that the RCPCH review team were entirely satisfied and had raised no concerns; however, they had recommended that a detailed case note review be undertaken. He told Mr Rheinberg that this review was in progress. It is not apparent that Mr Rheinberg, having been told that the review team were entirely satisfied and had raised no concerns, asked why a detailed case note review

---

* Mr Rheinberg had no recollection of being told by Mr Moore he had taken a call that was intended for him about the RCPCH review. However, he stated that Mr Moore was meticulous in that regard, and he thought Mr Moore did tell him, as he was aware that the RCPCH review was taking place.

was being undertaken. That said, Mr Cross deliberately withheld the letter of instruction to Dr Hawdon, who conducted the review, which he should have provided. He said nothing about the fact that a nurse, Letby, had been moved off the unit in July 2016 either.

24.43 Mr Rheinberg confirmed in evidence that he did not receive Dr Hawdon's letter of instruction. He was referred to the section of the letter in which Mr Harvey explained to Dr Hawdon that the RCPCH "*review team agreed that the pattern of recent deaths and the mode of deterioration prior to death in some of them appeared unusual and needed further enquiry*".[50] Mr Rheinberg stated it would have been "*extremely helpful*" to have had that information available to him prior to Baby A's inquest, and it may have prompted him to obtain independent expert advice about the death.[51]

24.44 Both Mr Rheinberg and Mr Moore said that the Countess did not inform them that the consultant paediatricians had raised concerns that a member of staff may be responsible for some or all of the deaths.[52] In his witness statement, Mr Cross said he "*fully briefed the*

*Deputy Coroner for Cheshire*".[53] I have set out at paragraph 24.28 Mr Cross's written evidence that he briefed Mr Moore fully.

## The Countess's preparations for the inquest into the death of Baby A

24.45 The GMC's guidance *Good Medical Practice* (2013), in effect at the time, required doctors when giving evidence to legal proceedings not to leave out relevant information deliberately.[54]

24.46 At the time, it was standard practice for the hospital to provide all potential witnesses to an inquest with a copy of a document titled 'Guidance on Writing Statements'.[55] In written evidence, Ms Harper-Lea, as Head of Legal Services at the Countess, explained that the purpose of the guidance was "*to assist the witness with how to write a statement in an appropriate format*".[56] Ms Harper-Lea said that the guidance had been drafted prior to her appointment at the hospital.[57]

24.47 All of the witnesses in this inquest were provided with this guidance. It goes well beyond advice on the appropriate format. The first part of the advice, that statements "*should be accurate and complete*" and not "*leave out significant information*", is unobjectionable. The second, to "*avoid criticism of colleagues/*

*other departments*" and not to "*give opinions*" but rather "*just stick to facts*",[58] is plainly objectionable. Much medical evidence is evidence of opinion, not just facts. Advising doctors to 'just stick to the facts' has the effect of causing them not to stray outside known facts. It would, and did, have the effect of discouraging the doctors from saying anything about their suspicions or concerns.

24.48 In oral evidence, Mr Louis Browne KC (who was instructed by the Countess in respect of Baby A's inquest) gave his view on the advice to avoid criticism of colleagues:

> "*I wouldn't regard that as being a sound position to take in all cases. I can understand why that might be included but if … there was a case where a clinician or a nurse was criticising a colleague, or another department, for reasons that were connected with the Inquest I would expect that matter to be addressed.*
>
> *… if a clinician or nurse was reading this document, and landed on that bullet point, then … it would not necessarily encourage openness and transparency*."[59]

24.49 Mr Cross's note of an Executive Team meeting on 3 August 2016 recorded discussion of Baby A's inquest. The note recorded that statements "*need to* [be] *reviewed by IH* [Mr Harvey] *& AK* [Ms Kelly] *– Coroner pushing for statements. ACTION prepare* [statement] *bundle for AK IH*."[60]

24.50 In oral evidence, Mr Harvey said that he had no recollection of being sent or reviewing statements produced for the inquest.[61] He may not recall, but I see no reason why Mr Cross would not have taken the action required. In the event, there is no evidence of Ms Kelly or Mr Harvey seeking to amend the statements.

## Mr Browne KC

24.51 Mr Cross instructed Mr Browne KC, then a junior barrister, to represent the Countess at the inquest on 10 October 2016, as well as to advise in conference pre-inquest on 8 September 2016 and 6 October 2016.

24.52 Mr Browne KC was adamant throughout his oral evidence that at no point was he told there was any suspicion that Baby A or any other babies in the neonatal unit had been, or might have been, deliberately harmed by a nurse.[62] Mr Browne KC said that had he

been told about those suspicions: "*I would have taken action and advised in respect of it … I would have told the Trust in no uncertain terms that they must inform their own safeguarding unit of that and the police should be informed*."[63]

24.53 On 8 September 2016, Mr Browne KC attended a pre-inquest conference with Mr Swash, Dr Wood and Dr Ogden. Mr Swash took a handwritten note of the meeting. Near the top of the note was written:

> "*– Was nurse involved in Child A's care? Re: Wider review.*
>
> *– Where Child A's death fits into the sequence.*
>
> *Q. Sequence.*
>
> *Nurse*
>
> *↳ If yes, DISCLOSURE to family*
>
> *– + Spike in deaths, not just nurse = DISCLOSURE*"[64]

24.54 Mr Browne KC explained in oral evidence:

> "*I suspect that I will have been informed that there had been … reviews and that there was an investigation into a cluster of unexpected deaths and one of the matters that the hospital were considering was who*

> *was on duty at the time of those deaths and in that context, I suspect that it was said that a nurse … appeared to have been on duty at the time of some of these deaths*."[65]

24.55 Mr Browne KC said that he was "*interested*" in the implicit concern that Letby might have done something or failed to do something in respect of Baby A, and he would have wanted to know whether the nurse was involved in Baby A's care and, if so, why that was relevant.[66] Mr Browne KC accepted that there was no record of his asking Mr Swash or the doctors what the nurse was alleged to have done.[67] Mr Browne KC explained why he did not ask further, specific questions:

> "*At that stage I didn't ask any questions because I was waiting for further information as to whether it was or was not relevant.*
>
> …
>
> *Firstly, I was not instructed to consider issues more widely and with the benefit of hindsight of course the pieces of the jigsaw fit together that Letby was deliberately harming children.*

*But that was not a matter that I was aware of or had ever been told. So the first reason is there was no basis for me to ask the clinicians about particular care given by a particular nurse because of a suspicion … of that nurse deliberately harming.*

*But the second reason is in the context of this Inquest I had no evidence available to me to suggest that that nurse's conduct, whether viewed from a perspective of competence or from any other perspective, was called into question. I wanted to know whether that nurse had been on duty and I will have wanted to have known that so I could explore if it became relevant*."[68]

24.56 In respect of the references to disclosure in Mr Swash's note above, Mr Browne KC said:

"*That is advice that I will have given and … it will have been based upon information that I had been provided that the wider review had identified a spike in the number of deaths on the unit and that consideration was being given as to nurses who were on duty at the time of those deaths.*

*Without sight of … either the* [RCPCH] *report or the thematic review, at the time I wouldn't have been able to identify an issue regarding any particular nurse but I*

*suspect … for the fact that I've referenced nurse or there is a reference to 'nurse' probably indicates that I had been told there was a nurse where there was consistency of – that nurse being on duty at the time of some of these neonatal deaths. And I will then have advised: well, if that nurse was on duty at the time of Child A's death, then that fact must be disclosed to the Family. And whether or not that nurse was on duty, the fact of a spike … in deaths should be disclosed to the Family*."[69]

24.57 Mr Browne KC reiterated in his oral evidence that the family of Baby A should have been given disclosure about the suspected involvement of a nurse in Baby A's death and the fact that Baby A's death was part of a cluster of unexpected deaths.[70] I agree.

24.58 Speaking generally about independent reviews into the deaths, Mother A and B said: "[T]*here needs to be given more information to the parents, because as I've stressed the whole time, we are people, and that is our child. That's our world. And I was never given an opportunity to sit in an official setting and ask questions that I wanted answered*."[71] The same applies to Baby A's inquest hearing.

By not following Mr Browne KC's disclosure advice, the hospital failed to provide Parents A and B with important information about their child. As a result, no questions could be asked about it on their behalf by their lawyers at the inquest, or anywhere else. This was a serious failing.

24.59 At the bottom of Mr Swash's note, written in different ink, was a series of action points, apparently arising from the meeting. The note read:

> "*Actions:*
>
> …
>
> → *check through medical notes Re: was nurse involved in care? LUCY LETBY*
>
> *yes – nursing notes 09 Jun 15 17:56 09 June 15 18:23*
>
> + *SPC* [Mr Cross] *to feedback Re: review from neonates*."[72]

24.60 In his written evidence, Mr Swash explained:

> "*I recollect being asked by Stephen Cross to examine the medical records of Child A to establish whether Lucy Letby was involved in the care of Child A. The red writing stating 'Yes' and the associated*

*times and dates are references to the nursing notes which were attributed to Lucy Letby and therefore confirming her involvement in the care of Child A. I would have written the red part of the note on return to the Legal Services Office when I will have reviewed the medical records*."[73]

24.61 Mr Browne KC stated that his understanding was that "*Mr Swash went back to the office, checked the notes and on checking the notes, made that entry*".[74] Mr Browne KC said he had no recollection of knowing Letby's name before it was publicly reported in the media.[75] He pointed out that the dates in red in Mr Swash's notes were obviously wrong.[76] Baby A died on 8 June 2015.

24.62 On 27 September 2016, Mr Swash emailed Mr Browne KC, attaching the hospital policies mentioned in witness statements for the inquest, and asking when Mr Browne KC would be available for a pre-inquest telephone conference. Mr Swash also wrote:

"*Finally, following on from our conversation prior to the pre-inquest meeting on the 8th of September surrounding the nurses involvement in the care of* [Baby A]*, having investigated the records, I can confirm she was involved in the care of*

> [Baby A]*. Stephen* [Cross] *has suggested that it would be helpful if he could have a conversation with you regarding this issue this week if possible?*"[77]

24.63 Mr Swash forwarded this email to Mr Harvey the same day, adding: "[Y]*ou will note that the nurse that has recently been moved out of the neonatal unit was involved in the care of* [Baby A]*. You will also note that Stephen Is going to speak with counsel about disclosure to the Coroner on this matter*."[78]

24.64 In oral evidence, Mr Browne KC said that he did not recall being told by Mr Cross, or by anybody else at the hospital, that the nurse had been moved out of the neonatal unit.[79] Mr Browne KC stated: "*Had I been told that, it would have led me to ask questions about it because it would have been important*."[80] Mr Browne KC also did not recall having a conversation with Mr Cross about disclosure. He said: "[I]*f we had a conversation about the issue of disclosure I would have reminded him what I had already said that both the Family and the Coroner should be informed*."[81]

24.65 The same day, Mr Browne KC was sent a number of documents, including the Thematic Review. Mr Browne KC could not remember which version of the Thematic Review he

was sent. It was suggested to him that the Thematic Review made it obvious that Letby was the nurse concerned and that she was potentially connected with Baby A's and a number of other deaths. Mr Browne KC responded:

> "*I was not instructed to enquire whether any one or other of these nurses was deliberately harming babies. Had I been told that there was any suspicion of that, my approach to advising and representing the hospital would have been fundamentally different.*
>
> *What I will have taken in part from this Thematic Review, that there's no suggestion of criminality on the part of any person in the review. It specifically says as I recall there was no unifying theme to explain the spikes in deaths. So I will have read all of that. I won't have focused on appendix 1 and looked at that name and thought: well, there may well be some issue there. I was being reassured that there was not an issue about the level of care provided by this nurse or any nurse and nobody indicated that there was a suspicion that that named nurse was deliberately harming babies*."[82]

24.66 On 6 October 2016, Mr Browne KC had a telephone conference with Mr Cross, Mr Swash, Dr Jayaram, Dr Saladi, Dr Harkness and Dr MacCarrick. Again, Mr Swash took a handwritten note.[83] Part of the note recorded: "*Still to this day Ravi* [Jayaram] *doesn't know why this happened. In 27 years in paediatrics, never seen this kind of situation*."[84]

24.67 Under the heading 'Dr Saladi', the note also recorded:

> "*- If review is outside the remit of your knowledge, then say so.*
>
> *↳ Don't say anything unless you know. REVIEW IS ONGOING.*"[85]

24.68 When asked why he did not expressly ask the doctors whether they were concerned about the nursing care provided to Baby A, Mr Browne KC answered:

> "[B]*y virtue of the fact that Dr Jayaram had gone through, if I might put it this way, a checklist of potential causes of a sudden unexpected deterioration, and hadn't highlighted any issue about any other matter on the unit, I wouldn't have felt it necessary to explore with him whether* [he]

*felt that a failure of one or more nurses might have been contributory to Child A's death.*"[86]

24.69 Mr Browne KC said that at no stage did Dr Jayaram explain he had any concerns or suspicions.[87] Mr Browne KC said he could not understand why he had not been told by anybody at the hospital that the consultants were concerned that Letby had killed Baby A.[88] Further, Mr Browne KC said:

> "[T]*here was other material that* [Dr Jayaram] *didn't tell me that I have now found out that might have been a matter that I would have wished to have explored.*
>
> *So, for example, issues of discolouration of the child's body. I would have wanted to have known.*"[89]

24.70 The same day, Mr Cross emailed Mr Rheinberg. He advised Mr Rheinberg that the hospital was awaiting the RCPCH report. Mr Cross stated that the RCPCH review team had "*indicated that they were entirely satisfied with the care within the neonatal unit and raised no concerns*". Mr Cross also said that the RCPCH had recommended that a detailed

forensic case note review of each of the deaths from July 2015 should be undertaken, and this was a work in progress.[90]

24.71 Mr Cross thus failed in the run-up to Baby A's inquest to provide information and documents to the coroner that would have made the coroner aware of the concerns raised by the consultant paediatricians that Letby may have murdered Baby A.

24.72 Mr Cross forwarded to Mr Browne KC and Dr Jayaram a copy of the email to Mr Rheinberg, about the RCPCH report, along with a copy of Dr Hawdon's letter of instruction.[91] Mr Browne KC was explicitly told that the letter of instruction had not been sent on to Mr Rheinberg. That letter said, among other things:

> "*The* [RCPCH] *review team agreed that the pattern of recent deaths and the mode of deterioration prior to death in some of them appeared unusual and needed further enquiry to try to explain the cluster of deaths … They recommended a detailed forensic case note review of each of the deaths from July 2015 be undertaken.*

*They also recommended that the investigation should include as a minimum the following elements:*

…

*(d) details of all staff with access to the unit from 4 hours before the death of each infant. Ancillary and facilities staff should be included."*[92]

24.73 Mr Browne KC was asked whether the contents of the letter of instruction had caused him any concern or raised any alerts with him. He said:

"*Absolutely not. No. I will have read subparagraph D in the context of the Thematic Review that I had been provided with by that date and from recollection I think one of the recommendations of the Thematic Review was that there should be a consideration of precisely that issue.*

…

*I would have interpreted forensic in the context of a letter of instruction as meaning a thorough review, having regard to the records within the scope of what* [Dr Hawdon] *was being asked to do as the expert. But again, this was not a matter that I was being asked to consider*

*expressly. It was part of the wider picture as to what the Trust were doing to deal with the findings as I understood them to be of the* [RCPCH]."[93]

24.74 It was also suggested to Mr Browne KC that the letter of instruction, which he knew had not been sent to the coroner, ought to have been provided to Mr Rheinberg.[94] There was no question that it ought to have been. Mr Browne KC said that the disclosure obligation fell on the hospital and not him.[95] The Countess accepted this in their closing submissions.

24.75 Mr Rheinberg said that the letter of instruction contained the type of information he needed to know when approaching Baby A's inquest:

> "[I]*t would be extremely helpful. I think one of the things that wasn't undertaken in relation to Child A's Inquest was an independent examination of evidence by an expert instructed by me.*
>
> *The more information that I had raising questions, might well have prompted me to get independent expert advice*."[96]

24.76 Mr Rheinberg agreed that the characterisation of the mode of deterioration as unusual and the cluster of deaths were factors of concern and something to be investigated.[97]

24.77 It is important, however, to remember the information that Mr Rheinberg or his office had received by the date of Baby A's inquest:

a. Mr Rheinberg was aware of the cluster of deaths in June 2015, which Baby A was part of. Mr Rheinberg said he discussed this cluster with Ms Hurst contemporaneously.[98]

b. The record of Dr Newby's report of Baby D's death to the coroner's office in June 2015 noted: "*CPR for previous twin death; surviving twin had successful CPR*."[99] Though not explicit, this was a reference to the fact that Baby A's twin, Baby B, had also suffered a collapse.

c. The deaths of Baby A, Baby C, Baby D, Baby E, Baby I, Baby O and Baby P had all been reported to the coroner.

d. Mr Rheinberg had been told that the neonatal unit at the Countess had been downgraded, due to an increase in neonatal deaths.[100]

e. Mr Rheinberg was aware that the RCPCH was conducting a review at the hospital, due to the increase in neonatal deaths. He had also been told that the review team were satisfied and had raised no concerns but had recommended that a case note review be conducted.

f. As set out earlier, the coroner's office had received an edited copy of the Thematic Review. It identified a common theme that: "*Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM* [post-mortem]*.*"[101] Baby A was, of course, one of the babies in this category, and this suggested that Baby A's death had at least one feature in common with other babies who had died at the neonatal unit.

g. The coroner's office had been told that a forensic case note review of deaths had been recommended by the RCPCH and was under way.[102]

24.78 Dr Jayaram, to whom Mr Cross's email of 6 October 2016 had also been forwarded, said he took the correspondence sent to Mr Rheinberg to mean that the coroner

had been told of the consultants' concerns regarding Letby. Dr Jayaram said in oral evidence:

> "*So my impression from this, although I note that Stephen Cross says he hasn't sent the letter of instruction to the Coroner, was that the Coroner, number one, was aware of our specific concern and that's a big assumption, because reading this, it doesn't specifically say that but –*
>
> …
>
> *Aware of our specific concern about an individual.*
>
> *The Coroner was also aware that very detailed forensic level reviews were going on and so my … understanding at the time of the Inquest is that the Coroner was already aware of the concerns that we had*."[103]

This was a reasonable assumption. It was Mr Cross's evidence that I do not accept, that he had fully briefed the coroner. It is likely that he had said as much to the paediatricians.

24.79 In fact, on 6 October 2016, Mr Cross had emailed multiple recipients (including Mr Harvey, Ms Kelly and Ms Hodkinson)

and copied in Mr Swash. In the body of the email, Mr Cross stated in respect of Baby A's inquest:

> "*6 of our clinicians are giving evidence at the inquest and I have provided support and held case conferences with the clinicians and all the necessary preparations have been completed.*
>
> *The Coroner is aware of the review undertaken by the RCPCH and the necessary disclosures have been made*."[104]

24.80 Whilst the coroner was aware that the RCPCH had undertaken a review of an increase in neonatal deaths, he was not aware that there were suspicions and concerns about a member of staff harming babies. Reference to 'necessary disclosures' did not include this crucial information. The use of the phrase 'necessary disclosures' may have led others to believe that it did.

## The inquest hearing

24.81 The inquest was held on 10 October 2016. The Inquiry has been provided with three notes of the hearing: an attendance note produced by the solicitors of Parents A and

B; an attendance note produced by the Countess; and the handwritten notes of Mr Swash.

24.82 Parents A and B, Dr Jayaram, Dr Saladi, Dr Ogden, Dr Harkness, Dr Wood, Dr MacCarrick and Dr Shukla were each called to give oral evidence.

24.83 The focus of the inquest's oral evidence was on the potential relevance of the long line. Dr Shukla is recorded in the attendance note produced by the solicitors of Parents A and B as saying in oral evidence that there was nothing that he could identify to link the death with the long line. He is recorded as going on to say that they "*had not found anything to suggest a natural disease but then there was no evidence that there had been anything unnatural either*" and that "*it would be very difficult for him to conclude that it was more likely than not natural causes because there was no evidence of it either way*".[105]

24.84 After Dr Shukla gave evidence, Dr Jayaram was recalled "*to try and assist with his paediatric knowledge of the circumstances in … concluding with any kind of cause of death*".[106] The careful and detailed attendance note made by the solicitors of Parents A and B recorded the evidence he gave as follows:

"*Mr Rheinberg asked Dr* [Jayaram] *whether or not he had seen anything similar. Dr* [Jayaram] *confirmed that normally death in neonates is the end point in a course of events and normally they can be resuscitated. He confirmed that there have been similar cases of neonates dying in similar circumstances on the unit which they have not been able to explain. He confirmed that they have therefore downgraded the unit so that* [they] *do not care currently for preterm babies and they have also requested an independent review and they are still awaiting the formal report. However the initial feedback from this is that nothing can be found that is wrong with any of the training, any of the practises or any of the equipment. However there is a potential issue with staffing. As far as Dr* [Jayaram] *is aware this report is then to go back to the Executive Board and they decide whether or not to release it to the public. Mr Rheinberg asked whether or not it would be possible for the family to receive a copy. Dr* [Jayaram] *said he is of the personal view that it should be made available for the public and he would have no issue with a copy of it being provided*

> *to the family, however as he pointed out it is the Executive Board's decision. He has to confirm however that the events that happened to Child A do not make any clinical sense to him at all.*"[107]

24.85 Dr Jayaram said in oral evidence that he thought the note accurately recorded what he had said.[108]

24.86 Neither Dr Jayaram nor Dr Saladi explicitly mentioned their concerns or suspicions about Letby. Dr Jayaram did refer to "*staffing*". Mr Rheinberg may not have realised that this word was used as a euphemism for a member of staff, in this case a nurse, as Dr Jayaram confirmed in evidence. Mr Rheinberg expressed dismay that neither Dr Jayaram nor Dr Saladi informed him about their concerns about the nurse.[109]

24.87 Mother A and B was asked how she felt regarding the concerns about Letby not being verbalised in Baby A's inquest hearing. She replied: "*Very, very concerned. At the inquest, we had no idea, and from the trial we know that by that time they did suspect her, but nobody mentioned it, not once, and they should have*."[110]

24.88 Dr Jayaram accepted in oral evidence that he should have told the coroner that a member of staff may have been responsible for Baby A's death.[111]

24.89 Dr Jayaram said that he understood that the neonatal deaths, bar one, had been referred to the coroner.[112] Dr Jayaram said he was "*cognisant of the fact we had been told: do not speculate*"[113] and he had the impression, reasonably, that the consultants' specific concerns regarding Letby were "*on the Coroner's radar*".[114] Dr Jayaram also said that he had tried to make it clear to the coroner that he did not understand what was going on, could not think of a clinical explanation, and that "*there had been other things like this as well*".[115] Dr Jayaram said the reference in his evidence at the inquest to "*a potential issue with staffing*" was an "*oblique reference to an individual member of staff*".[116] Finally, Dr Jayaram explained his omission as a lack of courage:

> "[Y]*ou are absolutely correct, you know, I am there in a Coroner's court and I should say what I think and again I didn't.*
>
> *I think … and I … reach out to Baby A and B's parents for this, and maybe I should have done a supplementary statement or*

*talked afterwards – I was trying to in my discussion about the fact I couldn't explain this, you know, in the context that my understanding was that the Coroner knew of our concerns I was trying to sort of throw as many breadcrumbs as possible for the Coroner to pick up without explicitly saying what the suspicion was.*

*Why did I do that? And again – and I appreciate that this was the wrong judgment – I had Baby A's parents sitting 10 feet away from me and, yes, absolutely, duty of candour.*

*I just didn't have the courage to say it and I think part of this, part of this was already from … I guess being influenced by the … pushback that we were getting that, 'There's nothing to see here' and … I regret not explicitly saying that then on many, many levels because it should have been said … and I am not going to make excuses. I did have an understanding that the Coroner was aware of our concerns because I interpreted that's what Stephen Cross had told the Coroner and I should have done better*."[117]

24.90 Dr Saladi also accepted it was a mistake not to have shared his concerns about Letby with the coroner.[118] Like Dr Jayaram, Dr Saladi also explained his omission by reference to advice he had received about giving evidence and the knowledge he believed the coroner already had. Dr Saladi also relied on his inexperience at giving evidence at inquests. Dr Saladi said:

> "[T]*hat was probably my first, maybe first or second appearance of Inquest and I was stressed and advice we got from the solicitors was answer the questions, what is asked, don't answer what you think was asked and keep it brief and do not speculate.*
>
> *So if the Coroner has asked me, I would have probably said. But because it wasn't asked, because what I didn't know is what is speculation at that stage …*
>
> *… as far as I am aware, Coroner is aware of the deaths. I didn't need to tell them …*
>
> *… because we were having these unexpected deaths, we were referring them to the Coroner.*
>
> …

> *I was thinking whether rightly or wrongly that I was answering in relation to Baby A my involvement, if I had any suspicion, and my answers were brief and to that point, what he asked.*
>
> *It is probably in retrospect mistake for me to not share my concerns but that is because of inexperience, I think.*"[119]

24.91 Mr Rheinberg thought that if the concerns had come out at the inquest he would have adjourned: "*I wouldn't have gone on any further, and probably sought police involvement*."[120]

24.92 Mr Rheinberg said that he would have expected Mr Cross or someone else to inform him before the inquest of the concerns regarding Letby, the unusual characteristics of Baby A's death and Baby B's subsequent collapse.[121] Mr Rheinberg said it was "*horribly disappointing*" that he was not made aware of these matters.[122] Mr Rheinberg explained:

> "*It was all within the … ethos of the … Sudden Unexpected Infant Death protocol, that we should approach all these tragedies not just in our own ivory towers;*

*that we should share all information because we might individually have pieces of the picture to put together.*

*So police, hospital, everybody that has anything to add should add to the discussion, as I say, to complete a full picture* [of] *what … has happened.*

…

[It is] *very, very disappointing that relevant information is not shared.*

…

*But quite outside the protocol, that … should be the case in any event. I am holding inquests. I need information. I am holding investigations. I need people to be forthcoming with information*."[123]

24.93 Against that background, I return to the failure of the coroner's office to provide the Thematic Review to Parents A and B. Had it been provided, as it should have been, it is likely that it would have prompted questions from their lawyers. That would also have alerted the coroner to the fact that there was a document missing from his papers and, in all likelihood, would have prompted him to ask some questions about the findings of the Thematic Review. In light of Dr Jayaram's

"*breadcrumbs*", the coroner may have asked some more probing questions, which might have obtained answers which might have caused him to adjourn. But the Thematic Review was not sent, and I cannot say with confidence what would have been done had it been sent.

24.94 In the event, the inquest of Baby A ended with a narrative conclusion: "*It cannot be determined what caused Child A's collapse and subsequent death and further it cannot be determined whether this was due to a natural or unnatural event*."[124]

24.95 Mother A and B expressed her frustration about the inquest in oral evidence. She said: "*I felt like it was a waste of time, if I was being completely honest, because nothing came of it*."[125] She was right about that.

## Further observations on the inquest for Baby A

24.96 Dr Jayaram told the coroner in evidence that there had been similar cases of neonates dying in similar circumstances on the neonatal unit, which the consultant paediatricians had been unable to explain. This was alarming. As Dr Hawdon said in her evidence to the Inquiry, neonates dying without explanation is worrying. That Mr Rheinberg did not

seek to explore this further suggests that he did not pick up on the worrying nature of Dr Jayaram's inquest evidence, presumably because this was outside his area of expertise.

24.97 Mr Rheinberg acknowledged in evidence that he knew about the cluster of three neonatal deaths in June 2015 and the general increase in mortality at the Countess; and he had been concerned by the deaths of Baby O and Baby P. By the time of the inquest for Baby A, he had been told of the RCPCH review (September 2016) and the recommendation for a forensic case note review (October 2016).[126]

24.98 In its closing submissions, the Countess accepted that the obligation to make disclosure to the coroner ultimately rested with the hospital.[127] Mr Browne KC had advised the hospital in conference, in September 2016, to disclose to the coroner any involvement of the nurse concerned in the care of Baby A.[128] Mr Browne KC said in oral evidence: "[H]*aving worked with Mr Cross on a number of occasions, there had not been an occasion to my memory where he had failed to follow my*

*advice*."[129] Mr Browne KC's error may have been in assuming that Mr Cross would follow his advice on this occasion.

24.99 Mr Cross's notebook entries are referred to in his supplementary statement. Following Baby A's inquest, there was a discussion between Mr Cross and Mr Swash.
Mr Cross records the discussion as follows: "*Narrative Verdict 'Unascertained' No negative comments No press.*"[130] Mr Cross's handwritten notes dated 10 October 2016 record that he briefed "*AK* [Ms Kelly] … *re outcome of* [Baby A] *Inq- Narrative conclusion. No adverse comments. No press present.*"[131] He also had a meeting with the Medical Director, Mr Harvey, to discuss the outcome of the inquest.[132] It is readily apparent that Mr Cross and the executives were following the events and any press interest with care. The notes make no reference to any discussion about, or concern for, the parents of Baby A. The obvious concern of Mr Cross and the executives about "*negative comments*" or "*press*" suggests that the prevention of reputational damage to the hospital was prized more highly than the transparency and inquisitorial function of the coronial process.

## February 2017

24.100 On 8 February 2017, Mr Rheinberg met Mr Harvey and Mr Cross. Mr Rheinberg had no recollection of the meeting, but a note was taken by Mr Cross.[133] The note recorded that Mr Rheinberg asked whether anything had "*come out*" of the investigations undertaken. Mr Harvey was noted to reply: "*No theme has emerged.*" The note also recorded Mr Rheinberg as saying that the hospital had done the right thing, but Mr Rheinberg was unable to recall what he had meant by this.[134] In his witness statement, Mr Cross said that Mr Harvey "*fully briefed the Coroner on the neonatal matters to date*".[135] Again, Mr Cross did not explain what a full brief involved. Mr Rheinberg's evidence was that he was not told of any suspicions or concerns relating to the involvement of a nurse in the deaths of babies at the hospital.[136] Given the way matters developed, this is likely to be correct. Mr Cross should have told Mr Rheinberg.

24.101 On 15 February 2017, Mr Rheinberg and Mr Moore met Mr Harvey and Mr Cross. During the course of the meeting, Mr Rheinberg was handed a letter which enclosed: (a) a document comprising the portions of the RCPCH report that had been

redacted for the dissemination version; (b) Dr Hawdon's report; and (c) the 10 February 2017 letter from the consultant paediatricians to Mr Chambers.[137]

24.102 Mr Rheinberg could not recall the meeting, but did take a note of it.[138] The note recorded discussion of Dr Hawdon's report and the consultant paediatricians' letter. The bulk of the meeting appeared to have involved discussion of the request that the coroner undertake an investigation into the deaths and unexpected collapses that had occurred on the neonatal unit. In oral evidence, Mr Rheinberg summarised his response to that as follows:

> "*I … got the idea that what the Consultants wanted was* [for] *me to have an overall review of all the cases to see if there were any … mistakes or any common themes or whatever. And I was explaining that … I don't have jurisdiction … to do that, no authority to carry out a general review, as it were, only to hold an Inquest into a specific death.*"[139]

24.103 Mr Rheinberg's note contained no reference to the document containing the extracts from the unredacted RCPCH report. Mr Rheinberg explained in his witness statement:

*"I am confident that the document which is dated November 2016 was not referred to at the meeting. If it had been the subject of any discussion, I would have made reference to this in my note. The first time that I saw this note was when I received the bundle of relevant papers in order to assist in the preparation of my statement of evidence to the inquiry. There are two possible explanations for the document not coming to my attention. The first is that it was not in fact included with the other papers accompanying the letter of 15th February 2017. The other and more likely explanation is that it was included but that I overlooked it. Although the note is less than an accusation of wrongdoing the suggestion that one nurse had been 'rostered on shift for all the deaths' would have prompted me to ask for the identity of the nurse in question and I believe that I would probably have spoken to DI Mark Tasker or another police officer and have asked if the officer was aware of the fact that, coincident with all the deaths, was the presence on each occasion of one nurse."*[140]

24.104 In oral evidence, Mr Rheinberg repeated that he had not read the RCPCH report extracts during the meeting and there was no reference to that document during the meeting.[141] Mr Rheinberg accepted, however, that it would have been a fair assumption for Mr Harvey and Mr Cross to make that he had and could look at the information contained in the bundle of documents provided to him.[142] He did not look at the other documents and did not tell Mr Harvey or Mr Cross that he would not do so.

24.105 The final paragraph in Mr Rheinberg's note of the meeting on 15 February 2017 recorded a question asked by Mr Moore: "*AGM* [Mr Moore] *asked what the clinicians hoped to achieve by seeking Inquests and wondered whether there were reputational motives* [for] *there being no right of 'appeal' from the Royal College's findings*."[143]

24.106 Mr Moore was asked in oral evidence what he meant by this. He explained:

> "[T]*his is a letter from the Consultants to the … Chief Executive at the hospital and I thought this is somewhat unusual. Why would the Consultants be writing to the Chief Executive? So in my own mind I am asking the question: what could be the*

*motivation behind that? There must be some reason. And I asked that question at the meeting. And I … think … I asked: is it perhaps they have suffered reputationally from something in that report which of course I hadn't seen.*"[144]

24.107 When it was suggested that one interpretation of the note was that Mr Moore was ascribing to the consultant paediatricians a bad faith motivation of concern about self-reputation, Mr Moore denied that that was what he had meant.[145] He suggested he meant the opposite. Mr Rheinberg, however, working on the basis of his note rather than his recollection, did interpret Mr Moore as saying just that: "*By that I suppose he meant, was it a question of trying to deflect blame and find some other factor that could exonerate.*"[146] Given the state of the evidence I make no finding. I say only that there was no basis upon which bad faith could have been attributed to the paediatricians in writing the letter. What they were asking for was a review of the cases by the coroner. That would be an odd request to make in bad faith.

24.108 Both Mr Moore and Mr Rheinberg were adamant that at no point during the meeting were they told of any suspicions or concerns

relating to the involvement of a nurse in the deaths of babies at the hospital.[147] Mr Moore said in oral evidence: "*There was no mention whatsoever of anything of that kind. If there had been, the outcome of this meeting would have been very different, I assure you*."[148]

24.109 Mr Rheinberg's note of the meeting did not record mention of any such concerns. Similarly, Mr Moore's email of 3 May 2017 to Detective Superintendent Aaron Duggan, recalling the meeting of 15 February 2017, also made no mention of Mr Rheinberg and Mr Moore being told about concerns regarding a member of staff.[149]

24.110 Mr Harvey differed in his recollection. In his oral evidence, Mr Harvey said of the meeting on 15 February 2017:

> "*I recall that either Mr Cross or I, in passing the paediatricians' letter across to Mr Rheinberg explained the background to the letter and the paediatricians' concerns. I am also aware that there is documentation within the Inquiry that confirms part of the bundle that Mr Rheinberg received was actually the full RCPCH report, which included reference to the paediatricians' concerns.*"[150]

24.111 Mr Harvey said there was absolutely no doubt in his mind that such a conversation took place.[151] Again, Mr Cross's written evidence was that Mr Harvey "*fully briefed the Coroner on all matters*", without explanation of what a full brief involved.[152] I think it unlikely that had Mr Rheinberg been told of the concerns about the nurse he would not have written it down. However, in handing over the redacted report, albeit buried amongst other documents, Mr Harvey and Mr Cross were able to say, as they did, to the paediatricians and others, that they had briefed the coroner about all matters.

24.112 Given the unusual nature of the visit from Mr Harvey and Mr Cross and the unusual letter to Mr Chambers from the consultants, it is surprising that Mr Rheinberg did not read the sections of the unredacted report. Had he done so he would have realised immediately that until that stage he had not been given the full story and had been given no clue that this was the case. Realising this was the case would have caused him irritation and consternation. He would then, I have no doubt, acted in accordance with his normal process and contacted the police.

24.113 I recognise that Mr Rheinberg was under enormous pressure of work at that time and was about to retire. He had made it very clear to Mr Harvey and Mr Cross that he would not be carrying out the investigation being asked for. At that point Mr Harvey and Mr Cross should have pointed out the additional material in the bundle and explained why the consultants were making the request in the letter.

24.114 Mr Rheinberg retired on 10 March 2017 and Mr Moore became Senior Coroner the same day.[153]

# Endnotes

1 Coroners and Justice Act 2009 (**https://www.legislation.gov.uk/ukpga/2009/25/contents**)

2 Coroners and Justice Act 2009, section 14 (**https://www.legislation.gov.uk/ukpga/2009/25/section/14**)

3 **INQ0017840/3**

4 **INQ0002042/4**

5 **INQ0002042/9**

6 **Nicholas Rheinberg 6 December 2024 14/17-18**

7 **INQ0002047/3-5**; **INQ0002047/11**

8 **Dr John Gibbs 1 October 2025 65/9 to 66/12**

9 **Dr John Gibbs 1 October 2024 123/12-23**

10 **Dr John Gibbs 1 October 2024 98/13 to 99/5**

11 **Nicholas Rheinberg 6 December 2025 90/3-7**

12 **Nicholas Rheinberg 6 December 2024 91/2-11**

13 **Dr John Gibbs 1 October 2024 66/11-12**

14 **INQ0002045/4**

15 **INQ0002045/8**

16 **Nicholas Rheinberg 6 December 2024 100/19-21**

17 **Nicholas Rheinberg 6 December 2024 29/14-22**

18 Alan Moore 4 December 2024 116/18 to 119/4
19 Dr ZA 7 October 2024 24/6 to 26/21
20 INQ0002043/3
21 INQ0002046/3; INQ0002044/3
22 Alan Moore 4 December 2024 118/6-8
23 INQ0008927/7
24 Mother A and B 16 September 2024 17/1-24
25 INQ0008927/7
26 Dr Stephen Brearey 19 November 2024 204/21 to 205/3
27 INQ0003089/1-2
28 INQ0008927/5
29 Witness statement of Nicholas Rheinberg INQ0017842/26/para 84
30 Nicholas Rheinberg 6 December 2024 33/23-25
31 Witness statement of Nicholas Rheinberg INQ0017842/23/para 74
32 Witness statement of Nicholas Rheinberg INQ0017842/26/para 84
33 Alan Moore 4 December 2024 119/8-22
34 Alan Moore 4 December 2024 120/5-12
35 Witness statement of Stephen Cross INQ0108952/4/para 19
36 Alan Moore 4 December 2024 120/25 to 121/3

37 INQ0002042/174

38 INQ0002042/173

39 INQ0002042/167

40 INQ0002042/186

41 INQ0050707; INQ0008841

42 INQ0008841/3

43 INQ0002042/777

44 INQ0002042/155

45 INQ0002042/154

46 Nicholas Rheinberg 6 December 2024 105/16-18

47 Nicholas Rheinberg 6 December 2024 107/17-19

48 Written Closing Submissions on Behalf of Family Group 1 4 March 2025 71/footnote 237

49 INQ0053069

50 INQ0012066/1

51 Nicholas Rheinberg 6 December 2024 68/12-18

52 Nicholas Rheinberg 6 December 2024 23/18 to 24/6; Alan Moore 4 December 2024 120/13-20

53 Witness statement of Stephen Cross INQ0107707/19/para 66

54 INQ0007314/25

55 INQ0008638/1-3

56 Witness statement of Sarah Harper-Lea INQ0108403/2/para 5

57 Witness statement of Sarah Harper-Lea INQ0108403/1/para 2

58 INQ0008638/1-3

59 Louis Browne KC 4 December 2024 16/23 to 17/13

60 INQ0007197/138

61 Ian Harvey 28 November 2024 124/24 to 125/3

62 Louis Browne KC 4 December 2024 9/3-7

63 Louis Browne KC 4 December 2024 9/9-18

64 INQ0108406/3

65 Louis Browne KC 4 December 2024 45/23 to 46/5

66 Louis Browne KC 4 December 2024 46/6 to 47/6

67 Louis Browne KC 4 December 2024 48/2-8

68 Louis Browne KC 4 December 2024 47/19 to 48/1 and 52/16 to 53/7

69 Louis Browne KC 4 December 2024 12/20 to 13/14

70 Louis Browne KC 4 December 2024 13/9-14, 49/22-25 and 55/4-15

71 Mother A and B 16 September 2024 45/7-12

72 INQ0108406/7

73 Witness statement of Joshua Swash INQ0108481/6/para 24

74 Louis Browne KC 4 December 2024 77/1-5

75 Louis Browne KC 4 December 2024 38/25 to 39/7

76 Louis Browne KC 4 December 2024 25/9-11

77 INQ0052593/2

78 INQ0052593/1

79 Louis Browne KC 4 December 2024 28/14-17

80 Louis Browne KC 4 December 2024 28/18-19

81 Louis Browne KC 4 December 2024 55/21-24

82 Louis Browne KC 4 December 2024 58/16 to 59/7

83 INQ0108406/9-12

84 INQ0108406/11

85 INQ0108406/12

86 Louis Browne KC 4 December 2024 61/15-22

87 Louis Browne KC 4 December 2024 61/24-25

88 Louis Browne KC 4 December 2024 62/21-22

89 Louis Browne KC 4 December 2024 62/1-5

90 INQ0053069

91 INQ0053069

92 INQ0012066

93 Louis Browne KC 4 December 2024 37/19-24 and 40/2-10

94 Louis Browne KC 4 December 2024 66/8-14

95 Louis Browne KC 4 December 2024 66/17-19

96 Nicholas Rheinberg 6 December 2024 68/12-15

97 Nicholas Rheinberg 6 December 2024 68/19 to 69/1

98 Nicholas Rheinberg 6 December 2024 99/21 to 100/10

99 INQ0002045/8

100 INQ0107909/8

101 INQ0008841/3

102 INQ0053069

103 Dr Ravi Jayaram 13 November 2024 65/19-24 and 66/3-8. Also see Dr Ravi Jayaram 13 November 2024 239/9-13

104 INQ0108480/17

105 INQ0107909/8

106 INQ0107909/8

107 INQ0107909/8

108 Dr Ravi Jayaram 13 November 2024 68/7-11

109 Nicholas Rheinberg 6 December 2024 72/2-18

110 Mother A and B 16 September 2024 52/7-10

111 Dr Ravi Jayaram 13 November 2024 246/11-14

112 **Dr Ravi Jayaram 13 November 2024 68/17-19**

113 **Dr Ravi Jayaram 13 November 2024 68/19-20**

114 **Dr Ravi Jayaram 13 November 2024 69/7-9**

115 **Dr Ravi Jayaram 13 November 2024 68/24 to 69/2**

116 **Dr Ravi Jayaram 13 November 2024 244/12 and 244/21-22**

117 **Dr Ravi Jayaram 13 November 2024 245/9 to 246/10**

118 **Dr Murthy Saladi 3 October 2024 118/14-16**

119 **Dr Murthy Saladi 3 October 2024 117/3 to 118/16**

120 **Nicholas Rheinberg 6 December 2024 72/11-13**

121 **Nicholas Rheinberg 6 December 2024 60/12-15**

122 **Nicholas Rheinberg 6 December 2024 60/8**

123 **Nicholas Rheinberg 6 December 2024 60/15-23, 61/9-10 and 62/18-22**

124 **Nicholas Rheinberg 6 December 2026 25/22-25**

125 **Mother A and B 16 September 2024 25/9-11**

126 **Nicholas Rheinberg 6 December 2024 24/1-14** and **33/7-25**

127 **Written Closing Submissions on Behalf of the Countess of Chester Hospital NHS Foundation Trust 4 March 2025 58/para 227**

128 **INQ0108406/3**

129 **Louis Browne KC 4 December 2024 50/5-7**

130 **INQ0108953/5**

131 **INQ0108953/6**

132 **INQ0108953/6**

133 **Nicholas Rheinberg 6 December 2024 45/17-20**; **INQ0106817/34**

134 **Nicholas Rheinberg 6 December 2024 108/15-23**

135 **Witness statement of Stephen Cross INQ0107707/42 para 160**

136 **Witness statement of Nicholas Rheinberg INQ0017842/32 para 100**

137 **INQ0002048/34**; **Witness statement of Nicholas Rheinberg INQ0017842/30 para 95**

138 **INQ0002048/102**

139 **Nicholas Rheinberg 6 December 2024 57/9-15**

140 **Witness statement of Nicholas Rheinberg INQ0017842/32 para 98**

141 **Nicholas Rheinberg 6 December 2026 99/10-11** and **112/2-9**

142 **Nicholas Rheinberg 6 December 2024 58/2-7**

143 **INQ002048/102**

144 **Alan Moore 4 December 2024 132/8-17**

145 **Alan Moore 4 December 2024 133/18-23**

146 **Nicholas Rheinberg 6 December 2024 111/15-18**

147 **Witness statement of Nicholas Rheinberg INQ0017842/32 para 100**

148 **Alan Moore 4 December 2024 136/22-24**

149 **INQ0002048/110**

150 **Ian Harvey 29 November 2024 117/17-24**

151 **Ian Harvey 29 November 2024 219/15-17**

152 **Witness statement of Stephen Cross INQ0107707/44 para 168**

153 **Alan Moore 4 December 2024 108/10-12**

# Chapter 25. NHS England and the Countess

## Background

25.1 During the period 2015 to 2017, certain functions that currently sit within NHS England were split between different organisations:

a. Until 1 April 2016, Monitor was the independent regulator of NHS Foundation Trusts. It licensed them and enforced the conditions of their licences.[1] (The NHS Trust Development Authority provided a similar regulatory function for Non-Foundation Trusts.)

b. From 1 April 2016, the functions of Monitor and the NHS Trust Development Authority were brought together to create NHS Improvement.[2]

NHS England remained responsible for oversight of local CCGs and had direct responsibility for commissioning of specialised services.[3]

25.2 Throughout the relevant period, and until 31 March 2025, NHS England was directly responsible for the commissioning of neonatal services at the Countess as a specialised service.[4]

25.3 Management of the neonatal services commissioning contract with the hospital was delegated to the NHS England Regional Specialised Commissioning Team for the North (Specialised Commissioning (North)).[5] In practice, this meant that Specialised Commissioning (North) was responsible for quality-assuring neonatal services at the Countess.[6]

25.4 The NHS North regional team also had oversight and surveillance of Serious Incident management within NHS-funded care in its area. In his first witness statement, Sir Stephen Powis described NHS England at a regional level as having a "*dual role*" in relation to Serious Incident management:

> "*(a) As the commissioner, it would discharge the duties set out in the Serious Incident Framework and monitor contractual performance … If issues were detected around serious incidents that had an impact on the quality and safety of commissioned services, then NHS*

*England regional teams could take action <u>as the commissioner</u>* [emphasis in original] *… This action might include enhanced monitoring and reporting of temporary changes in commissioned services. The downgrading of the neonatal unit at the … Hospital was an example of this …*

*(b) An oversight role (consistent with its patient safety responsibilities at the time) to ensure there was effective serious incident reporting and subsequent management of incidents by the lead commissioner.*"[7]

25.5 NHS Improvement also had a regional team for the North, headed by Ms Lyn Simpson, Executive Regional Managing Director (North).

25.6 Annex 6 of the first witness statement of Sir Stephen contains a list of persons holding key regional positions in NHS England and NHS Improvement since 2015.[8]

25.7 The organisational split between NHS England and NHS Improvement, and the regional/national separation within each organisation, led to a mismatch of data flow and information:

a. The NRLS was monitored by NHS England at a national level only. The regional team

would only become aware of issues or concerns identified through the NRLS database if the national team brought them to its attention.[9] This is surprising. If something merits a report to the national system, surely it merits consideration and action at a regional level. That said, it is not apparent that this made any difference to events at the Countess. CQC did have access to the database.

b. StEIS, on which Serious Incidents were reported and logged, could be accessed by NHS England regional teams but not by NHS Improvement/Monitor. The latter "*instead relied on either commissioners sharing relevant information with them or on matters of relevance being directly reported to them by providers*".[10]

25.8 Operational Delivery Networks were established by NHS England in 2014. In its written closing submissions, NHS England described Operational Delivery Networks as being "*still in their infancy*" during the period 2015 to 2017.[11]

25.9 In her witness statement, Ms Julie McCabe (née Maddocks), Director, North West Neonatal Operational Delivery Network (NWNODN), described the Network's function

as being "*to coordinate patient pathways between providers over a wide area to ensure access and egress of specialist neonatal care. The NWNODN supported neonatal services in the region to meet national, local and Trust standards and optimise resources to improve services*."[12]

25.10 The Cheshire and Merseyside Neonatal Network Clinical Effectiveness Group was a sub-group within the Operational Delivery Network, which provided clinically driven governance and "*an assurance framework*" in its locality. Its role included "*co-ordinat*[ing] *incident reporting across the Network as well as reviewing mortality cases across the network, sharing learning gained from these reviews where appropriate*".[13]

## Interactions between Monitor and the Countess

25.11 In his first witness statement, Sir Stephen said:

> "*During the period up until 30 June 2016, Monitor had no contact with the Countess of Chester Hospital outside of its routine review of the annual submissions provided by the Hospital … No by-exception*

*reporting requirements were required by Monitor or proactively made by the Countess*."[14]

25.12 Two possible explanations for the lack of contact are found in Sir Stephen's evidence.

25.13 First, the Countess was considered by Monitor and NHS Improvement to be a high-performing organisation. As such:

> "*It was not on Monitor's radar as a Foundation Trust requiring additional support or intervention and its reported performance did not suggest it was an outlier in any respect.*
>
> *This was in contrast to the challenges that other providers were experiencing, both in the North Region and nationally.*"[15]

25.14 Second, in respect of NHS Improvement, Sir Stephen said:

> "*NHS Improvement's primary focus shortly after it was established was on financial management at a provider level, due to the concerns that existed at the time around financial performance. Whilst NHS Improvement did have several workstreams that related to quality, it relied primarily on the oversight provided*

*by the Care Quality Commission and commissioners when it came to assessing the quality and safety of particular services."*[16]

25.15 Sir Stephen described how Monitor/NHS Improvement placed considerable reliance on inspections and assessments performed by CQC.[17] It appears that Monitor/NHS Improvement was not informed in advance of CQC's inspection of the Countess in February 2016.[18] Further, the June 2016 report produced following that inspection was not thought to raise any particular concerns.[19] My analysis of CQC's inspection is at Chapter 7. It is likely that CQC's approach, too, was affected by the fact that the Countess was high-performing.

## The reporting of neonatal deaths to NHS England and associated bodies

25.16 As set out in Chapter 4, on 3 July 2015, a report was filed to StEIS in relation to the death of Baby D.[20] Baby D was the only baby to feature on the indictment whose collapse or death was the subject of a Serious Incident report during this period until the deaths of Baby O and Baby P a year later.

25.17 The Wirral CCG was the lead commissioning organisation with oversight of the investigation into the Serious Incident reported in relation to Baby D. As described in paragraphs 4.58 to 4.60, Chapter 4, the Countess finalised the case review after the post-mortem, and it was reviewed by the CCG on 14 December 2015. The CCG agreed that the Serious Incident had been adequately investigated, and it closed the investigation.

25.18 It was the shared view of NHS England[21] and Family Group 1[22] that each of the clusters, as well as each of the individual unexpected collapses or deaths, should have been reported to StEIS as Serious Incidents. What difference that would have made is not clear, given that the report of Baby D led to nothing. Separately, the deaths of Baby A, Baby C, Baby D, Baby E and Baby I were each reported to the NRLS. Nothing seems to have happened as a result of this. The clinicians were not hiding anything.

25.19 The North West Neonatal Operational Delivery Network knew about the deaths on the Countess's neonatal unit: see the meetings of the Cheshire and Merseyside Neonatal Network Clinical Effectiveness Group to which I refer in Chapters 5 and 6.

25.20 The minutes of the meeting of the Clinical Effectiveness Group on 16 September 2015 recorded: "*Mortality: 3 deaths under review will be discussed at subsequent CEGs*."[23] The meeting was chaired by Dr Subhedar, and attended by Dr Brearey.

25.21 Baby E's death was noted in the minutes of the meeting held on 12 November 2015.[24] The meeting was chaired by Dr Subhedar and attended by Dr Brearey and Ms Powell.

25.22 Baby I's death was noted in the minutes of the meeting held on 21 January 2016.[25] The meeting was chaired by Dr Subhedar and attended by Dr Brearey.

25.23 At none of the meetings were concerns about an increase in neonatal mortality discussed.

25.24 On 8 February 2016, Dr Subhedar participated in the meeting on the Thematic Review at the Countess (see Chapter 7). It was Dr Subhedar who, following the meeting, suggested adding to the Thematic Review report a 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]".[26]

25.25 NHS England maintained that those concerns were not passed on to them, nor to NHS Improvement, so that these organisations were unaware of the concerns regarding neonatal deaths and collapses at the hospital during the period of Letby's offending.[27] It is, however, right to say that NHS England did have reports on the NRLS about every death on the neonatal unit. So far as I can tell, NHS England did nothing with these reports. In particular, NHS England did not raise the deaths with the regional team.

## Interactions between NHS England and the Countess following the deaths of Baby O and Baby P, July 2016

25.26 NHS West Cheshire CCG was designated as lead commissioner overseeing the Serious Incident investigation.

25.27 On the day the deaths of Baby O and Baby P were reported to StEIS, Mr Peter Groggins, Quality and Experience Lead, NHS England (Cheshire and Merseyside), emailed Mr John Grant, Incidents and Assurance Co-ordinator, NHS West Cheshire CCG, to ask whether one of the two Serious Incidents was a duplicate

and needed to be removed. Mr Grant confirmed that they were not duplicates but related to the deaths of two different babies.

25.28 On 5 July 2016, Ms Lisa Cooper, Deputy Director Quality and Safeguarding (Cheshire and Merseyside) and Regional Lead Safeguarding (NHS North), emailed Mr Groggins and others at NHS North asking to meet "*to discuss a number of serious incidents that have occurred at the Countess of Chester on the Neonatal unit and a potential review we will need to do this week*".[28] Mr Groggins was asked to collate any incidents reported in the previous 12 months.

25.29 The same day, Ms Patel sent an email to a number of addressees, including directors and senior clinicians within the NHS North regional team, senior directors of operations within NHS England, NHS West Cheshire CCG and NHS Improvement. In the email, Ms Patel wrote:

> "*We have been made aware of some serious issues relating to the Countess of Chester Hospital Neonatal Services …*
>
> *The Unit was under some local scrutiny earlier in the year following an infection concern. A thematic review was*

*undertaken 10 cases reviewed with no clinical issues identified. The Director of Nursing has confirmed that there are other issues coming to light now, that have not necessarily been reported, the recent deaths identify the Trust as an outlier.*

…

*The Countess also has some work to do in order for the system to be assured regarding their internal governance within this speciality.*"[29]

25.30 Ms Patel also outlined the hospital's plan to downgrade the neonatal unit and for an "[e]*xternal review*" to be carried out.[30]

25.31 On 6 July 2016, Mr Groggins contacted the hospital to request the 72-hour review of the deaths of Baby O and Baby P (in line with the Serious Incident Framework).[31] The same day, Ms Millward emailed Mr Groggins, stating:

"*I understand that you have been in touch regarding the 72 hour review of the triplets who died.*

*I can confirm that the initial review was held yesterday and that this has triggered a number of areas for deeper dive, including peer review of the x-rays undertaken on* [Baby O] *and a further review by*

> *obstetricians regarding delivery and the possibility that the liver sub-capsular haematoma [identified on PM] occurred in perinatal period. No clear cause of death was identified for* [Baby P] *from the initial review*."[32]

25.32 Ms Millward did not mention in her email the concerns that had been raised by the consultant paediatricians regarding Letby. This was despite Ms Millward having attended a meeting on 29 June 2016 during which those concerns were discussed.*

25.33 On 7 July 2016, the neonatal unit at the Countess was downgraded from Level 2 to Level 1. The hospital made another Serious Incident report to StEIS in respect of this downgrade. The report gave the reason for the downgrade as "*an increase in neonatal mortality rates for 2015 and 2016 compared to previous years*".[33] The report made no mention of the fact that concerns had been raised about a particular member of staff's association with neonatal mortality.

---

* See notes of the meeting on 29 June 2016 at **INQ0098334** and **INQ0106816/5-7**.

25.34 The same day, Mr Harvey, Ms Kelly, Ms Townsend and Ms Millward met Ms Lisa Cooper, Ms Paula Wedd (Director, Quality and Safeguarding, NHS West Cheshire CCG) and Ms Sue McGorry (Quality Lead, North West Hub, Specialised Commissioning, NHS England). Mr Bibby sent his apologies for absence.

25.35 The purpose of the meeting was to discuss the downgrading of the Countess's neonatal unit and the Trust's plan to commission a review of neonatology services by the RCPCH. The Inquiry has not seen any formal note of the meeting but was provided with Ms Kelly's handwritten note.[34]

25.36 Ms Kelly recorded the following main points as being discussed at the meeting:

- Whether the "*system*" was safe today and tomorrow. Side notes were "*thematic review*" and "*safeguarding referral*".
- The "*external review Jan 15 – June 16*" (i.e. the proposed RCPCH review), "*data set*" and "*tick box re StEIS*". Side note: "*clarify and agree*".
- "*Duty of Candour – (?)19 mums*".
- "*Special Care Baby Unit*" and "*small, sicker babies*". Side note: "*KT* [Karen Townsend]

*d/w* [dealing with] *NNU network re: comms & other units*."

- "*CDOP – no knowledge of all deaths*" and "*PW* [Paula Wedd] *to look at CDOP list*". Side note: "*CDOP list and notification*".
- "*Gill* [Frame]" (Chair) and "*Sian* [Jones]" (Business Manager) of the Cheshire West and Chester "*LSCB* [Local Safeguarding Children Board]", next to whose names is written: "*Email Re Welcome a discussion with you of all deaths*".
- "*Nigel Wenham* [Detective Superintendent] – *Police Route*".[35]

25.37 Ms Kelly also recorded the actions to be taken.[36] They included: "*AK* [Alison Kelly] *safeguarding team*" and, later, "*consider any safeguarding concerns*" and "*Sue* [McGorry]*, Lisa* [Cooper]*, Paula* [Wedd] – *call re: Police re: or any further*".

25.38 In oral evidence Ms Kelly said she could not remember the context of the discussion which led to her noting "*safeguarding referral*". She was pressed on whether this was an action for her, but said she could not recall agreeing to make any safeguarding referral. That she did not recall this is likely to be true. In her witness statement, she said that the reference

to "*safeguarding referral*" was so that she could consider whether any of the deaths gave rise to any safeguarding concerns.[37] She told the Inquiry that she did not recall telling the NHS England attendees about the consultants' concerns or about any suspicion that there was deliberate harm. Her reason for not doing so was out of consideration for Letby's welfare. She agreed that she had not made a formal safeguarding referral at that time but had spoken to Ms Gill Frame, Independent Chair, Cheshire West and Chester Local Safeguarding Children Board, to inform her of the downgrade and action being taken (just as she informed other "*partners*").[38]

25.39 The note of this telephone call in Ms Kelly's notebook is on the page before this 7 July 2016 meeting; but, given the content of the note on 7 July 2016 (regarding emailing about a discussion), it is likely that the phone call occurred the following day. But whenever the call was made, it was not a safeguarding referral, formal or otherwise. She sought – and, it appears, received – reassurance that the hospital was "*doing the right things*". There is a further reference to the police: "*?Police action may be required*."[39] Ms Kelly did not make a safeguarding referral for another year.

25.40 Mr Harvey, Ms Kelly and Ms Millward were well aware of the seriousness of the doctors' concerns. They should have informed NHS England about them. This was another significant failure by managers, two of them at Board level.

25.41 It is clear that, at the meeting on 7 July 2016, the NHS England attendees raised the possibility of a safeguarding referral and whether the police may need to be involved, along with the possibility of doing so via DCS Wenham, who was the police member on the Local Safeguarding Children Board and the CDOP. It is also clear that none of those attending from the Countess acted upon that possibility, even though they did know about the concerns. This was a serious failure by Ms Kelly, Mr Harvey and Ms Millward. The failure by Ms Kelly was particularly egregious.

25.42 Thus, Mr Bibby described his understanding at the time as follows:

> "*In July 2016, the Trust was telling the Specialised Commissioning (North West) Team that they did not know what had caused the run of outcomes on the Unit. While I now understand that clinicians at the Hospital had raised concerns about LL this was not disclosed to me*

*and, as far as I am aware, this was not disclosed to anyone else in the Specialised Commissioning (North West) Team at NHS England.*"[40]

25.43 Dr Gregory similarly said:

"*I am now aware that LL was moved from the Neonatal Unit to the risk team in July 2016 because of concerns raised about her. I was not made aware of this by the Hospital. If the Hospital had informed us at the time, then that would have prompted a series of questions from Specialised Commissioning and might have led to a recalibration of the risk profile for the Hospital. Clinicians raising concerns about an individual in relation to increased mortality is something that I would expect Specialised Commissioning to have been informed of by the Medical or Nursing Director at a hospital*."[41]

25.44 Ms Kitching said she was not aware "*that the finger was being pointed at any particular individual at this time*", nor did she believe anyone else in NHS North was aware.[42]

25.45 Despite the close organisational connection between NHS England and the North West Neonatal Operational Delivery Network,

there is no evidence that this information was passed on to NHS England. Ms McCabe, then Director of the Network, had been told by Dr Subhedar and Dr Brearey that the clinicians had "*concerns about a particular member of staff in connection with the increased mortality rate*" at about the time the hospital was downgraded. She did not pass this on to NHS England. She said:

> "*In my role it would not have been professional to make enquiries about any concerns with the capability or performance of a particular employee. My understanding was that an individual had been moved from the unit and was going through a HR process at the Trust. Following her removal from the Neonatal Unit, I was subsequently informed that the mortality rate and number of collapses had reduced significantly*."[43]

25.46 The first meeting of the Local Safeguarding Children Board held after the 7 July 2016 meeting was on 26 September 2016. Amongst a large cast of board members were Ms Gill Frame, Ms Wedd, Ms Lisa Cooper, DCS Wenham (on behalf of Cheshire Police Public Protection Unit) and Ms Kelly. In attendance also was the consultant

paediatrician Dr Mittal as Designated Doctor for Safeguarding and Child Deaths, ICB. Even at that stage, there was no discussion of any issues concerning the Countess.

## RCPCH review, further investigations and failure to share information

25.47 On 12 August 2016, Mr Bibby, as Assistant Regional Director, Specialised Commissioning (North), chaired a teleconference with the hospital and other stakeholders. Attendees included Ms Kelly and representatives from the NHS West Cheshire CCG, NHS Improvement and NHS England's Cheshire and Merseyside team. In his witness statement, Mr Bibby said that the meeting served two purposes: "[F]*irst, to seek updates and assurances around the steps that the Hospital was taking to understand what was driving the run of poor outcomes on the Unit, and secondly, to discuss the operational management of the Unit following the downgrade of that Unit*."[44]

25.48 An email sent by Mr Bibby following the meeting summarised what was discussed, including:

> "*Nothing significant to report either in Neonatal or Maternity since the last call. Further analysis of the data that was discussed last time has not identified anything in terms of trends.*
>
> …
>
> *External Review has been delayed to 1 and 2 Sept …*
>
> *Briefing paper going to Trust Quality and Safety Committee next week summarising the analysis of the data of the internal review.*"[45]

The plan was for a face-to-face meeting to take place once the RCPCH review was completed and the report received.

25.49 There appears to have been no mention of the case review performed by Dr Gibbs and Ms McGlade, nor the staff review completed by Ms Sian Williams, and Ms Fogarty, in July 2016. The case review had identified six babies in whose cases something unexpected or unusual had occurred;[46] and the staff review had identified that Letby was on duty more often than other staff when a baby had died or collapsed.[47]

25.50 In August 2016, the hospital was also on enhanced surveillance. Mr Bibby explained in his witness statement: "*The threshold for enhanced surveillance is relatively low, and enhanced surveillance may be triggered by any level of concern our quality team had about patient care, quality, or outcomes, with any of our providers*."[48]

25.51 On 14 September 2016, commissioners from Specialised Commissioning (North West) requested a copy of the RCPCH report from the hospital.[49] The response from the hospital was to inform the Specialised Commissioning Team that the RCPCH had recommended a "*forensic deep dive into the clinical cases*" but had not advised any immediate actions in terms of safety.[50]

25.52 By this time, Mr Harvey had received the letter from Ms Eardley, RCPCH, dated 5 September 2016. In that letter, Ms Eardley recommended that the hospital take immediate steps to formalise the actions it had taken with Letby, including by commencing a process of investigation, setting out the nature of the allegations against her. The letter also stated that "*the pattern of recent deaths and the mode of deterioration prior to death in some of them appears unusual and needs*

*further enquiry*" and recommended a "*detailed forensic casenote review of each of the deaths*".[51]

25.53 There is no evidence that NHS England or NHS Improvement were provided by the hospital with a copy of Ms Eardley's letter or told about the recommendation to take "*immediate steps*" to commence an investigation into the allegations made against Letby. To the contrary, Ms Kitching said in her evidence: "*My recollection is that Specialised Commissioning only had a verbal update and reassurance from the Hospital at this time*."[52]

25.54 On 16 September 2016, the North Regional Quality and Surveillance Group met. The meeting was chaired by Ms Kitching. The minutes of the meeting noted that the RCPCH review had gone "*well*" and therefore it had been agreed that "*the level of surveillance should be downgraded to 'routine'*".[53]

25.55 In her witness statement, Ms Kitching explained: "*I understood the comment that the review 'went well' to mean that there were no urgent patient safety issues being identified and the review had happened with full cooperation from the Hospital, and I recollect that it was reported that no single issue or individual was identified as a causal factor*."[54]

25.56 Dr Gregory, who also attended the meeting, gave similar written evidence.[55]

25.57 As at 2 December 2016, the Countess's surveillance level was "*enhanced*".[56]

25.58 On 16 December 2016, Mr Bibby wrote to Ms Kelly in the following terms:

> "*During our conversations, you offered to keep us updated on the situation and as such I am writing to request the following:*
>
> - *An update regarding progress towards the reinstatement of the neonatal cots*
> - *A copy of internal and external reports relating to the neonatal unit*
> - *Immediate risks or concerns*
> - *Formal action plan*
> - *Communications plan*
>
> *I am seeking your assurance that the Trust are progressing with the investigations and resulting outcomes are being actioned*."[57]

25.59 Ms Kelly replied by letter, dated 21 December 2016. She wrote: "*You will be aware that I sent an update to Sue McGorry via email on the 14th November 2016 explaining that the draft report had been received and was being checked by us for factual accuracy, this was*

*sent back accordingly and we have only just received the final approved document from the Royal College*."[58]

25.60 This was untrue. The final report had been received three weeks earlier, on 28 November 2016. The letter continued:

> "*One of the recommendations of the report was that a further independent case review was required of relevant cases. This is being undertaken by a Neonatologist from London and they require a second pathology review on a small number of cases before their final report is completed. As a consequence, we currently do not have a final report of this part of the review and therefore are not comfortable in sharing the Royal College report until we have the details of the case review.*
>
> …
>
> *Obviously the safety of our unit is paramount and on the day the review team left the Trust, they assured us that there were no immediate actions or concerns.*
>
> …

> … [t]*he relevant report will be shared with you as part of our communication plan and until that time, we will not be able to comment on the timescales or plan going forward*."[59]

25.61 In oral evidence, Ms Kelly was asked about the basis on which she said to Mr Bibby that the RCPCH review team had "*assured*" the hospital "*there were no immediate actions or concerns*", when the RCPCH report had in fact made a number of what it termed "*immediate recommendations*". Ms Kelly accepted that her language was "*potentially*" misleading but said it was "*not intentionally*" so.[60] Ms Kelly also accepted that, had she told NHS England that there were a number of immediate actions recommended by the RCPCH, that might have provoked NHS England to demand to see the report immediately.[61] She said, on more than one occasion, that she did not intend to mislead. What she said on this occasion can be read quite easily. It was not written by accident. It was misleading. I am satisfied that its purpose was to mislead, just as she intended to mislead about the date on which the RCPCH report had been received.

25.62 As to the decision not to provide the RCPCH report to NHS England at this time, Ms Kelly said that it was "*a collective decision from the Executives*".[62]

25.63 In his witness statement, Mr Bibby described his reaction to Ms Kelly's letter:

> "*I was concerned, although not necessarily surprised, by this response to my letter. As commissioners, our expectation is that providers of specialised services would share a report of this nature with us as soon as the final report was received. Indeed, NHS trusts and foundation trusts are contractually obliged to share these with us. However, it was clear to me that the Trust regarded us as analogous to any other stakeholder and felt that we needed to be managed as part of their wider communication plan*."[63]

25.64 Mr Bibby said that Specialised Commissioning (North) considered using its "*contractual levers*" to obtain a copy of the RCPCH report but felt that NHS Improvement and CQC were more likely to be successful in obtaining a copy.[64] Mr Cornall explained in his witness statement that this was because "*contact from NHS Improvement could have more impact in conveying the seriousness of an issue*

*because they could ultimately take regulatory action if they considered this necessary, including placing an organisation in special measures*".[65]

25.65 To that end, on 21 December 2016, three weeks later Specialised Commissioning (North) asked NHS Improvement for help in obtaining the RCPCH report from the hospital.[66]

25.66 Mr Vince Connolly, Medical Director (North), NHS Improvement, met Mr Harvey on 3 January 2017. Mr Connolly recorded what Mr Harvey told him as follows:

> "*Paediatricians concerned re ↑ in neonatal deaths over 18/12.*
>
> *V. low nos.*
> *Not an outlier* } → *Preliminary Investigation*
>
> *Meantime downgrade to unit* $L_3 \rightarrow L_2$
> *Review by RCPCH, v. thorough report in due course, no immediate concerns.*
>
> …
>
> *anticipate full report in 2/12*

> …
>
> *Ask for using this as example of*
>
> *'how to do it if needed in future'*
>
> *Example of governance*
>
> *Have involved families*
>
> *Met* [with] *CCG, Spec Comm* [Specialised Commissioning]*, NHSE* [NHS England] *+ informed them of what has been happening*
>
> *Mtg* [meeting] *with staff + parents ~ 10 Jan*"[67]

25.67 This was misleading in a number of respects. First, the families of babies who had died were not 'involved' at all in the RCPCH review, nor in the review by Dr Hawdon, nor the pathology review by Dr McPartland. Second, the CCG, Specialised Commissioning and NHS England had not been fully informed of what was happening, as they had not been told of the concerns regarding Letby. Third, while the hospital's Board of Directors met on 10 January 2017, no parents were contacted that day, and the only member of staff who seems to have been given the benefit of a meeting was Letby herself. The note was also factually incorrect, as the downgrade was

from a Level 2 to a Level 1 unit, not, as the note erroneously records, from a Level 3 to a Level 2.

25.68 The message passed on by Mr Connolly to NHS Improvement was that the hospital had said that the issues it was dealing with were complex and it needed more time.

25.69 On 3 February 2017, the *Sunday Times* contacted the Countess, seeking a copy of the RCPCH report. On the same day, Ms Kelly sent a copy of the embargoed RCPCH report to NHS England and other relevant organisations.[68] It was the (redacted) dissemination version.

25.70 Mr Harvey, Mr Bibby, Dr Gregory and Ms Patel met on 23 February 2017. The typed note of the meeting records that Mr Harvey confirmed that the hospital had completed the external review of babies who had died in the period January 2015 to July 2016.[69] In his written evidence, Dr Gregory said that the meeting arose because Ms Patel was raising concerns about the hospital's response to the RCPCH report. Dr Gregory further explained: "*It was at this point my concerns around the failure of the Hospital to volunteer information and its reluctance to share the RCPCH report first arose*."[70]

25.71 In their written statements, Mr Bibby and Dr Gregory both said that they were in the dark about the number of reviews that had been carried out and about which were still ongoing.[71] Dr Gregory stated:

> "*The notes prepared for the meeting do not refer to the completion of Dr Jane Hawdon's review. At that time the assumption was that the external review referred to the one carried out by the RCPCH … The language we were receiving from the Hospital throughout this period was ambiguous and I was confused as to the number of reviews being conducted and what the recommendations were.*"[72]

25.72 Similarly, Mr Bibby said that he was "*not sure*" he fully understood what Mr Harvey was saying about further reviews at the time.[73] It is unclear what steps, if any, Mr Bibby and Dr Gregory took at the time to clarify their understanding of the reviews commissioned by the Countess.

25.73 Again, there was no discussion of Letby, or of any individual members of staff, during the meeting.

25.74 In light of growing concerns about the hospital, a quality risk profile of the Countess was performed by Specialised Commissioning (North) on 25 February 2017. Mr Cornall said in his witness statement: "*This was a step we would take where we were managing a situation of this nature as a way of bringing together known risks and ensuring we had an agreed approach to managing them*."[74] Mr Bibby explained in more detail:

> "*A quality risk profile is usually undertaken where a specific concern or issue is identified that might indicate wider failings within an NHS Trust or Foundation Trust. It involves trawling the data submitted by providers across a wide range of metrics and using this data to analyse risk across the piece to understand whether an individual trust is an outlier across that wide range of metrics against a spectrum … While this quality risk profile … did not highlight any specific risks around neonatal services, it did reaffirm our view that the Trust were not in a good place in respect of their governance. The Specialised Commissioning (North West) Team would not have taken any action around this, as*

*such action would have been done more broadly by colleagues in NHS England and NHS Improvement*."[75]

25.75 Given that Mr Bibby and Dr Gregory considered that they were in the dark and did not understand what Mr Harvey was telling them, before spending effort on a quality risk profile it would have been more useful to require answers from Mr Harvey to their reasonable questions. Up to this point, the NHS England regional team were curiously diffident in their dealings with the hospital. It was easy for the executives at the Countess to keep them out.

## NHS England's response to the concerns about Letby

25.76 On 27 March 2017, Ms McCabe and Dr Subhedar attended a meeting with Mr Chambers, Mr Harvey, Ms Hodkinson, Dr Jayaram and Dr Brearey. A typed note of the meeting was taken.[76] The note recorded Ms McCabe saying: "*Given the information, on the balance of probability, illegal activity has caused the deaths*."[77] In her witness statement, Ms McCabe said this was a question she was putting to the clinicians.

Dr Jayaram and Dr Brearey "*responded by nodding their heads, indicating that they believed that this was the case*".[78]

25.77 Ms McCabe also gave her account of the atmosphere at the meeting:

> "*There was a high level of anxiety at the meeting. I remember it being challenging and intense and there was a palpable sense of tension in the room. I remember the clinicians trembling, my recollection was that the clinicians felt like they were putting their careers on the line, but they were prepared to do this given the seriousness of the matter …*
>
> *After the clinicians confirmed that they suspected criminality, Tony Chambers said that if that was the case then they should call the police. This sounded like an ultimatum and that there were negative connotations to involving the police. The clinicians wanted the Trust to go to the police as an organisation, and although I think that they would have done so if that was the only option, they believed that the right thing to do was for the Executive to take this action*."[79]

25.78 Ms McCabe said that, as a result of the meeting, she believed that the hospital had made the decision to contact the police.[80]

25.79 On 28 March 2017,† Ms McCabe told Mr Bibby about the recent meeting and that the hospital "*had concerns relating to additional cases paediatricians felt required review. ? Whether a police investigation required.*"[81] In her written evidence, Ms McCabe provided further detail:

> "[Mr Bibby] *said he had spoken to the Trust, and they thought that the clinicians had gone maverick. I told Andrew very firmly that my impression from the meeting was that the clinicians had not gone maverick, but rather they were concerned about deaths and collapses to which they could find no clinical explanation. I said that they believed that the next step was to bring the police in, which was something that the Trust was going to action.*"[82]

† The timeline at **INQ0014692/4** gives a date of 29 March 2017. Ms McCabe's witness statement at **Witness statement of Julie McCabe INQ0107030/21/para 82** suggests a date of 28 March 2017.

25.80 In turn, this appears to have prompted Dr Gregory to contact Mr Harvey on 29 March 2017. They spoke over the phone.[83] What precisely was said between them is a matter of dispute. The paragraphs of Dr Gregory's witness statement dealing with this are worth setting out in full:

> "*I raised the possibility that an individual member of staff might be involved with the increased mortality on the Neonatal Unit. I had no information or evidence that this was the case, but I felt it was a question that needed to be asked. At this stage I was considering all possibilities. I recall also discussing the question of an individual having a disproportionate involvement in a meeting with Ian Harvey and Lesley Patel on 23rd February* [2017]*, however I did not document it. When I asked in the 29th March meeting, Ian Harvey stated that they had looked into an individual being involved as a possibility but, due to a combination of skill mixture and rotas, it had been discounted. He explained that, given the severity of the cases, the rotas meant that certain, more experienced members of staff would naturally have greater contact with those babies. In addition, some babies had fallen*

*ill after being transferred off the unit and this would seem to discount an individual on the unit having involvement …*

*When I pushed Ian Harvey on the involvement of an individual staff member, he stated that he did not want to go into any more detail until the Hospital had made a significant announcement about the decision they had taken to speak to an 'appropriate body' on the following Monday. He did not indicate what that announcement was, nor what 'appropriate body' he was referring to. I do not believe that an announcement was ever made on the Monday. Ian Harvey told me that he was handling a very difficult situation and was asking for more time so that he could handle matters within the Hospital. When I pressed Ian Harvey as to what this difficult situation was, he indicated that the Hospital were having some issues with the paediatricians.*

*It was at this meeting that I first learnt about a clinician that raised concerns about the babies that had died or needed resuscitation in the Hospital or other units. My understanding was that the clinicians were picking up signs and symptoms that they didn't understand.*

*Ian Harvey mentioned that the clinicians were confused about the signs that they were seeing and that they had observed mottling of skin, which they had not seen before. However, Ian Harvey also seemed to suggest that one clinician had some other sort of agenda. I got the impression that there was a complex situation going on and Ian Harvey was trying to piece together a consistent thread in the unexpected mortalities and illnesses. At no point during my involvement was I informed by the Hospital that two clinicians were concerned about an individual nurse, and I was not aware that this individual was LL until her arrest in 2018*."[84]

25.81 In oral evidence, Mr Harvey disagreed with this characterisation of the meeting:

"*In the first instance, I would dispute* [Dr Gregory's] *assertion that he had raised the possibility of an individual with disproportionate involvement. I believe that, in the meeting with him, I had described that. I have accepted that we were slow in sharing information with*

*Specialised Commissioning but I would also dispute the degree to which they pressured to obtain information.*

…

*I believe that, given that a more senior Medical Director working with Specialised Commissioning was involved, he was in a position to actually enforce if he felt it was appropriate and … I wouldn't have, in those circumstances, withheld anything*."[85]

25.82 The contention that Mr Harvey was reluctant to share information with Dr Gregory during the telephone call finds support in the contemporaneous email that Dr Gregory sent to Mr Bibby, Ms Patel and Mr Cornall after the meeting. He wrote:

"*To summarise our conversation:*

…

*There is a member of staff whose presence has been seemingly disproportionate but (as was discussed when we met) this was originally accounted for by rotas and skill level. However, when pushed about staff members Ian stated that this matter was best dealt with when they make*

*the significant announcement about the decision they have taken to speak to an 'appropriate body' on Monday.*

*Clearly something very serious is going on and they must have their hands tied somewhere – but it would be speculation to guess what …*

*He will keep me briefed about that announcement.*

*Not sure if we can do any more until Monday unless we wish to escalate further."*[86]

25.83 In his witness statement, Dr Gregory explained how he felt at the time:

"*At this time it felt like we were going to the Hospital repeatedly and having to ask questions, rather than them volunteering the information and giving us updates. This lack of co-operation from the Hospital meant that I did not feel as though Specialised Commissioning North was able to fulfil its assurance role. Every time that we went to the Hospital we were met with obscure terminology and a lack of explanations. As Ian Harvey was the Medical Director of a Hospital, I did not feel that I had the clear lines of escalation*

*which I would if I was regional Medical Director. I escalated my concerns within NHS England who could escalate to NHS Improvement, who had the power to take regulatory action.*"[87]

25.84 Mr Cornall forwarded Dr Gregory's email to Ms Kitching for discussion.[88] Ms Kitching, however, was on annual leave.

25.85 On 30 March 2017, Dr Gregory spoke with Mr Harvey and Mr Chambers. Mr Harvey took a note of the meeting.[89] The note recorded an apparent query by Dr Gregory as to what the hospital meant by "*appropriate authority*". Mr Chambers was recorded to have said that there were no immediate concerns regarding safety and the major concern was for families and the effects on them. The RCPCH review and "*case reviews*" were said not to identify a single cause, but the clinicians remained "*unconvinced that excluded unnatural causes*". The intention was said to be to consult the police the following week.

25.86 In his witness statement, Dr Gregory said he recalled Mr Harvey and Mr Chambers saying that "*they did not want to go public as there would be a media backlash and this would*

*cause concerns with the families*". Dr Gregory did not recall any mention of "*unnatural causes*" during the meeting.[90]

25.87 In his written evidence, Dr Gregory again said that he was "*becoming increasingly concerned by the lack of answers from the Hospital*". As to Mr Chambers' reference to case reviews, Dr Gregory said he was "*personally confused as to which review was being referred to as they were mentioned without specific nomenclature in emails*". The end effect, Dr Gregory said, was that he was "*growing increasingly concerned as to why the Hospital was not being open*".[91]

25.88 The NHS England North Regional Specialised Leadership Group met on 4 April 2017.[92] Attendees included Mr Bibby, Mr Cornall and Dr Gregory. An email was circulated summarising the "*key messages*" from the meeting, which included: "*There are still concerns in relation to the Neo Natal Service following the review into the high numbers of patient deaths. Members of the RLG [regional leadership group] are working with the Trust and members of the North Regional Team to understand these more fully*."[93]

25.89 On 5 April 2017, Dr Gregory sent Mr Harvey an email requesting a copy of the "*external review report*" that had been undertaken. In the email, Dr Gregory also requested: (a) a copy of the brief given to Mr Simon Medland KC; (b) "*a written record of the concerns expressed by the two paediatricians*"; and (c) a "*proposed timeline of events*" going forward.[94]

25.90 As to the instruction of a barrister by the hospital, Dr Gregory commented in his written evidence: "*We couldn't understand this decision to involve a QC* [Queen's Counsel] *as they do not have the investigative powers of the police. It increasingly felt like the Hospital were making a concerted effort to avoid going to the police*."[95]

25.91 On 6 April 2017, Ms Kitching emailed Dr Gregory, stating that she had had "*a very helpful conversation*" with Mr Chambers, who had given her "*the run down re the Trust's position and potential future actions*".[96] Ms Kitching said that Mr Chambers would provide a further brief when the process with the paediatricians had concluded. Dr Gregory replied in more urgent terms, writing:

> "*It has been difficult to manage internally because we don't have all the information from the Trust. I understand the situation is delicate and should hopefully lead to nothing but if it does escalate we need to be prepared and have good documentation.*
>
> *There have been a number of separate phone calls and conversations but nothing is written at the moment and we have no understanding of timescales – hence my request to Ian* [Harvey] …
>
> *I am not sure what we should do if I don't get a response.*"[97]

25.92 Ms Kitching replied to say that she agreed and would chase Mr Chambers the following week.[98]

25.93 The chasing, however, appears to have been done by Dr Gregory. On 19 April 2017, Dr Gregory emailed Mr Harvey asking for an update as to any decision made following the Board meeting held on 13 April 2017.[99] Mr Harvey replied the same day, advising that four deaths remained unexplained and the hospital intended to approach the CDOP. Dr Gregory responded to ask whether the clinicians still had concerns, and to request

a timeframe as to when "*the report of the external reviewer*" would be available. Mr Harvey replied once more, writing:

> "*We are going through this process because there isn't yet a complete and definitive answer in all cases … Re the process, I shall appraise you after my conversation tomorrow. I don't think that there was ever an agreement that the individual case report would be shared – this contains identifiable data – this would need a conversation*."[100]

25.94 This prompted Dr Gregory to forward the email chain to Mr Cornall, Ms Patel and Ms Kitching, with the comment: "*Still no response as to whether the clinicians have had their concerns addressed*."[101] Mr Cornall replied, stating: "*It all feels a little evasive again*." Ms Kitching said that she would contact the hospital.

25.95 In his witness statement, Mr Cornall commented: "*I felt that Ian Harvey's response was evasive, because we did not get straight answers to questions and he was still unwilling to share information*."[102] Dr Gregory gave similar evidence.[103]

25.96 Ms Kitching recalled having a conversation with Mr Chambers or Mr Harvey at some point between 19 April and 25 April 2017. Ms Kitching said in her witness statement:

> "*At this stage, I was not aware that an individual had been implicated, just that two consultants had concerns that the external investigation didn't go far enough, and they hadn't received sufficient assurance. That of itself was not uncommon … I understood from this call that the Hospital was going back to the chair of the Child Death Overview Panel to look at the cluster of neonatal deaths*."[104]

25.97 Ms Kitching seems to have forgotten, when making her statement, that she had received Dr Gregory's email referring to the disproportionate presence of a member of staff.[105]

25.98 A Regional Management Team meeting was held on 25 April 2017. Attendees of the meeting included Ms Kitching and Dr Gregory. During the meeting, Ms Kitching advised Dr Gregory that they should give the hospital a bit more time to respond. In her written evidence, Ms Kitching said that by this she meant "*a week or so*" and that the suggestion was "*supported by those present*".[106]

25.99 The same day, Mr Harvey emailed Dr Gregory, stating that he and Mr Chambers would be happy to meet Dr Gregory once the hospital had "*completed* [its] *process*".[107] Dr Gregory forwarded the email to Mr Cornall, Ms Patel and Mr Bibby the following day, with a list of suggested further requests for information for Mr Harvey.[108] In the ensuing email chain, Ms Patel expressed concern that the CDOP process could take weeks, and so a meeting after it had finished would not be timely enough.[109] Mr Cornall said that he had spoken with both the Nursing Director and Medical Director from the National Specialised Commissioning Team (Ms Teresa French and Professor James Palmer respectively), and all thought that a referral to police should be made now.[110]

25.100 Ms Kitching, however, again preferred a more cautious approach. She copied the email chain to Mr Richard Barker, Regional Director (North), and wrote:

> "*I believe a call with their CE* [Chief Executive] *should happen tomorrow to clarify our position and if we are still*

*concerned we should give them the opportunity to seek advice from the police first.*

*In my experience CDOP processes are not lengthy and I suggested at the RMT* [Regional Management Team meeting] *that we would give them to the end of this week if we have not received any further assurance.*"[111]

25.101 In a later email, sent just to Mr Barker, Ms Kitching wrote:

"*When I last spoke with Tony* [Chambers]*, he explained that the independent* [investigations] *did not identify any criminality, two of their paediatricians are disputing and casting doubt on the findings*

*Hence them taking further steps, we did discuss involving the police which they intend to do if full assurance is not gained, the two paeds could be the problem but we need to be sure Tony and the team want to exhaust internal processes first as they recognise that involving the police could cause further significant distress to the families*

> … *Michael* [Gregory] *is worried that he believes they are being evasive hence escalation to the national leads, Tony is not happy at this accusation as he believes that they have been fully transparent,*
>
> *I don't think we should involve the police without appraising the Trust and giving them the opportunity to explain and contact the police if needed*
>
> *The unit is safe as it has continued to stop admitting complex cases*."[112]

25.102 Mr Barker agreed to this approach and commented, presciently: "*However, if it transpires that we do need to subsequently involve the Police then the delay will not look good and lead to further concerns from the families*."[113]

25.103 In her witness statement, Ms Kitching said that she recalled speaking with Mr Chambers around this time. Ms Kitching's full account of that conversation is set out at paragraphs 110 to 112 of her witness statement. The most important parts are set out below:

"*He* [Mr Chambers] *explained that there was no evidence to suggest any criminality or unnatural causes had occurred …*

*Mr Chambers expressed that it was his view that the two consultants were the problem as they were not happy with the findings of the investigations … It was at* [this] *point when I learnt that the consultant paediatricians were pointing the finger at a member of staff, and I pressed Mr Chambers to engage the police immediately for advice as I was not sure how long their internal process would take. He stated that there was no evidence to support the* [consultants'] *view but I explained that just the accusation alone was sufficient to seek police advice as they are the experts in this field. Mr Chambers assured me he would do it that day.*

*… I said Specialised Commissioning were really concerned about the Hospital's lack of transparency. He was upset by that … Mr Chambers agreed to expedite his conversation with the police, and I agreed to set up an urgent meeting the following day with the Hospital so we could be briefed fully and determine appropriate actions and escalations*."[114]

25.104 On 27 April 2017, Mr Connolly and Ms Kitching had a teleconference with Mr Harvey and Mr Cross. Ms Kitching took a note of the meeting.[115] Ms Kitching again raised the concerns of Specialised Commissioning, that they had not been provided sufficient information, and communicated their view that the police should now be involved.

25.105 The note of the meeting records that Mr Harvey said that he was "*unsure why the commissioners felt this way as he had met with MG* [Dr Gregory]*, AB* [Mr Bibby] *and LP* [Ms Patel] *and updated them accordingly*". He referred to "*the sensationalist story reported in the* Sunday Times *which caused further upset to some of the families and therefore it was important information sharing was kept to a minimum*". This was ironic, given his own failure to share information with parents in a timely fashion. He did not refer to the fact that the nurse about whom the paediatricians had expressed concern had not been on duty since the unit was downgraded. He explained: "[T]*he incident occurred as a result of a Paediatrician and neonatologist alert re numbers of deaths in the unit, which resulted in the Trust commissioning the RCPCH to undertake an investigation into all the deaths*."

This was not accurate. There was no doubt by April 2017 that the RCPCH had not conducted an investigation into all the deaths, and it was never going to. Mr Harvey continued: "*There was no single factor identified rather it was multi factorial.*"[116] Nowhere did the RCPCH report suggest that the cause of the deaths was multifactorial. Its findings explained none of the deaths.

25.106 In Mr Harvey's outline of events given at the meeting, the note records no mention by him that the consultant paediatricians were concerned about deliberate harm. He said: "*It was determined that a single member of the nursing staff was on duty and attended to most of the cases, but not all, and her full time status meant that this was probably not unusual*."[117] He informed the meeting that the Trust had sought an independent legal opinion, on evidence so far, and the findings were that they could not see any evidence of criminality. He did not mention what the lawyer had been asked to consider, nor that the lawyer had said that, if reasonable people were concerned, the police should be consulted. He said that the hospital had shared everything with the coroner. It had not.

Nor had the Countess kept families involved in the process, contrary to what Mr Harvey asserted.

25.107 It was agreed that Ms Kitching would act as the single point of contact for the hospital, and that Mr Harvey would keep her informed of the outcome of discussions with the police.

25.108 Mr Chambers wrote to Chief Constable Simon Byrne QPM of Cheshire Constabulary, and meetings were held between the hospital and the police on 5 May and 12 May 2017. Following the latter meeting, Mr Harvey emailed Ms Kitching in the following terms:

> "*They* [the police] *are minded not* [emphasis in original] *to hold an investigation – firstly they don't feel that there is evidence of criminal activity and secondly they are mindful of the effects on families. However, our Paediatricians sent a document to them that was a listing of their concerns which was a very prejudiced view, effectively pointing the finger at one nurse … It does not contain anything new*

*that multiple people and agencies haven't heard despite the Paediatricians assertion that they haven't been listened to …*

*My own feeling is that unless there is something that the Paediatricians haven't disclosed previously that evidences criminal activity there will not be an investigation and the police will assist us in a message that will allow us to close down the speculation here and deal with the issues of culture etc*."[118]

25.109 In her written evidence, Ms Kitching said that she "*was very concerned*" with Mr Harvey's email. She explained:

> "[C]*learly the Hospital was still focused on the two consultants being the problem. I was worried that the police may be listening to the Hospital view without looking at all the facts and speaking with the two consultants. I recollect speaking to Ian and asking him to make sure the police did speak to the two consultants before any decisions were made*."[119]

25.110 The police met Dr Brearey, Dr Jayaram and Dr Holt on 15 May 2017. The commencement of a police investigation was announced the same day.

## Lack of candour

25.111 Mr Bibby was severely critical of the information provided to him and to Specialised Commissioning (North). He said:

> "*I was never fully informed about the concerns at the Hospital, and I felt my attempts to obtain the information I needed to take informed decisions were repeatedly frustrated. By way of example, I was unaware that clinicians at the Hospital had raised concerns about a possible link between the increased mortality rate on the Unit and a particular individual until the end of March 2017, I did not know that that the Trust had removed LL from the Unit, and I did not learn of LL's identity until the day of her arrest*."[120]

25.112 The effect, Mr Bibby said, was to delay the involvement of the police:

> "*I do strongly believe that the Trust should have been significantly more transparent with us … about the concerns that had been raised by clinicians regarding LL, and about what the Trust knew. There were key pieces of information that should have been shared with the Specialised Commissioning (North West) Team,*

*that would, I think, have led us to the conclusion that the police should be involved much sooner. We were of the understanding throughout the Relevant Period that there was no known or suspected cause for the poor outcomes of the Unit. Consequently, we followed our standard processes and worked to eliminate the most likely causes, before turning to consider the alternatives. Had we known that consultant paediatricians had identified a link between the poor outcomes on the Unit and a particular individual, that individual had been moved off the Unit in June/July 2016, and outcomes had thereafter improved, we would likely have viewed the Royal College of Paediatrics and Child Health's findings very differently and I am certain that we would have pushed for greater scrutiny of LL's performance and conduct on the Unit, and for the police to be involved, much sooner*."[121]

25.113 As to the reasons behind the hospital's reluctance to share information with NHS England, Mr Bibby thought:

> "*The Trust's apparent unwillingness to be open and transparent with the Specialised Commissioning (North West) Team seemed to me to reflect a broader culture within the Trust, and a desire to avoid or mitigate adverse assumptions about what might be causing the increased local mortality rate on the Unit until a definitive cause had been determined. I suspect that reputational considerations may have been a factor in this*."[122]

25.114 Dr Gregory gave evidence of his frustration with the hospital's interactions with the Specialised Commissioning (North) team:

> "*During this period it was my responsibility to get a full understanding of what had happened and to have assurance through the action plan that the Hospital was addressing the situation. I was asking questions and seeking clarification on the reviews and the actions the Hospital had taken. I did not consider that the responses I was getting from the Hospital helped with that clarification. If anything they served to create more confusion. I asked direct questions about concerns that were being raised by clinicians and they were not answered. I should not have*

*needed to keep pressing the Hospital for answers. In the interests of patient safety I should have expected that Ian Harvey, as Medical Director, be open and transparent with me and disclose that information that, as Commissioner for the service, we needed to know. The answers that we received never made reference to an individual or the specific concerns that the paediatricians had about LL. The Hospital alluded to clinical issues and the internal processes that they were following but were not clear on what these were … I have not since experienced the same level of lack of cooperation from a hospital.*

…

*I felt that there was a lack of transparency from the Hospital, avoidance of answers and wanting to defer the issues we raised … My sense was that the Hospital was intent on conducting its own process through their board and were evasive in response to our questions*."[123]

25.115 Like Mr Bibby, Dr Gregory thought that the hospital's failure to share information impeded the ability of NHS England to take further action in respect of the hospital, including involving the police.[124]

25.116 Ultimately, Dr Gregory was at a loss as to why the senior management of the hospital acted as it did: "*I personally do not understand why this important information was not being shared and what the Hospital thought would be gained by avoiding our questions and asking for more time to respond to our requests*."[125]

25.117 Ms Kitching was similarly critical of the failure of the hospital to share information with NHS England. She said:

> "*I do believe that the Hospital was being evasive and uncooperative with NHS England and NHS Improvement, particularly in early 2017. I do not understand why the Hospital didn't just give the information requested and do not consider that concerns around confidentiality were justified; these concerns are standard and can be addressed by redacting any identifiable patient information if necessary.*
>
> *It is my firm view that the Hospital should have informed NHS England much sooner regarding the suspicions held by clinicians that an individual (LL) was the reason for the increased mortality rate within the neonatal unit*."[126]

25.118 Mr Cornall summarised the actions of the senior management of the hospital as follows: "*I think the Trust executive team controlled the narrative so that it was hard to unravel the issues*."[127]

25.119 Mr Chambers was asked whether he accepted that NHS England should have been told about the concerns regarding Letby when those concerns first arose. The answer to the question was plainly 'yes'. Instead of giving that answer, Mr Chambers did not engage with the question and said that he did not know. He was the Chief Executive of the hospital. He had had years to reflect on what had happened. He suggested that the Inquiry make recommendations that provided greater clarity as to when concerns should be shared[128] (see Chapter 41). He explained: "*The … answer is I don't know, it's just that balance between … duty of candour and duty of care … I'm not sure at that time whether we had got the balance right.*"[129] This balance was referred to by several people. In this example there is no question of balancing two duties. There was a clear duty to inform NHS England about what was happening in the hospital. There was no counterbalance to that.

25.120 Mr Harvey accepted in oral evidence that the hospital was "*slow in sharing information with Specialised Commissioning*". He explained that this was not because of "*a desire to hide anything from them*" but rather due to "*perhaps an inappropriate degree of concern about documents leaking into the public domain*".[130] Mr Harvey also went on to suggest that NHS England ought to have imposed more pressure on the hospital to obtain information.[131] Had Mr Harvey and the other executives been open with NHS England, no pressure would have been needed.

25.121 NHS England should not have agreed to repeated delays with regard to the provision of documents and information by the hospital. Ms Kitching was too ready to accept Mr Chambers' reassurances. At the end of the meeting on 27 April 2017, Ms Kitching records that she thanked Mr Harvey for his time and briefing, and recognised that the Trust was doing all it could in order to resolve this. Given the way matters had emerged, this was an overly generous assessment. She added: "*The involvement of CDOP and the police is welcomed*."[132]

25.122 It remains the case, however, that the principal responsibility was upon the Countess to tell NHS England that it was dealing with a situation of possible deliberate harm of babies by a neonatal nurse, and that this had been the position for many months. The hospital's failure was that of Mr Chambers, Mr Harvey and Ms Kelly.

# Endnotes

1 **Witness statement of Prof. Sir Stephen Powis INQ0017495/43/para 167** and **45/paras 174-175**

2 **Witness statement of Prof. Sir Stephen Powis INQ0017495/62/para 239**

3 **Witness statement of Prof. Sir Stephen Powis INQ0017495/20/para 65**

4 **Witness statement of Prof. Sir Stephen Powis INQ0017495/26/para 96**

5 **Witness statement of Prof. Sir Stephen Powis INQ0017495/121/para 478**

6 **Witness statement of Andrew Bibby INQ0106970/14/para 47**

7 **Witness statement of Prof. Sir Stephen Powis INQ0017495/121/para 480**

8 **Witness statement of Prof. Sir Stephen Powis INQ0017495/309-311**

9 **Witness statement of Prof. Sir Stephen Powis INQ0017495/116/para 456**

10 **Witness statement of Prof. Sir Stephen Powis INQ0017495/117/paras 457-458**

11 **Written Closing Submissions on Behalf of NHS England 4 March 2025 7/para 21**

12 **Witness statement of Julie McCabe INQ0107030/5/para 13**

13 Witness statement of Julie McCabe INQ0107030/9/para 30

14 Witness statement of Prof. Sir Stephen Powis INQ0017495/125/para 495

15 Witness statement of Prof. Sir Stephen Powis INQ0017495/125/paras 496-497

16 Witness statement of Prof. Sir Stephen Powis INQ0017495/119/para 469

17 Witness statement of Prof. Sir Stephen Powis INQ0017495/122/para 484

18 Witness statement of Prof. Sir Stephen Powis INQ0017495/124/para 492

19 Witness statement of Prof. Sir Stephen Powis INQ0017495/124/para 493

20 INQ0108752

21 Witness statement of Prof. Sir Stephen Powis INQ0017495/128/para 508

22 Written Closing Statement on Behalf of Family Group 1 4 March 2025 33-34/paras 116-117

23 INQ0005531/5

24 INQ0009762/6

25 INQ0005559/8

26 INQ0103111/1

27 Written Opening Statement on Behalf of NHS England 30 August 2024 5/para 26

28 INQ0014634

29 INQ0102984

30 INQ0102984

31 INQ0009236/33

32 INQ0014635

33 INQ0014636/1

34 INQ0004320

35 INQ0106930/126

36 INQ0106930/127

37 Witness statement of Alison Kelly INQ0107704/41/paras 126-127

38 Alison Kelly 25 November 2024 25/3 to 30/25

39 INQ0106930/125

40 Witness statement of Andrew Bibby INQ0106970/41/para 146

41 Witness statement of Dr Michael Gregory INQ0107034/22/para 84

42 Witness statement of Margaret Kitching INQ0107036/18/para 72

43 Witness statement of Julie McCabe INQ0107030/14/para 50

44 Witness statement of Andrew Bibby INQ0106970/41/para 147

45 INQ0014679

46 INQ0005336/6

47 Witness statement of Sian Williams INQ0101320/9/para 54

48 Witness statement of Andrew Bibby INQ0106970/42/para 149

49 Witness statement of Andrew Bibby INQ0106970/44/para 158

50 INQ0014642/103

51 INQ0002751

52 Witness statement of Margaret Kitching INQ0107036/20/para 78

53 INQ0014687/7

54 Witness statement of Margaret Kitching INQ0107036/20/para 78

55 Witness statement of Dr Michael Gregory INQ0107034/23/para 87

56 INQ0106988/3; INQ0106992/9

57 INQ0102994

58 INQ0008077/1

59 INQ0008077/1-2

60 Alison Kelly 25 November 2024 175/21 to 176/25

61 Alison Kelly 25 November 2024 177/13-17

62 Alison Kelly 25 November 2024 177/1-12

63 Witness statement of Andrew Bibby INQ0106970/46/para 170

64 **Witness statement of Andrew Bibby INQ0106970/47/para 176**

65 **Witness statement of Robert Cornall INQ0107032/31/para 101**

66 **Witness statement of Andrew Bibby INQ0106970/47/para 177**

67 **INQ0014771/4**

68 **INQ0103029/3-4**

69 **INQ0006081**

70 **Witness statement of Dr Michael Gregory INQ0107034/25/para 99**

71 **Witness statement of Andrew Bibby INQ0106970/50/para 187**

72 **Witness statement of Dr Michael Gregory INQ0107034/25/para 100**

73 **Witness statement of Andrew Bibby INQ0106970/50/para 187**

74 **Witness statement of Robert Cornall INQ0107032/32/para 109**

75 **Witness statement of Andrew Bibby INQ0106970/51/para 191**

76 **INQ0003150/1-6**

77 **INQ0003150/2**

78 **Witness statement of Julie McCabe INQ0107030/20/para 77**

79 Witness statement of Julie McCabe INQ0107030/21/paras 79-80

80 Witness statement of Julie McCabe INQ0107030/21/para 81

81 INQ0014692/4; Witness statement of Andrew Bibby INQ0106970/53/para 200

82 Witness statement of Julie McCabe INQ0107030/22/para 83

83 Witness statement of Dr Michael Gregory INQ0107034/26/para 103

84 Witness statement of Dr Michael Gregory INQ0107034/26-27/paras 103-105

85 Ian Harvey 29 November 2024 134/2 to 135/24

86 INQ0014651

87 Witness statement of Dr Michael Gregory INQ0107034/27/para 106

88 INQ0014651/1

89 INQ0003245

90 Witness statement of Dr Michael Gregory INQ0107034/28/para 108

91 Witness statement of Dr Michael Gregory INQ0107034/28/paras 109-110

92 Witness statement of Andrew Bibby INQ0106970/54/para 204

93 Witness statement of Prof. Sir Stephen Powis INQ0017495/139/para 553

94 INQ0003126

95 Witness statement of Dr Michael Gregory INQ0107034/29/para 111

96 INQ0103067/2

97 INQ0103067/1

98 INQ0103067/1

99 INQ0014667/4

100 INQ0014667/3

101 INQ0014667/2

102 Witness statement of Robert Cornall INQ0107032/34/para 115

103 Witness statement of Dr Michael Gregory INQ0107034/32/para 123

104 Witness statement of Margaret Kitching INQ0107036/27/para 107

105 INQ0014651

106 Witness statement of Margaret Kitching INQ0107036/27/para 106

107 INQ0014673/5

108 INQ0014673/4

109 INQ0014673/3

110 Witness statement of Robert Cornall INQ0107032/34/para 117; INQ0014673/3

111 INQ0014673/2

112 INQ0014673/1

113 **INQ0014673/1**

114 **Witness statement of Margaret Kitching INQ0107036/28/paras 110-112**

115 **INQ0003193**

116 **INQ0003193**

117 **INQ0003193**

118 **INQ0014678**

119 **Witness statement of Margaret Kitching INQ0107036/35/para 130**

120 **Witness statement of Andrew Bibby INQ0106970/3/para 4d**

121 **Witness statement of Andrew Bibby INQ0106970/57/para 217**

122 **Witness statement of Andrew Bibby INQ0106970/58/para 220**

123 **Witness statement of Dr Michael Gregory INQ0107034/34/para 132** and **36/para 140**

124 **Witness statement of Dr Michael Gregory INQ0107034/38/para 151** and **39/para 153**

125 **Witness statement of Dr Michael Gregory INQ0107034/39/para 152**

126 **Witness statement of Margaret Kitching INQ0107036/36/paras 135-136**

127 **Witness statement of Robert Cornall INQ0107032/37/para 133**

128 **Tony Chambers 27 November 2024 209/4 to 210/4**

129 **Tony Chambers 27 November 2024 211/7-11**

130 **Ian Harvey 29 November 2024 134/6-14**

131 **Ian Harvey 29 November 2024 134/7-9**

132 **INQ0003193**

# Chapter 26. Contacting the police

26.1 On 28 February 2017, Mr Harvey held a meeting with Dr Subhedar, Dr Brearey, Dr Jayaram and Dr Gibbs to discuss the hospital's response to the concerns raised by the consultants, the issue of mediation with Letby, the case note review undertaken by Dr Hawdon and the need for further investigation.

26.2 The consultants informed Mr Harvey that they had reviewed Dr Hawdon's report and considered there were eight cases that required further forensic review.[1] Dr Subhedar could not remember whether a staff member was discussed in this meeting, but he recalled there was a tone of concern expressed by the paediatricians.[2] Mr Harvey explained that the consultants:

> "*presented those babies for whom they still had major concerns and, on the back of* [this] *meeting, I felt that there was nothing further for us to do, short of speaking to*

> *the police. And I believe it was on the back of me describing that situation to my Executive colleagues and to Tony Chambers that this meeting, with some of the paediatricians and with the network, was scheduled.*"[3]

26.3 On 6 March 2017, Dr Brearey emailed Mr Harvey with a summary of the meeting of 28 February 2017.[4] This included that the consultants were dissatisfied with the way the Trust had handled their concerns, since they had been escalated, and considered that their professional opinions had been disregarded. They considered also that any attempt at mediation with Letby was too early, given that there was still uncertainty over the cause of the rise in mortality and the unexpected collapses. They agreed that further investigation was needed into the cases of eight babies, but that there were six other babies who had collapsed unexpectedly and were transferred to another hospital, and others who had collapsed but were not transferred from the Countess, whose cases had not been examined. Of Dr Subhedar's contribution, Dr Brearey wrote:

> "*Nim* [Subhedar] *also emphasised the Network's position that the observed excess in neonatal mortality at COCH* [the Countess] *could not be explained merely as a consequence of medical or nursing workforce deficits or increased activity and occupancy levels. Other network local neonatal units are working at similar levels of occupancy and staffing and COCH is not an outlier in this regard. Since these units are not reporting an excess in neonatal mortality, it suggests that there is a different explanation for our increased number of unexplained deaths.*"[5]

Dr Subhedar confirmed this in oral evidence.[6]

26.4 Mr Harvey replied by email. He wrote that he had not seen any evidence to support Dr Subhedar's suggestions. This was remarkable given, as Dr Subhedar said in evidence, that the data was included in the Cheshire and Merseyside Neonatal Network's annual report. Mr Harvey did not ask to see it.[7] Had he maintained an open mind, he would have looked at the report. He did not do so. This cannot have been accidental. In truth, he was still not interested in information that ran counter to his narrative that the consultants' concerns were unfounded.

## Concerns increase and relationships deteriorate

26.5 On 1 March 2017, the consultants sent a further letter to Mr Chambers thanking him for escalating their concerns to the coroner.[8] They reiterated their concerns that the events had not been fully investigated, as recommended by the RCPCH and by Dr Hawdon. They agreed that there were areas which could be improved, and offered to work with the Trust on an action plan to implement those recommendations. They explained that they had noticed a temporal association with the unexplained and unexpected collapses and the presence of one member of staff at the time of the events. Also, that they were concerned by the unusual nature of collapses and responses to efforts to resuscitate. The consultants considered it their professional obligation to highlight why they thought these matters had not been fully investigated, and cited three reasons as: (a) the RCPCH review was a service review which did not specifically investigate the deaths or causes for collapse; (b) the external case note review (by Dr Hawdon) was not the multidisciplinary review recommended by the RCPCH (but did identify four cases needing further review, to which another four had now been added); and (c) the review of activity, acuity

and staffing by Mr Harvey did not identify a reason for the increase in mortality, and was neither independent nor external. Finally, the consultants thanked Mr Chambers for "*sharing the additional comments and observations made by the RCPCH reviewers in the original report*".[9] They added that some of the comments contained factual inaccuracies, which they were willing to discuss. The consultants also confirmed that they had sent a letter of apology to Letby.

## Pressure on the consultants

26.6 The consultants' concerns over the mediation process led to Mr Harvey emailing both Dr Brearey and Dr Jayaram separately, on 1 March 2017, to encourage each to attend the meeting with the mediation facilitator scheduled for the following week.[10] Mr Harvey warned both doctors that "*this gesture would also go a long way to protect you from a possible referral to the GMC from other parties which, having supported many doctors who have done no wrong through, even then isn't a comfortable process*".[11]

26.7 Dr Jayaram responded to Mr Harvey's email on 2 March 2017.[12] He sought to clarify why he and Dr Brearey were the only two consultants being required to enter mediation, given that:

a. During the grievance process, someone had reported that he (Dr Jayaram) and two other consultants had been heard to say potentially slanderous things about Letby.

b. Mr Harvey did not know what was alleged to have been said, did not know who had reported it, nor who had fed it back to Letby. It was not known if the remarks had been made in a formal setting or in private. It was also not known how accurate the reports were, and how much had been lost or exaggerated.

c. If the process was to help re-integrate Letby into the neonatal unit, then all seven consultants should take part, as all had expressed the same sentiments. Mr Harvey had explained that the recommendation for only Dr Brearey and Dr Jayaram to participate in mediation had come from the grievance (that is, Ms Weatherley).

26.8 Dr Jayaram also reminded Mr Harvey that the concerns they had raised eight months ago were still present, and that it may be inappropriate to proceed with mediation at this stage. He noted Mr Harvey's reference to 'self-protection' and said he would attend the preliminary meeting after taking advice from his BMA representative.[13]

26.9 The first of Dr Brearey's preliminary mediation meetings was arranged for 7 March 2017, when Dr Brearey was unavailable, being away on RCPCH duties. He alerted Ms Hodkinson to this by email on 6 March 2017. Ms Hodkinson then arranged for Dr Brearey's two preliminary meetings to take place on 16 March 2017, with a meeting with Letby later. On 6 March 2017, Ms Rees emailed Ms Kelly and Ms Hodkinson, copying Mr Harvey, Ms Cooper and Letby.[14] Although Ms Rees knew that the meeting had been rescheduled to 16 March 2017, she seems to have been unaware that Dr Brearey had never been available on 7 March. She wrote that she found it "*hard to believe that Steve* [Brearey] *cannot make an effort* ***for 1 hour*** [emphasis in original]".[15] She expressed concern that Dr Brearey was "*not fully committed to resolving this issue*" and she sought assurances that he should not be

allowed to cancel again, given that "*Lucy has suffered enough over the last eight months*".[16] In evidence, she said that she was frustrated that mediation was not insisted upon, and she thought that the consultants were being treated more favourably than a nurse in the same position would have been treated. She was unaware, I infer, that mediation is not compulsory. There was no difference in treatment.

26.10 On 9 March 2017, Dr Brearey accepted the date for the mediation meeting with Letby. In his email to Ms Hodkinson, he reiterated his view that it was inappropriate to proceed with mediation when the hospital was still investigating the cause of the increase in mortality.[17] Dr Jayaram also emailed Ms Hodkinson, on 13 March, to say he was "*extremely uncomfortable*" with the mediation process, given the significant concerns of the consultants.[18] He pointed out that the mediator had said that the process was entirely voluntary, with no obligation to engage, but that Mr Chambers had said (on 26 January 2017) that the Board had a plan which the consultants would be expected to follow, or they would be "*crossing a line*".[19] Also, that Mr Harvey had intimated that "*not engaging* …

*could increase* [his] *chances of being reported to the GMC for whatever I am alleged to have done*".[20]

## Meeting between Ms Hodkinson and Dr Jayaram, 15 March 2017

26.11 Dr Jayaram and Ms Hodkinson met on 15 March 2017.[21] At the meeting, Dr Jayaram expressed concerns about the mediation process (as described above), but he was reassured enough to agree to provide his availability for the next mediation meeting. He told Ms Hodkinson he could not understand how the Board had been reassured, and had reached their decisions on the basis of the RCPCH and Dr Hawdon's report, including their decision to reinstate Letby. He felt that the Board had been misled by Mr Harvey.

26.12 The meeting then took an unexpected turn. Ms Hodkinson's file note of the meeting records that Dr Jayaram "*remembers 3 occasions when there were concerns. One* [where] *baby deteriorated and LL at end of cot* [this was Baby K]. *Another* [where] *valve at different setting and it was explained that it was a mistake when she was looking after the baby* [this was Baby H]*. And a third.*"[22]

26.13 Ms Hodkinson was asked in evidence to the Inquiry when she considered the police should have been contacted. She replied: "*For definite 15 March 2017.*"[23] The reason she gave for not contacting the police immediately after this meeting was that she was confused as to why Dr Jayaram waited this long to tell her, and that she needed to triangulate with others what she had been told.[24] I would put it another way. She could not quite believe what she had been told and wanted to see if there was any support for it. She and her colleagues would have to decide what to do with this new information. In the event, they did nothing.

## Meeting of executives, 16 March 2017

26.14 At the executives' meeting the following day, 16 March 2017, they discussed Dr Jayaram's suggestion for a meeting of all parties. Mr Chambers was against this, and it was agreed instead that he, Mr Harvey and Ms Hodkinson would meet with Dr Brearey, Dr Jayaram and Dr Subhedar.[25]

26.15 Ms Hodkinson also informed the Executive Team that Dr Jayaram had told her the consultants felt bullied, intimidated and victimised, and that they did not feel reassured by how Mr Chambers and

Mr Harvey were managing the process.[26] In evidence to the Inquiry, Ms Hodkinson said that the relationship between the consultants and executives "*had broken down at that stage*".[27] Ms Hodkinson also informed the executives about the three incidents Dr Jayaram had disclosed. Below is an excerpt from her meeting notes:

> "*Sue* [Hodkinson]. *3 deaths. Lucy at cot. Real concerns. Lucy moved valves.*
>
> *AK* [Ms Kelly]. *Why not before? Serious allegations.*
>
> …
>
> *TC* [Mr Chambers]. *Lucy cannot go back to Unit. They want us to throw Lucy under a bus.*
>
> *AK. Challenge – she* [should] *go back.*
>
> *TC. Okay she goes back and something happens. New comments – deal with a Speak Out Safely. Part of me says ring police and GMC*."[28]

26.16 This is the first record of Mr Chambers referring to ringing the GMC. This could only have been about the paediatricians, as became clear two weeks later (see paragraph 26.36).

26.17 When asked about the reaction to the new information from Dr Jayaram, Ms Kelly described the executives as "*shocked and horrified*".[29] Yet her response in the meeting is recorded as being one of challenge, and that Letby "[should] *go back*".[30] Earlier, she had said: "*Why not before? Serious allegations.*"[31] This suggests that Ms Kelly did not believe the serious allegations because they had not been reported to the executives before that time. Whilst it was a natural and reasonable human reaction to wonder why Dr Jayaram was giving this information now, rather than earlier, it was not reasonable to do nothing at all about what he was saying. I am satisfied that Ms Kelly did not believe it. But that was not the issue. This was evidence that absolutely required safeguarding action. Her response, to which she could have given no thought, was that Letby "[should] *go back*".[32]

26.18 Mr Chambers thought he ought to speak to Dr Jayaram, and a meeting was arranged for 17 March 2017 between Mr Chambers, Ms Hodkinson and Dr Jayaram. Mr Chambers described this as a very short meeting that "*felt very rushed, it was a two-minute thing*".[33] He gave evidence that there were two parts to the conversation. First, Ms Hodkinson set out Letby's conduct in relation to Baby K,

as described by Dr Jayaram. Second, he recalled Dr Jayaram's high level of anxiety at the meeting.[34]

26.19 Mr Chambers did not ask Dr Jayaram any direct questions about his disclosures; instead, he asked him general questions about whether there was anything else he needed to know, and how he was feeling. Mr Chambers accepted in evidence that he should have been more direct. He explained that he did not want to intimidate Dr Jayaram.[35]

## Meetings between 27 and 30 March 2017

26.20 As agreed at the executives' meeting on 16 March 2017, a further meeting took place on 27 March 2017.[36] Present were Mr Chambers, Mr Harvey, Ms Hodkinson, Dr Brearey, Dr Jayaram, Ms McCabe and Dr Subhedar.[37]

26.21 Dr Subhedar told the Inquiry that, by the time of this meeting, he had learnt that the consultants suspected deliberate harm was involved in the deaths. He explained that by attending the meeting, he and Ms McCabe were "*supporting the paediatricians in their view that this needed to be escalated to a police matter*".[38] Dr Subhedar recalled that

a "*referral to the police was discussed at that meeting*".[39] He did not remember that a decision was made.

26.22 Dr Brearey explained that, by this meeting, concern had grown because the consultants began to appreciate that some of the morbidity cases (i.e. non-fatal collapses) may have also been attributable to Letby. Dr Brearey read out an email that Dr McGuigan had sent him regarding his thoughts on the neonatal deaths. Dr McGuigan wrote: "*My opinion is that this can never be investigated properly without a police led investigation … I have read the RCPCH service review and I don't see anything that explains the high mortality rates*."[40] Dr Brearey said in this meeting: "[W]*e directly told or asked the Chief Executive Tony Chambers to go to the police.*"[41] He said that Mr Chambers and Mr Harvey had agreed to go to the police.[42]

26.23 Dr Jayaram told the Inquiry that he thought the meeting was set up in response to the concerns he raised in his meeting with Ms Hodkinson earlier that month. He stated that, by this time, he had "*lost faith*" in Mr Harvey's judgement.[43] Dr Jayaram said: "*We decided before this meeting* [having] *discussed with colleagues that we would*

*explicitly say we just need to talk to the people who are the only people who can look at this forensically which are the police.*"[44] Dr Jayaram understood from this meeting that it was agreed the police would be contacted.[45]

26.24 Ms Hodkinson explained she attended the meeting at Dr Jayaram's request, in case she needed to mediate. She gave evidence that, in this meeting, "*there was collective agreement around going to the police*".[46]

26.25 The minutes of the meeting recorded Dr Brearey expressing his dissatisfaction about the depth of the reviews thus far and raising that "[t]*his needs to escalate to the police*".[47] Mr Chambers said: "*I need to know if we do an individual case note review, or phone the police.*"[48] Ms McCabe was recorded as saying: "*Given the information, on the balance of probability, illegal activity has caused the deaths.*"[49] See also Chapter 25.

26.26 Mr Chambers was then recorded as saying: "*If that is where we are, then phone the police. You can call the police.*"[50] This was the Chief Executive speaking. It was for him to act. Instead, he attempted to pass responsibility to the doctors. On the same theme, later in the meeting, Mr Chambers asked: "*Why have you not phoned the police?*"[51] Dr Jayaram's reply

was recorded as being: "*Our career would be on the line if we contact* [the] *police, it would be whistleblowing. Following BMA advice, if there is an alternative of a deeper dive, we should go for it. But this is a worry.*"[52] It is not apparent that Dr Jayaram was given any reassurance about his position, about which he was entitled to be concerned given the conduct of the executives up to that point, in particular the insistence on a line being drawn.

26.27 Discussion about involving the police continued. In relation to criminal and non-criminal behaviour, Mr Chambers was recorded as saying: "*To get the distinction, the only thing to do is a police investigation.*"[53] Mr Chambers accepted in evidence that he had said this, and added that "*the decision was that we would go to the police*".[54]

26.28 Later that evening, Mr Chambers telephoned Mr Cross. Mr Cross's handwritten note of their conversation recorded: "*TC's* [Mr Chambers'] *mtg with Ian Harvey, Steve B and Ravi* [Jayaram]*. No alternative but to report to police – that's what Steve B wants supported by Ravi. Need to discuss a plan.*"[55]

26.29 Mr Chambers' understanding was that, after this meeting, Mr Cross and Sir Duncan Nichol had a conversation about obtaining

independent support to assist the Trust to manage the escalation to the police, which resulted in Mr Simon Medland KC being instructed.[56]

26.30 There was a further meeting on the following day, 28 March 2017. Present were Sir Duncan, Mr Chambers, Mr Harvey, Ms Kelly, Ms Hodkinson and Mr Cross. Mr Cross's handwritten notes of this meeting summarised the position of the consultants as follows: "*Position now only independent robust investigation is police investigation according to docs.*"[57] An unattributed comment in the notes also reads: "*Not when but how do we manage police.*"[58] There is reference to a bundle of documents being prepared for Friday 31 March 2017 and "*SPC* [Mr Cross] *to contact police … suggest making appointment with police for Mon 3 April 17*".[59] Mr Cross also noted an action for "*clarity on Steve B's and Ravi's position on reporting matter to police. Direct question to them.*"[60] In other words, the intention was to put the consultants on the spot about whether the matter should be reported to the police. The executives had known the position of the consultants on this matter for some time.

26.31 The notes also recorded Ms Hodkinson and Ms Kelly telling the group that the plan was to return Letby to the neonatal unit, the week commencing 3 April 2017, for one hour a day. This makes plain that Dr Jayaram's disclosure about Baby K and the other incidents had been ignored. Mr Cross was noted as telling the group that Letby could not return to the unit the following week, as had been the plan, because of the potential police investigation.[61]

26.32 In Ms Hodkinson's oral evidence, she was referred to her Inquiry statement, dated 14 August 2024, in which she wrote: "*It remained a collective decision … to work towards Letby's return to the NNU* [neonatal unit] *on 3 April 2017. Whilst there were ongoing clinical concerns and the potential for a police referral, there continued to be no substantive evidence.*"[62] Ms Hodkinson confirmed that the purpose of this was to ensure the executives were "*maintaining a status quo with Letby*".[63] She explained that "*there was not a plan at that stage for her* [Letby] *to go back but I think in terms of communication with her we were stating that there was still that plan to happen. But internally from an Exec perspective that was not going to proceed*."[64] Whether Ms Hodkinson believed the consultants'

concerns or not, she had received a very clear disclosure from Dr Jayaram. She could not simply pretend this had not happened. Nor could the other executives.

26.33 Ms Hodkinson was asked why, despite her saying that she thought the police should be called from 15 March 2017, she was still involved in efforts to return Letby to the neonatal unit, and, in August 2024, had written that there was no substantive evidence. Ms Hodkinson responded: "*I apologise for that.*"[65] The apology did not begin to explain why she had continued with her efforts to return Letby to the neonatal unit.

26.34 On 29 March 2017, at an executives' meeting, there was a brief discussion about "*an additional external review*" which Mr Cross was coordinating.[66] Mr Chambers explained that this was a "*pragmatic option*" and referred to it as "*my*" review arising from his concern for all the parents involved. Mr Chambers also asked Ms Hodkinson, Ms Kelly and Mr Harvey to produce a single timeline, which "*would help explain the process and actions undertaken to my external review*".[67] Two other documents were being produced: (a) 'Rationale' by Mr Cross (see below), and (b) 'Neonatal Services at the Countess of Chester

Hospital NHS FT [Foundation Trust]', which was produced by Mr Harvey and included that "*we can demonstrate that we have taken the concerns raised seriously … However, despite extensive and intensive review, the Paediatric Consultants still feel that there are questions to be answered and we feel that we need to share the details and discuss with the police.*"[68] It appears that Mr Chambers' "*external review*" would be conducted while preparations were made to report matters to the police, if necessary. Nothing seems to have come from Mr Chambers' "*external review*".

26.35 On 30 March 2017, Ms Hodkinson spoke by telephone to Ms Slingo.[69] Ms Slingo's handwritten note of this meeting, and the typed summary sent on 4 April 2017 (set out further below), gives some insight into what Ms Hodkinson told her about the thoughts of the executives in relation to contacting the police:

a. "*neonatal unit – particular individual linked by association*" and "*cons* [consultants] *think Trust should call police*"

b. "*? Avoidable deaths – 5 unexplained deaths*"

c. "*if decide to go to police? → consider not much option*"

d. "*? Consider refer cons* [consultants] *to GMC*"

e. "*MD* [Medical Director] *has also* [reviewed] *cases against shift patterns – she* [Letby] *is there a lot but MD considers satisfied incident investigated*"

f. On the final page:"**meet with police*".[70]

26.36 The excerpt at (d) above makes it plain that, in light of the consultants' persistent concerns, a referral to the GMC was to be considered. This underscores, were such underscoring necessary, that there was no question in the minds of the executives of protection for the doctors. The contrary was the case. They were at risk of referral by their employer to the regulator.

26.37 In Ms Slingo's email, she advises Ms Hodkinson based on the information she was provided with during their call on 30 March 2017. She wrote:

> "*The question the Trust is now considering is whether, and if so how, to liaise with the police in this matter, with particular*

> *pressure being brought by a consultant and others, about the desire to continue to investigate the issue in the neonatal unit. The motivation for this concern is unclear, but may spring from the personal accountability and involvement of the consultant in the care of the neonates on the unit.*"[71]

The motivation was clear. The doctors were concerned that the investigations had not revealed why the babies had died. The suggestion that the motivation may spring from "*the personal accountability and involvement of the consultant in the care of the neonates on the unit*" is baffling. Unsurprisingly, the advice was that, if the police were to be called, rather than wait for a whistleblower, the hospital should bring in the police first.

26.38 Ms Slingo advised: "*If the matter is to be referred to the police, it is more helpful on balance for this to be the Trust's decision than for the Trust to await a potential whistleblower situation.*"[72] She then sets out various ways the Trust may wish to contact the police. Ms Hodkinson forwarded the email on to Mr Cross.

26.39 Ms Slingo accepted that she did not advise the Trust in direct terms that they should contact the police and in hindsight wishes she had done that. In the event, the wheels were already in motion.

26.40 Ms Slingo reflected on the provision of information provided to her by Ms Hodkinson. She said: "*I do think that I didn't have all the information that you suggest it was available by the July period in 2016, because it doesn't feature in my note as part of the narrative and the history given by Sue … if I wasn't told everything that was known, then that would be disappointing to find out and that appears to be the case.*"[73]

26.41 When Ms Hodkinson was informed of Ms Slingo's evidence that she was not told everything that was known at the time, Ms Hodkinson responded: "[S]*he should have asked me more questions … I felt that I was giving a clear and honest and truthful overview at that time.*"[74]

## Preparing for possible referral to the police

### ‘Rationale’ document

26.42 On 3 April 2017, Mr Cross prepared a document titled ‘Rationale’. The opening paragraph reads: “*In our view, there is no evidence to justify a criminal investigation. However, in the spirit of openness and transparency, the matter is being reported to the Police, having regard to the fact that a number of Consultant Paediatricians are not satisfied with the very thorough investigations and reviews undertaken*.”[75]

26.43 The document also included (not exhaustive):

> “*2. A Trust review had highlighted increasing levels of activity and acuity, cross-referenced to lower than recommended staffing levels.*
>
> *…*
>
> *5. Whilst the RCPCH Review identified a number of areas for improvement, they did not identify a single causal factor for the deaths.*

*6. A further independent in-depth review … highlighted some areas for improvement. It did not identify a single causal factor or raise concerns regarding unnatural causes of death.*

*7. Twelve of the deaths have been subject to post mortem, but there have been no suspicious findings.*

*8. A secondary review of four deaths, by Pathologists at Alder Hey Children's Hospital, did not raise any concerns regarding unnatural causes of deaths.*

*9. HM Coroner for Cheshire has been kept fully informed of this matter from the beginning and has not directed any further action, save for holding three inquests …*

*10. The allegation against the nurse was based on her having been present on the unit disproportionately frequently, not necessarily caring for the baby, at the time of the collapse.*

*11. The nurse is one of a few who are full time and regularly worked overtime.*

*12. The nurse is highly qualified, so tended to look after the sicker babies.*

*13. There were no concerns regarding the nurse's performance – she had not been involved in any other incidents.*

*14. The Trust has demonstrated that it has taken the concerns raised seriously and has been open and transparent with the Coroner, its regulators, parents and the public."*[76]

26.44 In his witness statement to the Inquiry, Mr Cross said that this document was a record of a discussion between Mr Chambers and Sir Duncan, and was a reflection of their views as at 3 April 2017.[77] Mr Chambers said that the purpose of this note was unclear. Whatever its purpose, its title and content make plain the executives' views at that time, with which Sir Duncan was in agreement.

26.45 The 'Rationale' document can only be viewed as a last-ditch attempt to persuade independent people such as Mr Medland KC and the police that the suspicions harboured by the clinicians had no foundation.

26.46 The first paragraph said it all.[78] The document was highly selective. It contained none of the points which the consultants had made repeatedly, and omitted all the information which might have caused an open-minded,

independent person to pause and seek more information. It did not refer, for example, to the RCPCH's immediate recommendations, or the temporal association of collapses with Letby's shifts, and it was economical with the truth elsewhere. I accept that the information describing Letby as an exemplary nurse was genuinely believed by the Executive Directors – they had accepted the word of Ms Powell and the other nurses on this.

26.47 The same day, Mr Harvey produced a document headed 'Neonatal Services at the Countess of Chester Hospital NHS FT'.[79] This was prepared in anticipation of the review by Mr Medland KC. It sets out a sequence of events in relation to the increased neonatal mortality. It includes a summary of the various reviews that took place and actions taken in relation to Letby. For example, it details that Letby's shifts had been moved from nights to days "*to ensure that she was supported*",[80] but makes no reference to the fact that deaths at night then stopped. Mr Harvey makes a point of saying, again, that Letby worked full time, had a Qualified in Specialty (QIS) qualification and worked overtime. As before, this information was not put in the context of the other nurses on the neonatal unit. It was a straight repetition of what Ms Powell had

said back in the meeting on 11 May 2016 (see Chapter 9). It is not apparent that Mr Harvey ever sought to scrutinise it.

26.48 There was no reference in the document to the staffing analysis done by Ms Sian Williams, or the concerns she had expressed about the need to go to the police. Nor was there mention of the disclosure from Dr Jayaram three weeks earlier.

26.49 Mr Harvey concluded thus:

> "*In summary, we can demonstrate that we have taken the concerns raised seriously and have been open and transparent with the Coroner, our regulators, parents and the public. However, despite extensive and intensive review, the Paediatric Consultants still feel that there are questions to be answered and we feel that we need to share the details and discuss with the police.*"[81]

The first sentence overstates by some margin the openness and transparency shown by the hospital, via the executives.

26.50 In a telephone call, Mr Medland KC received instructions from Mr Cross to advise the hospital. Mr Medland KC said, and I accept, that he knew Mr Cross professionally, as he

had been instructed by him to act on about half a dozen inquests over a couple of years. He was a criminal barrister. When asked, he said that he was a Freemason and has never made a secret of that fact. Mr Cross was also a Freemason, but they were members of different lodges and did not see each other socially, save in passing. I am satisfied that Freemasonry is irrelevant to the Inquiry and say no more about it.[82]

26.51 Mr Medland KC told the Inquiry that, during his initial phone call with Mr Cross, Mr Cross explained: "*There was concern amongst some of the Consultants about serious occurrences in their part of the hospital and he wanted me to consider those and then report to the board.*"[83]

26.52 On 3 April 2017, Mr Medland KC was sent a bundle of papers via email from the Countess. This included the RCPCH 'Final Confidential Report', the summary document 'Neonatal Services at the Countess of Chester Hospital NHS FT' by Mr Harvey, 'Rationale' by Mr Cross, and a timeline created by Ms Hodkinson.[84] Although it was not attached to the email of 3 April 2017, Mr Medland KC

thought that he had been sent Dr Hawdon's report. At the very least, he said he was aware of Dr Hawdon's name in April 2017.

26.53 Mr Medland KC said that he took a degree of reassurance from the documents that were sent, because they had not determined that a crime had been committed. However, he also acknowledged that the "*people who had investigated the matters were not tasked with putting together a criminal case*".[85]

26.54 The following day, 4 April 2017, Sir Duncan, Mr Harvey and Mr Chambers met Mr Medland KC. Mr Cross was in attendance and made notes. They discussed the 'Rationale' document.[86] Mr Medland KC advised against the use of the first paragraph "*re: no evidence to justify a criminal investigation*".[87] At the end of the meeting, Mr Medland KC understood that he was being asked to advise the hospital about whether there was sufficient evidence to justify a report to the police. He advised that, before giving that advice, he should hear from the consultants. A meeting was arranged for 12 April 2017.

26.55 On 5 April 2017, Letby was informed that she would not be returning immediately to the neonatal unit.[88]

26.56 Mr Medland KC prepared typed notes of the meeting with the consultants on 12 April 2017. He explained that the purpose of the meeting was "*to bring an independent objective view to present situation and see if formal report to police was presently merited, in other words whether there is presently information giving rise to reasonable grounds for suspecting that a criminal offence has been committed in respect of any one of the neonatal deaths in question*".[89] In Mr Cross's statement, he confirmed that this was the purpose of Mr Medland KC's instruction.[90] This coincided with Sir Duncan's understanding. He explained: "[W]*e had sought Mr Medland's independent view at a meeting with the paediatricians, which he held, as to whether there was sufficient evidence of criminality*."[91]

26.57 Mr Harvey's and Mr Chambers' recollection of why Mr Medland KC was instructed was at odds with the recollections of Mr Cross, Mr Medland KC and Sir Duncan. Mr Harvey stated Mr Medland KC's role was to "*collate all the information, meet with the paediatricians and advise us the best approach and with what information to go to the police*". In oral evidence, Mr Harvey affirmed this, saying: "*My view was that, prior to the instruction of Mr Medland, we were going to the*

*police.*"[92] Mr Chambers told the Inquiry that Mr Medland KC was instructed to assist the Trust to prepare how to approach the police.[93]

26.58 Mr Medland KC acknowledged that, from the outset, "*there was a difference in understanding*" as to the purpose of the meeting between him and the consultants.[94] Whilst he understood that his instructions were to determine whether there was merit in contacting the police, contrastingly, the consultants were under the impression the decision had already been made to contact the police, and Mr Medland KC was there to help frame their concerns. It is not necessary to resolve this issue. Mr Medland KC answered both questions.

26.59 Mr Medland KC confirmed that, during the meeting, the consultants set out clinical details regarding the neonatal deaths that concerned them. This included examples of specific babies, such as Baby I's frequent transfers to other hospitals, where she stabilised, was returned to the Countess and then rapidly declined; the highly unexpected outcomes for twins; and that rashes were seen on some of the babies. The key passages of the minutes explored with Mr Medland KC in oral evidence were:[95]

a. Paragraph 5 – there was a reference to Beverly Allitt. Mr Medland KC was not sure who raised Allitt's name. However, he stated that in the meeting he drew a distinction between the Allitt and Letby cases. His view was that, at the time, the common thread linking Allitt to the deaths was clearer than the Letby case.[96]

b. Paragraph 6 – Mr Medland KC wrote: "[T]*he police, being strapped for resources and in any event, can only sensibly investigate cases where there is – at the very least – reasonable grounds for suspecting that a criminal offence has been committed. He* [Mr Medland KC] *emphasised that this was very different from there being mere suspicion.*"[97]
Mr Medland KC corrected this in evidence. He said that the police do investigate when mere suspicions are brought to them, and that he had overstated the threshold. He said that he should have told the consultants that mere suspicion was enough, and that the police would have been interested in the level of information that the consultants had.[98]
Mr Medland KC conceded: "[O]*n the basis of the information I was given I got it very badly wrong*."[99]

c. Also at paragraph 6 – Mr Medland KC wrote: "[R]*eporting any matter to the police was a condign step which was effectively a public action and would incur adverse publicity.*"[100] Mr Medland KC explained in evidence that, in his view, he and the executives were not concerned about the headlines from a superficial point of view, and that the principal consideration was the impact on the families if a criminal investigation took place and it turned out a crime had not been committed.[101]

26.60 Mr Medland KC strongly encouraged the consultants and the Countess to work together to resolve this, rather than take entrenched or opposed positions. He concluded the meeting by saying: "[A]*s things stand he* [Mr Medland KC] *did not see that there was such material as might give rise to reasonable grounds for suspecting that a criminal offence had been committed.*"[102]

26.61 Nevertheless, Mr Medland KC encouraged the consultants to make a list of their "*best points*".[103] He also raised the possibility of a private discussion with Detective Chief Superintendent (DCS) Nigel Wenham (Cheshire Constabulary), on the basis that

DCS Wenham sat on the CDOP.[104] It was this advice that led, in short order, to contact with the police.

## Extraordinary Board meeting, 13 April 2017

26.62 The following day, on 13 April 2017, an Extraordinary Board meeting was convened.[105] Mr Medland KC was invited to attend. The minutes recorded that Mr Medland KC said:

> "[I]*n his* [Mr Medland KC's] *view there is no evidence of a crime but the consultant view is to go to the police. He suggested that an alternative approach would be to approach the police member of the Child Death Overview Panel … We cannot say no to a further review of some sort as* [Dr Hawdon's] *report says a broader forensic review is needed of the class 2 cases.*"

Mr Medland KC added: "**[Y]*ou need to accept that if something is still unanswered or there are still genuine concerns in well minded people, you should go to the police*** [emphasis added]."[106]

26.63 Mr Medland KC also suggested that it would be helpful to ask Dr Hawdon what she meant by forensic review.[107] He considered that the executives should work with the consultants and involve them in the commissioning of any further forensic review, so that everyone would understand what was being done, and there would be no secrets between them. He urged the executives to let the consultants decide which cases should be included in the further forensic review. The agreed action from the meeting was that the Trust would ask Dr Hawdon to take the forensic review forward.[108] Mr Medland KC explained that this meeting was his last involvement in the case.

26.64 During the course of the meeting, Sir Duncan referred to the Beverly Allitt case.[109] There was no reference to the case of Allitt in the minutes of previous Board meetings. As far as Sir Duncan could recall, this was the first time he mentioned the Allitt case to the Board.[110] This was despite Sir Duncan's professional involvement in the circulation of the Allitt Inquiry and despite Dr McCormack having raised the names of Shipman and Allitt at the meeting on 30 June 2016, which Sir Duncan attended[111] – a matter Sir Duncan was unable to recall in oral evidence.[112]

26.65 Sir Duncan described Mr Medland KC's input as follows:

> "*Mr Medland reported back to us as I recall that he didn't find any evidence of -- of criminality. But he used an expression that stayed in my memory arguably since then, along the lines that: if events are still unexplained and if well-minded people still have concerns, then the police should be called and I wish we had had that advice in July 16.*"[113]

26.66 I don't accept that the Board needed a KC to make that point. I do accept, as I have said elsewhere in the Report, that running a hospital is a complex and demanding task. However, Mr Harvey, Mr Chambers, Ms Kelly and Ms Hodkinson had all known for about a year that the consultants had concerns. Had they treated the consultants with the respect due to any colleague, the executives would have acknowledged that these were concerns of well-minded people, and that action was required. Instead, they disregarded the consultants' views, and, in the end, were thinking of ways to deal with them. The Non-Executive Directors and the Chair should have scrutinised what they were being

told by the executives at this meeting, and challenged them about their attitude to the whistleblowers.

26.67 The Board also discussed communications with the parents of babies who had died. Mr Harvey told the Board that the hospital had endeavoured to keep the families up to date, although there were things to be learned.[114] Mr Chambers stated that the hospital had written to the families, advising them in an open and transparent way of what the hospital knew. In oral evidence, Ms Hopwood said she wished she had asked for sight of a written communications plan.[115] Sir Duncan accepted the hospital did not exercise the "*appropriate duty of candour*" towards parents, which was a "*serious failure*".[116]

## Involvement of the CDOP

26.68 At a meeting of the executives on 19 April 2017, "[i]*t was agreed that the way forward was through the Child Death Overview Panel (CDOP) and IH* [Mr Harvey] *agreed to arrange a meeting with representatives of CDOP as soon as possible*".[117]

26.69 On 20 April 2017, a telephone call took place between Mr Harvey and Ms Hayley Frame, Independent Chair of the Pan Cheshire

CDOP. Mr Harvey's note of the meeting is brief. It contains one line: "*?notified rapid response process for any ? deaths.*"[118] 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 protocol for unexpected deaths was not always followed, and that the Countess "*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*".[119] There was no reference at that time to an intention to call the police.

26.70 On 27 April 2017, a meeting was held with DCS Wenham, the police representative on the CDOP. This was two weeks after the Extraordinary Board meeting. The meeting was attended by Ms Hayley Frame, DCS Wenham, Mr Harvey, Mr Cross, Dr Jayaram and Dr Holt. Dr Mittal was also there at Ms Hayley Frame's request. 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.*"[120]

This was the first time she became aware there were suspicions a staff member was involved in the deaths.

26.71 Ms Hayley Frame said that it became "*clear that the reviews that had taken place so far hadn't ruled out anything untoward*". She remarked it was "*clear coming out of that meeting that there was something very worrying and Nigel* [Wenham] *had the same view*".[121] Ms Hayley Frame said in evidence that, during the meeting, DCS Wenham said this was a matter for his officers.

## The police

26.72 The same day, on 27 April 2017, DCS Wenham emailed Mr Harvey, informing him that he had:

> "*provided initial high level briefing to ACC Darren Martland (Crime)* [Assistant Chief Constable Darren Martland, Cheshire Constabulary]
>
> …

*Mr Martland is in agreement with the approach outlined*

- *COCH to provide me copies of all reports completed to date (my email is secure)*
- *COCH to prepare more detailed briefing and arrange a briefing session with key people (Including myself, Det Supt Duggan, and ACC Martland) …*

  *…*
- *As discussed, please progress with addressing a formal letter to Chief Constable Simon Byrne,* [formally] *requesting that Cheshire Police conduct a forensic investigation into the circumstances surrounding the deaths*

*Following the formal briefing*[,] *the Constabulary will make a formal decision as to conduct a forensic investigation or not.*"[122]

26.73 Mr Harvey responded to DCS Wenham on 28 April 2017,[123] attaching documents for his review: Mr Harvey's summary document dated 3 April 2017 ('Neonatal Services at the Countess of Chester Hospital NHS FT'), the timeline of events produced by Ms Hodkinson and Dr Hawdon's review.

26.74 On 2 May 2017, after an Extraordinary Board meeting,[124] Mr Chambers wrote to CC Byrne: "[O]*n the advice of T/Detective Chief Superintendent Nigel Wenham … I am writing formally requesting that Cheshire Police conduct a forensic investigation into the circumstances surrounding the deaths with a view to excluding any unnatural causes*."[125] This was an unusual approach to the police. Their role is to prevent and investigate crime. DCS Wenham considered that the clause "*with a view to excluding any unnatural causes*" had no place in the letter, and it appeared Mr Chambers was trying to "*direct a mindset*".[126] For almost a year, Mr Chambers had sought 'to exclude unnatural causes'. This was more of the same.

26.75 Mr Chambers was asked why the police were not contacted earlier. He explained that the decision from 27 March 2017 to contact the police still stood. However, "*we needed help and advice … this was a serious escalation of matters and we needed to be clear around how we would manage that next step.*"[127] This echoes what he said in July 2016 about "*pressing the doomsday button*".[128]

26.76 On 5 May 2017, there was a meeting between Assistant Chief Constable (ACC) Martland and DCS Wenham, of Cheshire Constabulary, and Mr Chambers, Mr Cross and Mr Harvey.[129] The executives told the police, in summary, that:

- a criminal KC had advised that there was no evidence to suggest criminal activity
- there was a shift commonality between Letby and the deaths
- there was no evidence against Letby other than coincidence
- Letby was moved from night shifts to day shifts for her protection
- Letby was QIS, and was therefore more likely to be caring for sicker babies.[130]

26.77 In oral evidence, Mr Chambers agreed it was important that he explained the consultants' concerns at their highest when he communicated with the police.[131] It was put to Mr Chambers that he did not present the full extent of the consultants' concerns in the meeting on 5 May 2017. He conceded that "*it's not been articulated*" in the minutes that:[132]

- Letby was moved from night shifts to day shifts and then the pattern of deaths changed
- when Letby was moved off the neonatal unit, the unexpected deaths and collapses stopped.

26.78 The closing statement of the meeting minutes read: "*There are no significant concerns to suggest any unlawful acts, it appears a series of anomalies that needs to be investigated further.*" It was noted that ACC Martland and DCS Wenham would draft investigative Terms of Reference. A further meeting was arranged for 12 May 2017.[133]

26.79 On 10 May 2017, Dr Jayaram sent a number of documents to DCS Wenham by email. He explained that the documents "*attempt to articulate the clinical concerns of the 7 consultant hospital paediatricians*".[134] Two of the documents were headed:

- 'Reasons for concerns regarding a possible criminal cause for increased neonatal mortality at the Countess of Chester Hospital NHS Foundation Trust, June 2015–July 2016'[135]
- 'Mortality, Acuity and Staffing 2015–2016'.[136]

26.80 DCS Wenham said in evidence to the Inquiry that, collectively, the documents sent to him were "*incredibly powerful and important in terms of how we moved forward*".[137]

## Meeting between Mr Chambers, Mr Cross, Mr Harvey and Cheshire Constabulary, 12 May 2017

26.81 On 12 May 2017, Mr Chambers, Mr Cross and Mr Harvey met Cheshire Constabulary: ACC Martland, DCS Wenham (Deputy Head, Public Protection Directorate), Detective Inspector (DI) Paul Hughes (Major Investigation Team), Mr David Bryan (Head of Legal) and Ms Laura Fox (secretary). The minutes of this meeting record that the documents which Dr Jayaram had sent to DCS Wenham on 10 May 2017 had now been shared with the Executive Team. The minutes record that the executives made the following comments.[138]

26.82 Mr Chambers stated:

- There was nothing new in the documents that Dr Jayaram had not already shared with the RCPCH and others.
- It was disappointing that the group of clinicians had not moved on, despite all of

the reviews and enquiries that had been completed.

- He would be "*comfortable to pause at this point, but equally would be comfortable to see what level of enquiry could be done*".
- The matter may "*become a wider GMC issue as there becomes a point where a group of clinicians who are not prepared to take the recommendations of RCPCH are blocking the ability to move forward*".[139]

26.83 The minutes record Mr Harvey noted that the concerns were considered an "*HR issue*" and "*nothing that could potentially be evidence of a criminal investigation*".[140]

26.84 DCS Wenham was invited in evidence to the Inquiry to comment on the remarks made by Mr Chambers and Mr Harvey. He opined: "[W]*hen you read some of the comments now it's like indeed doors are trying to be shut.*"[141] Mr Chambers was asked about this. He rejected DCS Wenham's interpretation of what he and Mr Harvey said.[142] He denied that he was discouraging, as opposed to encouraging, an investigation.[143] Mr Harvey also disagreed with DCS Wenham's view. Mr Harvey said: "*I wouldn't accept that I was actually trying to dissuade them.*"[144]

26.85 At the meeting, ACC Martland is recorded as saying: "[T]*here is no specific allegation at this point to suggest a criminal act. We do not have any reasonable grounds to suspect or believe that this may have been the case.*"[145] ACC Martland questioned whether there was an independent body that could consider all the reviews and note any issues, including possible evidence of criminal wrongdoing, prior to a criminal investigation. The executives might reasonably have inferred that the police were not unanimously in favour of starting an investigation. The minutes also record Mr Chambers' agreement that the police needed to speak with the consultants about their concerns.

26.86 An agreed outcome from the meeting was that the police would meet Dr Jayaram. In the event, they met Dr Jayaram, Dr Brearey and Dr Holt.[146]

## Mr Chambers' plan for the consultants

26.87 Mr Chambers drove back to the Countess after the meeting. By that stage, he must have realised there was a prospect that the police would investigate, but there was also a realistic prospect that they would not. If they did investigate, matters would be out

of his hands. If they did not, he would have to decide what to do. He and Ms Hodkinson had a pre-arranged one-to-one meeting in their diaries. He used the meeting to work through a plan for what to do if the police did not investigate. As was her usual practice, Ms Hodkinson made a note. It reads:

> "*RJ/SB* [Dr Jayaram/Dr Brearey] *plan re management.*
> *1. GMC*
> *2. Actions from grievance*
> *3. Mitigation from SoS* [Speak Out Safely]*/ whistleblowing*
> *4. Action plan to manage out.*"[147]

26.88 This note is one of the most revealing documents in the Inquiry. It sets out an aggressive plan to get rid of Dr Brearey and Dr Jayaram, the consultants. When asked about it in evidence, Ms Hodkinson began by saying that Mr Chambers did not really mean it. She then said that Mr Chambers was frustrated and had discussed plans with her to manage Dr Brearey and Dr Jayaram out of the Trust around the Speak Out Safely Policy. However, she had challenged him, and the plan ultimately did not go ahead.[148]

26.89 Initially, Mr Chambers said he did not recollect this meeting. He later gave the following explanation:

> "*For me, what this meeting was all about was patient safety and insomuch as if we have a scenario that there is a breakdown in relationship between the leaders of our services and the nurses in those services, then that's never going to be good for patient safety. So I kind of was thinking if there isn't a police investigation, what are we going to do? So this was just almost a -- a -- well, we can do this, we can do that. 'Sue, guide me.'*"[149]

26.90 This explanation, which I reject, is on a par with his wordy and untruthful explanation of what he had actually said to Mr Letby, when he was recorded as saying, "*we didn't believe it*" (see Chapter 22).[150] There is no evidence in the note to suggest that patient safety crossed his mind. Nor that he considered there was anything to be done in respect of anyone other than Dr Jayaram and Dr Brearey. He could not explain, when answering questions, why the GMC was an option, nor why the question of mitigation around Speak Out Safely and whistleblowing was noted.

26.91 In my view, his obvious intention was to punish the consultants for persisting with their concerns. I do not accept that he was seeking Ms Hodkinson's advice (and she did not suggest he was). His plan was clear. Each point on the management plan noted by Ms Hodkinson needs no explanation. The two consultants were to be reported to the GMC. The punitive recommendations from the grievance were to be actioned. A way was to be found around the Speak out Safely/Freedom to Speak Up/whistleblowing provisions. There would be an action plan to manage the doctors out. It could not have been clearer. I note that, having said he had no recollection of the meeting (and he had heard Ms Hodkinson's evidence the previous day, so the questions about the meeting cannot have been a surprise), he went on apparently to confirm Ms Hodkinson's evidence that she had pushed back on his suggestions, saying: "[A]*s Sue said yesterday, her advice was: well, that wouldn't be sensible.*"[151] Whether or not she advised against such a misconceived and unfair plan matters not. What caused him to change course was the fact that, a few days later, contrary to his expectation, the police announced they were going to investigate.

26.92 What Mr Chambers is recorded as saying is entirely consistent with his approach for nearly 11 months, that the problem here was the doctors. He never once scrutinised his own thought processes. He failed to consider whether his views were unfair or unfounded. If the doctors' concerns turned out to be well founded, the consequences for patients and their families were catastrophic. Mr Chambers was so determined to bring down the doctors that he lost objectivity and made poor decisions.

26.93 On 15 May 2017, Dr Brearey, Dr Holt and Dr Jayaram met DCS Wenham and DI Hughes of Cheshire Constabulary.[152] In the meeting, the consultants set out the detail of their concerns about the clinical features and circumstances of the deaths, Letby's association, and their concerns that she may be deliberately harming babies. They pointed out that, before she was moved onto day shifts, the sudden collapses occurred between midnight and 04:00. Once she was on day shifts, there were no sudden collapses during the night. After Letby had been moved off the neonatal unit, there were no neonatal deaths, and no unexpected or unexplained sudden deteriorations. The redesignation of the unit could not be the only reason for this,

since it was now permitted to care only for babies of over 32 weeks' gestation. Six of the babies who died in 2015 to 2016 while Letby was working on the unit were over 32 weeks' gestation. Three of these babies featured on the indictment, three did not.

26.94 DCS Wenham stated:

> "*The meeting was -- I can't describe how powerful it was. They were knowledgeable, they spoke from the points of view whereby they were dealing with these things real-time and the -- they have had -- they have had -- they have lived and* [have] *breathed these events* …
>
> *I think we all owe them a great deal for coming forward and speaking out the way they did.*"[153]

26.95 Following the meeting with the doctors, DCS Wenham had a telephone meeting with the executives and informed them that he had decided to begin a police investigation.

## Should the police have been notified earlier?

26.96 DCS Wenham was asked about whether the police should have been notified at an earlier stage. His response was: "[C] *learly with hindsight and looking back the*

*obvious answer to that is yes. You know, we should have been notified and engaged with earlier.*"[154]

26.97 Almost everything the consultants raised with the police in May 2017 was known to the executives after the deaths of Baby O and Baby P. Much of what was known in May 2017 was known in June 2016. Had they gone to the police then, the investigation would have begun then. That would have significantly reduced the time that parents had to endure uncertainty about what had happened to their babies. Responsibility for that delay lies squarely at the door of the executives.

26.98 As I have mentioned already, Mr Harvey said in evidence: "[I]*n June/July 2016 I had expressed an opinion that we should approach the police and I sincerely regret that we didn't at that time.*"[155] I accept his evidence about that. This was a major error of judgement, which was the result of a refusal to acknowledge that the doctors' concerns might be well founded, and a failure to act on concerns and suspicions that the executives all accepted were held in good faith.

26.99 Mr Chambers accepted that the concerns featured in the consultants' 'best points' document (the 'Reasons for concerns'

document given to the police in May 2017) were shared with the executives in 2016.[156] He denied seeking to stall or obstruct a police investigation.[157] That was precisely what he had done and was what he intended to do. The effect of the actions of the executives from June 2016 was that the police investigation was delayed by a year.

26.100 As I have set out in Chapter 11, Ms Kelly and Mr Harvey exchanged emails on 29 June 2016, stating that they both thought that the police should be contacted.[158] However, on 30 June 2016, Ms Kelly changed her position. When asked about this, she stated: "[O]*n reflection maybe we could have gone to the police then.*"[159] Even at the Inquiry, Ms Kelly could not bring herself to say that the executives should have gone to the police then. Her misguided determination to protect her nurse had overridden her judgement.

26.101 Ms Hodkinson was asked when she considered that the police should have been contacted. She replied: "*For definite 15 March 2017.*"[160] She said: "*I was disappointed that they took so long for the police to be instigated from that 15 March meeting.*"[161] I think it unlikely that was her view at the

time. She was still in favour of introducing Letby back onto the neonatal unit after 15 March 2017.

26.102 As I have set out in paragraph 26.65, Sir Duncan reflected:

> "*Mr Medland reported back to us as I recall that he didn't find any evidence of -- of criminality. But he used an expression that stayed in my memory arguably since then, along the lines that: if events are still unexplained and if well-minded people still have concerns, then the police should be called and I wish we had had that advice in July 16.*"[162]

26.103 A number of witnesses, including Non-Executive Directors, recalled that Mr Cross had explained the level of disruption that would occur if the police were called (closure of the unit, blue tape everywhere). I accept that this was something Mr Cross said, more than once. I doubt it was said in the hope of encouraging a referral to the police. It should not have been said, not least because it was wholly inaccurate. Whatever was said did not constitute a reason not to call the police. In the event, the reality of the approach of the police to the investigation was nothing like Mr Cross's description. The unit was not

closed, there was no blue tape and disruption was kept to a minimum. Doctors reviewed the medical records over many hours and days, at the request of the police. They prepared statements. Nurses too provided statements. This was all done after working hours, which were spent treating and caring for patients.

## Parents

26.104 The Inquiry heard evidence from parents that they were not aware of any concerns that an individual had caused neonatal deaths and collapses at the Countess until Letby was arrested and the police contacted them in July 2018.

26.105 Mother A and B said she had "*mixed feelings*" when she learnt that the consultants had made allegations about a nurse which had resulted in the nurse being removed from the unit.[163] She said: "*I'm forever grateful because the consultants did speak up and did say something, but it's also very sad that nothing was ever shared with us.*"[164]

26.106 Some of the babies who had non-fatal collapses were still being seen as outpatients at the Countess, long after the consultants raised concerns to the executives about

Letby and the police had become involved. One of those babies was Baby G. Mother G's evidence was:

> "*Dr Brearey never said anything about an investigation at the Countess of Chester or about concerns over Lucy Letby's care of our daughter. It really upset me to think that he might have helped cover it all up …*
>
> *I did receive a call from Dr Brearey on the day when the police came to see us in July 2018. He apologised and said he had been unable to tell us about any of the concerns while the police were investigating.*"[165]

26.107 Mother C told the Inquiry: "*We had absolutely no idea that there had been layer upon layer upon layer of concern voiced by various people within the hospital about the conduct of Lucy Letby and her association with these deaths.*"[166] She said:

> "*The first time that we knew that there was anybody linked to our son's death was on 3 July 2018, when we were phoned by Cheshire Police to inform us that somebody had been arrested on suspicion of murdering our son. That was the first time that we had any information linking an individual.*

> …
>
> … *to not inform us at all until somebody is arrested is unforgivable.*"[167]

26.108 I agree. It is clear from the evidence of Dr Brearey and Dr Gilby that the executives did not expect the investigation to lead anywhere. This was consistent with their earlier conduct. To the extent that they thought about the parents at all at this point, it is likely that they considered it better to say nothing, since nothing was to come out of it. This, as it had been in respect of disclosure to the Board and then to the police, was the wrong call. Once the police were investigating the circumstances of the deaths of and injuries to their babies, the parents had the right to know about it. They should have been informed.

## Children's Champion

26.109 The RCPCH had recommended in its report that an executive member of the Board should take on the role of Children's Champion. Nothing was done about that for many months. Ultimately, it was imposed on Ms Hopwood, a Non-Executive Director. This was done, without warning, at a meeting of QSPEC on 17 July 2017. She recalled there were more than 20 people in attendance and

she was taken by surprise when Mr Harvey, in the course of an update on the neonatal unit action plan, announced that she had been appointed Children's Champion and that she would be attending monthly meetings. She had no relevant experience, she was not an Executive Director, and the issue had not been raised with her.[168] When she challenged Mr Harvey after the meeting, he said that it was necessary to appoint a Non-Executive Director to the role because of the breakdown of relationships with the consultants.[169]

26.110 Leaving aside the discourtesy to Ms Hopwood, the failure to implement this part of the RCPCH report for many months, followed by the appointment of a Non-Executive Director, was a box-ticking exercise at best. Ms Hopwood complained to Sir Duncan the next morning.[170] In due course, she introduced herself at QSPEC in October 2017, but nothing seems to have come of this.

# Endnotes

1 INQ0003395/2-3

2 Dr Nim Subhedar 20 November 2024 47/21 to 48/5

3 Ian Harvey 29 November 2024 120/5-12

4 INQ0003395/2-3

5 INQ0003395/3

6 Dr Nim Subhedar 20 November 2024 48/13 to 49/7

7 Dr Nim Subhedar 20 November 2024 50/11-13

8 INQ0006816

9 INQ0006816

10 INQ0103207

11 INQ0103207

12 INQ0003119

13 INQ0003119

14 INQ0060447/2

15 INQ0060447/2

16 INQ0060447/2

17 INQ0006432/1

18 INQ0011870/1

19 INQ0011870/1

20 INQ0011870/1

21 INQ0003219/1

22 INQ0003219/4

23 Sue Hodkinson 26 November 2024 89/17 to 90/1

24 Sue Hodkinson 26 November 2024 72/14 to 73/6

25 INQ0003344/1

26 INQ0003344/1

27 Sue Hodkinson 26 November 2024 77/4

28 INQ0003344/3

29 Alison Kelly 25 November 2024 208/1

30 INQ0003344/3

31 INQ0003344/3

32 INQ0003344/3

33 Tony Chambers 27 November 2024 127/25

34 Tony Chambers 27 November 2024 126/6-23

35 Tony Chambers 27 November 2024 126/21 to 129/8

36 Tony Chambers 27 November 2024 127/3-4

37 INQ0003150/1

38 Dr Nim Subhedar 20 November 2024 61/25 to 62/2

39 Dr Nim Subhedar 20 November 2024 51/12-13

40 INQ0101093/2

41 Dr Stephen Brearey 19 November 2024 179/9-10

42 Dr Stephen Brearey 19 November 2024 180/2-3
43 Dr Ravi Jayaram 13 November 2024 170/15
44 Dr Ravi Jayaram 13 November 2024 172/3-7
45 Dr Ravi Jayaram 13 November 2024 222/25 to 223/3
46 Sue Hodkinson 26 November 2024 156/12-13
47 INQ0003150/1
48 INQ0003150/2
49 INQ0003150/2
50 INQ0003150/2
51 INQ0003150/3
52 INQ0003150/3
53 INQ0003150/6
54 Tony Chambers 27 November 2024 157/5-6
55 INQ0003384
56 Tony Chambers 27 November 2024 44/21 to 45/11
57 INQ0014281
58 INQ0014281
59 INQ0014281
60 INQ0107706/169
61 INQ0014281

62 Sue Hodkinson 26 November 2024 182/23 to 183/2

63 Sue Hodkinson 26 November 2024 182/9-10

64 Sue Hodkinson 26 November 2024 182/10-14

65 Sue Hodkinson 26 November 2024 180/13 to 183/13

66 INQ0004409/1

67 INQ0004409/1

68 INQ0014378/4

69 INQ0101944

70 INQ0101944

71 INQ0003088/2

72 INQ0003088/2

73 Corinne Slingo 21 November 2024 157/18-22 and 158/10-12

74 Sue Hodkinson 26 November 2024 64/20-24

75 INQ0003226

76 INQ0003226

77 Witness statement of Stephen Cross INQ0107707/47/para 183

78 INQ0003226

79 INQ0014378/1

80 INQ0014378/1

81 INQ0014378/4

82 Simon Medland KC 21 November 2024 160/21 to 162/25 and 195/22 to 197/24

83 Simon Medland KC 21 November 2024 160/10-13

84 INQ0014378; INQ0006123; INQ0002927

85 Simon Medland KC 21 November 2024 201/7-9

86 INQ0006123

87 INQ0003351

88 INQ0003477

89 INQ0005857/1

90 Witness statement of Stephen Cross INQ0107707/48/para 185

91 Sir Duncan Nichol CBE 2 December 2024 80/25 to 81/3

92 Ian Harvey 29 November 2024 126/16-17

93 Tony Chambers 27 November 2024 45/2-5

94 Simon Medland KC 21 November 2024 181/7-11

95 INQ0005857/1

96 Simon Medland KC 21 November 2024 183/23 to 184/11

97 INQ0005857/2/para 6

98 Simon Medland KC 21 November 2024 185/3 to 188/5

99 Simon Medland KC 21 November 2024/204/13-14

100 INQ0005857/2/para 6

101 Simon Medland KC 21 November 2024 186/19 to 187/1

102 INQ0005857/4/para 12

103 INQ0005857/5/para 14

104 INQ0005857/5/paras 14-15

105 INQ0003236/1

106 INQ0003236/2

107 INQ0003236/2

108 INQ0003236/5

109 INQ0003236/4

110 Sir Duncan Nichol CBE 2 December 2024 133/8-12

111 INQ0015639/55

112 Sir Duncan Nichol CBE 2 December 2024 46/19 to 47/1

113 Sir Duncan Nichol CBE 2 December 2024 81/8-14

114 INQ0003236/5

115 Rachel Hopwood 3 December 2024 152/2-17

116 Sir Duncan Nichol CBE 2 December 2024 138/5-8

117 INQ0004414/1

118 INQ0003244

119 Hayley Frame 18 November 2024 122/6-8

120 Hayley Frame 18 November 2024 123/24 to 124/4

121 Hayley Frame 18 November 2024 124/9 to 125/2

122 INQ0003340

123 INQ0003337

124 INQ0004221/1

125 INQ0102319/2

126 DCS Nigel Wenham 20 November 2024 204/24 to 205/20

127 Tony Chambers 27 November 2024 44/18-20

128 INQ0003365/8

129 INQ0003077

130 INQ0003077/2

131 Tony Chambers 27 November 2024 46/3-6

132 Tony Chambers 27 November 2024 49/7-13

133 INQ0003077/2

134 INQ0102300/3

135 INQ0003671/1-3

136 INQ0102303/2-4

137 DCS Nigel Wenham 20 November 2024 165/17-18

138 INQ0003076/1-6

139 INQ0003076/1-6

140 INQ0003076/5-6

141 DCS Nigel Wenham 20 November 2024 172/5-6

142 Tony Chambers 28 November 2024 42/12-20

143 Tony Chambers 27 November 2024 50/21-24

144 Ian Harvey 29 November 2024 130/17-18

145 INQ0003076/2

146 INQ0003076/10

147 INQ0015642/48

148 Sue Hodkinson 26 November 2024 169/7-14

149 Tony Chambers 27 November 2024 180/2-10

150 INQ0003463/2

151 Tony Chambers 27 November 2024 184/5-6

152 INQ0102309/2-7

153 DCS Nigel Wenham 20 November 2024 179/22 to 180/12

154 DCS Nigel Wenham 20 November 2024 191/11-15

155 Ian Harvey 28 November 2024 72/5-7

156 Tony Chambers 27 November 2024 221/18 to 224/15

157 Tony Chambers 28 November 2024 23/5-14

158 **INQ0047571/1**

159 **Alison Kelly 25 November 2024 145/18-19**

160 **Sue Hodkinson 26 November 2024 89/24 to 90/1**

161 **Sue Hodkinson 26 November 2024 174/9-11**

162 **Sir Duncan Nichol CBE 2 December 2024 81/8-14**

163 **Mother A and B 16 September 2024 54/10**

164 **Mother A and B 16 September 2024 54/10-13**

165 **Mother G 18 September 2024 85/13-22**

166 **Mother C 16 September 2024 115/3-6**

167 **Mother C 16 September 2024 114/9-115/3**

168 **Rachel Hopwood 3 December 2024 155/2-11**

169 **Rachel Hopwood 3 December 2024 156/6-22**

170 **INQ0003122**

# Chapter 27. Events in 2018; the Inquiry 2023 to 2026

## Contact with Professor Modi, February 2018

27.1 On 5 February 2018, Dr Brearey emailed Professor Neena Modi, who was then the President of the RCPCH. In his email, he stated that the police investigation continued to cause "*a great deal of stress and upset for the nursing and medical staff on the neonatal unit and for the affected parents*". He raised a number of concerns about the involvement of the RCPCH, including: that the modified report (that is, the redacted dissemination report) did not include any of the paediatricians' concerns and "*was utilised by the Trust to follow a plan*" that had caused them "*considerable patient safety concerns*"; that the paediatricians and affected parents could have been "*supported in a more positive way*"; and that it was unacceptable to "*produce a report and then have no further involvement in the case*". He offered to discuss the problems in person at

the RCPCH headquarters, so that they could reflect on their role and be ready to respond to media interest.[1]

27.2 In her witness statement, Professor Modi described this email as the first communication she had received directly from the Countess regarding the RCPCH report.[2] She had not been involved in any aspect of the review and had not seen the final report until it was provided to her by the Inquiry.[3]

27.3 She emailed Ms Eardley, asking for her comments. Ms Eardley responded that the review was confidential. Ms Eardley suggested that the RCPCH did not have an obligation to support the paediatricians beyond providing an independent review.[4] This was a surprising observation from someone representing the RCPCH.

27.4 Professor Modi replied to Dr Brearey on 8 February 2018. She stated that the review manager (Ms Eardley) had maintained contact and follow-up with the client (Mr Harvey) and that the RCPCH did not have authority over what action was taken by the Trust. She asked Dr Brearey if he had something specific in mind when he referred to "*supported by the college in a more positive way*". She

stated that it would not be appropriate for the RCPCH to intervene due to the police investigation.[5]

27.5 Whilst this was not, as Professor Turner accepted, the most supportive response, given the issues that had been raised by Dr Brearey, Dr Brearey was undeterred and replied to Professor Modi the same day. He explained that the paediatricians had concerns "*regarding the integrity and competence of the … medical director*", so the RCPCH maintaining sole contact with him was making their problems worse. He stated that he was not sure who they "*should turn to for help*". He explained that the purpose of his email was not to request that the RCPCH intervene in the police investigation but to make Professor Modi aware of what was happening at the Countess and point out the problem of the RCPCH's redacted report, which had misled the public and affected families and delayed the onset of the police investigation. He asked whether the RCPCH "*could have done more*".[6]

27.6 Professor Modi emailed colleagues at the RCPCH saying: "*There is clearly a real problem here, a cry for help which we cannot ignore.*"[7] An internal RCPCH email dated

9 February 2018 notes that Professor Modi spoke to Dr Brearey that day.[8] A chronology of events was prepared in light of Dr Brearey's contact with Professor Modi.[9] She then wrote to Dr Brearey on 20 February 2018. She advised him to write to "*the Chair of the Trust Board of Directors and the Lead Governor*", copied to Professor Ted Baker (Chief Inspector of Hospitals for CQC), summarising his concerns about the senior leadership of the Trust and the distressing impact their actions were having on the morale of the staff.[10]

27.7 Professor Modi did not have any further communication with Dr Brearey, ceasing to be President of the RCPCH on 14 March 2018. Dr Brearey had contact with her successor (see paragraph 20.153, Chapter 20).

## Senior management changes – Mr Harvey retires, Dr Gilby arrives

## Dr Gilby arrives

27.8 Dr Gilby qualified as a doctor in 1992. She became a consultant in critical care and anaesthesia and is a Fellow of the Royal College of Anaesthetists and a Fellow of the Faculty of Intensive Care Medicine. From 2012 onwards, Dr Gilby held leadership roles

while maintaining a clinical practice. Between 2013 and March 2015, she was the Associate Medical Director at Mid Cheshire Hospitals NHS Foundation Trust. Between March 2015 and January 2017, she was the Executive Medical Director at Wye Valley NHS Trust, and from January 2017 to July 2018, she was the Executive Medical Director of the Wirral University Teaching Hospital NHS Foundation Trust. She was recruited to each of these posts to turn the hospital around.

27.9 In March 2018, Sir Duncan Nichol approached Dr Gilby to ask her to apply for the Medical Director role at the Countess. Mr Harvey had announced his intention to retire later that summer. Dr Gilby applied for the role, and on 1 August 2018, she took up her post as the Medical Director and Deputy Chief Executive. Mr Harvey retired on 21 August 2018.

27.10 Seven weeks after Dr Gilby joined the Countess, Mr Chambers stepped down as Chief Executive. At Sir Duncan's request, Dr Gilby became the acting Chief Executive from 18 September 2018. She occupied the role substantively from 1 April 2019 and, at the same time, stepped down from the post of Medical Director. On 2 December 2022, Dr Gilby was unlawfully excluded

from the hospital by the successor Chair to Sir Duncan and stepped down from the role of Chief Executive but remained employed as the Chief Executive until 5 June 2023. Dr Gilby was later successful in claims against the hospital for constructive unfair dismissal, automatic unfair dismissal and detriment on the ground that she had made protected disclosures between April and December 2022. The events surrounding Dr Gilby's departure are outside the Terms of Reference of this Inquiry. The judgment of the Employment Tribunal, distributed on 13 February 2025, was provided to the Inquiry. It is in the public domain on the Courts and Tribunals Judiciary website.[11] The judgment contains excoriating criticism of the leadership of the Countess at that time.

## What Dr Gilby knew prior to her appointment

27.11 Dr Gilby told the Inquiry that, prior to joining the Countess in 2018, her understanding was that the Countess had "*a solid reputation externally as an organisation which provided good medical care and attracted high calibre clinicians*".[12] She considered the Chair, Sir Duncan, to be an "*eminent NHS leader*" and, after reviewing the CQC report from June 2016, she felt it appeared to "*imply that*

*it was a good organisation … delivering good care … So I was expecting to go into a high performing organisation.*"[13]

27.12 She had, however, spoken to Mr Harvey in February 2017, when they were both working as Medical Directors. In a discussion about neonatal care at the Countess, he said:

> "'*This issue we've got with the paediatricians is how it started' and he went on to discuss how they had asked for more numbers in the consultant body in the department, that it had been not approved, it was unaffordable. But they had kept on making the point and stamping their feet, is how he put it, until they got what they wanted and, you know, they were the problem. So I left feeling that in the back of my mind, thinking: I wonder what that was about? But it wasn't until later that I discovered that he was referring to the concerns they had about the deaths and unexpected collapses on the neonatal unit, and his irritation at their persistence in that.*"[14]

27.13 A year later, in a meeting with Mr Chambers after her successful application for the role of Medical Director but prior to her joining the Countess, Mr Chambers told Dr Gilby

he might be leaving the hospital. He also discussed with her "*the problems that they were having with the paediatricians and Duncan was meeting with the paediatricians at the time to try to broker some sort of improvement in relations*".[15] She said that, in her initial discussions, Mr Chambers was "*very concerned about the breakdown in the relationship, and he emphasised the need to address that, to fix it*".[16]

27.14 On 30 April 2018, Mr Harvey and Mr Cross met all eight consultant paediatricians. This was the first such meeting for nearly a year. At the end of the meeting, Dr Jayaram handed a long letter to Mr Cross from the paediatricians.[17] It was then given to Mr Chambers. The consultants challenged the approach taken by Mr Harvey to their concerns and said that they felt that "*the chief executive and some members of the board treated the consultants' views with contempt*". The letter set out a number of searching questions about the approach taken by Mr Harvey and the rest of the Board to the paediatricians' concerns. On 24 May 2018 (also after Dr Gilby's successful application but before her appointment), Sir Duncan telephoned Dr Gilby to discuss the situation with the neonatal unit and asked for her help.

He sent her the list of questions that the consultants had submitted to Mr Chambers. He also provided her with Mr Chambers' draft response.[18] Dr Gilby described the draft response as "*tone deaf*".[19] I would add that it was incorrect in parts and ignored most of the questions. The final paragraph concludes with the following words: "*He … genuinely and sincerely wants the neonatal team to know they have his full support and respect and that of the entire board and colleagues throughout the trust and this has never changed*." This was untrue.

27.15 Dr Gilby explained that, when she read the paediatricians' list of questions, she could "*see the anguish coming off the page, and yet the response that had been formulated read … very defensive, it was dry, it didn't acknowledge their experience*".[20] She thought the response would be "*detrimental*" to what Sir Duncan was trying to achieve.[21]

27.16 Although at that time Dr Gilby had not met the paediatricians, in conversations with both Mr Harvey and Mr Chambers they had expressed to her:

> "*their frustration about the ongoing behaviours and about the reputation issues of the police investigation because this*

*was prior to Letby's arrest, and they were fairly confident, I would say very confident in some cases that, you know, they've been investigating for X number of months, I'm sure they're going to tell us soon that it's all over and, you know, the problem is the paediatricians and their department. And that was the mantra I was given right up until the day I started.*"[22]

27.17 Dr Gilby told the Inquiry: "*I felt they* [Mr Harvey and Mr Chambers] *did believe they* [the paediatricians] *were being genuine, but they were wrong.*"[23] She then described Mr Harvey and Mr Chambers as "*very dismissive of the paediatricians and on a number of occasions it was said to me that they were just looking for somebody to blame* [for poor patient outcomes]".[24] This observation was consistent with the response of Mr Chambers to the paediatricians in the summer of 2016 upon being told that they had concerns about a nurse ("*that would be convenient*").[25] Neither of those views was consistent with Mr Chambers' assertion that he believed the paediatricians were being genuine but were wrong.

27.18 Dr Gilby joined the Countess as the Medical Director and Deputy Chief Executive three weeks after Letby had been arrested.* When she started, she found that there "*were individuals who were shocked, but there was a denial that this meant that it needed to be taken really seriously … it certainly seemed to me that even at that point, it was believed that nothing would come of this, and the focus continued to be on the people who had raised concerns. So that was a surprise.*"[26]

27.19 She was particularly surprised to find that what "*Tony* [Chambers] *wanted to discuss with me, was his concern that actually, he still believed, in spite of the arrest, that no deliberate harm had been caused. He kept repeating that there was no single cause found*"[27] and that he was concerned about a "*wrongful conviction*".[28] In response, Dr Gilby told Mr Chambers: "[I]*t's not for you to find the cause. You have unexpected and unexplained collapses and deaths of patients, and that even one of those, is a cause of concern.*"[29] She was correct.

---

* Dr Gilby described the police and their investigation as "*very respectful and discreet*" and "*there was no disruption to services whatsoever*": **Dr Susan Gilby 24 February 2025 112/13 to 113/3-4**.

27.20 In oral evidence, Dr Gilby confirmed:

> "*Ian* [Harvey] *described the Royal College of Paediatrics and Child Health review to me, saying that the Terms of Reference could have been better and didn't include a review of the cases. He told me that pathologists at Alder Hey Children's Hospital had discussed the cases and that an expert review by Dr Jane Hawdon had found all but two of the deaths explained. He said that the pathologists at Alder Hey had felt that they were all explained. He also told me that the Coroner Alan Moore* [now in post after the retirement of Mr Rheinberg] *had no concerns.*"[30]

27.21 She added: "*I was told the Royal College review had not found any evidence of deliberate harm. I was told that there had been a detailed specialist review of the cases and that had not come up with any evidence of deliberate harm.*"[31] Dr Gilby's evidence was that Mr Harvey had not given her the opportunity to read any of the reports at this stage and that she did not see them until after he had retired in August 2018.[32] This was the same approach as he had taken with the Board of Directors, NHS England and, to some extent at least, the coroner and the

police. He sought to control the narrative. He presented the case, as he saw it, to others and made sure that only documents that supported his case were seen (if necessary, writing them himself).

27.22 After Mr Harvey retired, Dr Gilby met Dr Brearey to discuss the neonatal deaths and collapses. He asked to meet her away from the main executive offices at the Countess so that he would not run into Mr Chambers or any of the other executives. That simple fact demonstrates the breakdown of relationships in the hospital. Initially, Dr Brearey told Dr Gilby that the consultants "*had been raising concerns about … unexplained, unexpected clinical collapses and deaths in the unit, and they hadn't been listened to, and it hadn't been addressed appropriately*".[33]

27.23 Dr Gilby said that, as Dr Brearey shared the pattern of events: "[I]*t became obvious to me as a clinician, never mind as an Executive, that these just -- it was most unlikely that these were clinically explainable collapses.*"[34] Dr Gilby and Dr Brearey spent three hours together going through the timeline of each collapse and fatality.

27.24 Dr Gilby told the Inquiry: "*I learnt clinical information that gave me great concern.*"[35] She expanded:

> "*I discovered clinical histories of patients who were doing well, who were expected to go home, who perhaps even the day they were due to go home, suddenly having a cardiorespiratory collapse and being refactored to resuscitation in a way that you would never expect with a child or especially with a baby. Perhaps it was helpful that my background is critical care and I have spent quite a bit of time in paediatric critical care and in surgical neonatal and critical care … What Dr Brearey was describing to me was something that I have never ever seen or heard of in my clinical practice, and just one of those for me would have been enough as a Medical Director or a director of nursing to absolutely want to get to the bottom of what has happened here.*"[36]

27.25 Dr Gilby also reflected: "*I did have in my mind questions about why were they not able just to go to the police themselves? … But later … I learned that the interactions had been so threatening that they were fearful.*"[37]

## Mr Harvey's departure

27.26 Dr Gilby told the Inquiry that, at the end of a handover meeting with Mr Harvey in the summer of 2018, he made a "*shocking statement*".[38] She explained: "[A]*s we walked out the door, he's packing his things away and he said to me 'You need to refer those paediatricians to the GMC'.*"[39] In response, Dr Gilby asked Mr Harvey why he had not already done so. Mr Harvey told her that he did not want to break his record of not referring anyone. Dr Gilby was surprised that Mr Harvey had not referred any doctor to the GMC given that he had been in position as Medical Director for several years. Ms Langdale KC asked Dr Gilby whether Mr Harvey's statement was a flippant remark. She said it was not. Dr Gilby described Mr Harvey as "*serious … I was being given the impression that I had some problem doctors that needed dealing with*".[40] Mr Harvey denied this emphatically when he was asked about it.[41] For Dr Gilby, this was a striking and memorable remark. There is no reason to think she fabricated it. As a matter of fact, Mr Harvey had not referred any doctor to the GMC, so her memory of that part of what he said is consistent with what he had done. That suggests her memory is accurate. I accept

Dr Gilby's evidence about it. I also take into account that the remark is consistent with Mr Harvey's view of the paediatricians and the fact that, by this stage, he was very busy, clearing the decks before his departure. It seemed to me that, by the time of the Inquiry hearing, he had forgotten about this conversation and cannot now accept that he said it.

## Paediatricians report Mr Harvey to the GMC

27.27 On 29 August 2018, well after she had discovered a box of documents about the neonatal unit in Mr Harvey's former office,[42] Dr Gilby received a text message from Mr Harvey:

> "*Hi Susan - Hope all ok. Just had a long chat with Tony. Rumour has it that I can expect to hear from the GMC – alleged paeds* [paediatricians] *have referred. I left a file of neonates documents for you locked in desk drawer in T block office. Please could you get Claire Raggett to copy them for future reference?*"[43]

27.28 Dr Brearey, supported by other consultant paediatricians at the Countess, referred Mr Harvey to the GMC for misconduct. They complained about the way he had treated

them in response to their concerns about the neonatal deaths and the possibility that they had not been of natural causes. They complained about his probity and said that he had made misleading statements to internal and external stakeholders and to the public. Mr Harvey denied the allegations. The GMC investigated that matter. Ultimately, they concluded that, whilst some of Mr Harvey's communication with the paediatricians fell below the standard expected, there was no realistic prospect of establishing that Mr Harvey's fitness to practise was impaired to a degree that justified action on his registration. The case was closed with no further action in May 2022.[44] Mr Harvey reapplied for voluntary erasure from the Medical Register and this was granted in June 2022.[45]

## Mr Chambers' resignation

27.29 After meeting with Dr Brearey and Dr Jayaram and finding the box file of documents concerning the neonatal unit in Mr Harvey's old office, Dr Gilby told Sir Duncan that she "*had come to* [the] *conclusion that the board, and in particular the Executive team, had got this wrong, and I explained to him why*".[46] Dr Gilby's explanation to Sir Duncan included:

a. explaining the difference between an RCPCH invited service review and a forensic review

b. that Dr Hawdon had written to Mr Harvey explaining that she could not complete the review requested

c. that Dr Hawdon's brief synopsis of each case "*did not give any assurance whatsoever*".[47]

27.30 Dr Gilby said that Sir Duncan "*fully accepted what I was saying, which was in stark contrast to the same conversation that I had with Mr Chambers*".[48] She described Sir Duncan as "*very visibly upset. And he asked me if I would tell what I just told to him to the rest of the Non-Executive Directors.*"[49] Dr Gilby explained her conclusion to the Non-Executive Directors in a meeting on 13 September 2018, at which she was accompanied by Dr Paul Jameson, Chair of the Medical Staff Committee. She said that the response from the Non-Executive Directors was the same as from Sir Duncan: "*visibly upset, horrified*".[50]

27.31 Dr Gilby said:

> "*I don't think they had really understood everything that was being said and hadn't been sighted on the various reports in*

*detail, hadn't had time to consider them. Had very much deferred to the medical expertise of the Medical Director, and I think they had a lot of pieces of the jigsaw that just weren't there and so my discussion with them kind of was starting to fill those gaps, and it was an awful dawning realisation.*"[51]

27.32 By this stage, the consultant paediatricians had made a request of Dr Jameson for a meeting of the Medical Staff Committee, at which they wanted to share their experience of Mr Chambers and hear the experience of other doctors in order to decide whether to consider a vote of no confidence in Mr Chambers. Dr Jameson said in evidence that he thought it was highly likely that the Medical Staff Committee (which includes all senior doctors) might ask for a vote of no confidence in Mr Chambers.[52] At a meeting with the Non-Executive Directors, he told them that the consultant paediatricians were intending to ask for a vote of no confidence in Mr Chambers.[53]

27.33 Mr Chambers was made aware of Dr Jameson's intentions and asked Dr Gilby what she could do to persuade the paediatricians against this. Dr Gilby's

evidence was that Mr Chambers said he could not have a vote of no confidence against him because he had not done anything wrong and did not want it on his record.[54]

27.34 Dr Gilby said the paediatricians were intent on having the vote of no confidence and that nothing could deter them.

27.35 Sir Duncan said that, between 2013 and 2017, Mr Chambers had exceeded expectations as Chief Executive. In 2017/18, that changed. Sir Duncan said: "[I]*n 17/18, it was judged by me that he had not met expectations … It was also agreed at that meeting that I had, which was a one-on-one performance review, that -- that he would -- he would be looking for a new -- a new job, the best years possibly behind him.*"[55] Sir Duncan explained that his assessment was due to operational issues, such as the underperformance of the Accident and Emergency Department. He said that the breakdown in relationships with the paediatricians did not form part of the appraisal. This is surprising. By way of example, I note that on 14 February 2018 Dr Gibbs, Dr Jayaram, Dr V, Dr McGuigan, Dr Brearey, Dr Saladi, Dr ZA and Dr Holt wrote to Mr Chambers to express their concerns about the inaccuracy of public

statements he had made in relation to the neonatal unit. Mr Chambers responded to say he had "*received and noted*" the letter but he did not directly acknowledge their concerns.[56]

## NHS Improvement's role in facilitating senior leaders to find another NHS **role**

27.36 Sir Duncan explained his position:

> "*I think that we had reached the point where Mr Chambers was looking for a placement outside the Countess of Chester, and Mr Chambers had talked to Ian Dalton* [Chief Executive of NHS Improvement]*, Ian Dalton was open to helping him and he delegated that responsibility to Lyn Simpson to … put things in motion.*"[57]

27.37 Ms Lyn Simpson had a background as a nurse, midwife and health visitor. In 1987, she began working in hospital management. In 1998, she became the Executive Director of a hospital Trust and stayed in the role for approximately six years. She subsequently held various director positions within the NHS, including for one year as Deputy Chief Executive of South London Healthcare NHS Trust. Between 2013 and 2016, she was the NHS Trust Development Authority Director of Delivery and Development

(North), and between 2016 and 2019, she was the Regional Managing Director (North) at NHS Improvement (which became part of NHS England).

27.38 One of Ms Lyn Simpson's roles was to assist senior leadership staff to leave a Trust and find a new position within the NHS. Ms Lyn Simpson explained that, over time, "*NHSI* [NHS Improvement] *had taken on that role as a facilitator … to secure the retention of highly skilled, highly trained managers in the service if that was appropriate. It was sometimes to enable a board to move on, where it had become dysfunctional.*"[58]

27.39 On 17 September 2018, Mr Dalton gave Ms Lyn Simpson the task of finding a position for Mr Chambers. She said in evidence that he told her that there was to be a vote of no confidence in Mr Chambers and that "*there were concerns about the relationships in the board which was becoming dysfunctional at the Countess of Chester and … to work with Sir Duncan Nichol to resolve that, which was to facilitate a move of Tony Chambers*".[59] Ms Lyn Simpson said she understood this to mean that the Board were not working well together and Mr Chambers was thought to be the problem.[60]

27.40 Sir Duncan was informed of Ms Lyn Simpson's evidence that she understood the issues at the centre of the facilitated exit were issues between Mr Chambers and the Board.† Sir Duncan responded: "*I don't accept that. The -- the issue was the breakdown of relationships between Mr Chambers and the paediatricians.*"[61] Sir Duncan could not remember exactly what he told Ms Lyn Simpson; however, he stated she was aware that the breakdown in relationships with the paediatricians was the reason he was looking for a placement. It is in light of that evidence that I am surprised Sir Duncan had not raised the issue with Mr Chambers, since the difficulties between him and the consultant paediatricians had been evident for some time. By the time Ms Lyn Simpson was involved, not only had relationships broken down, but matters had escalated to the consultant body as a whole and a vote of no confidence was in prospect within days. Mr Chambers was clear that he did not

† Sir Duncan was informed of Ms Lyn Simpson's description of these moves as 'rehabilitation'. This was not a description he was familiar with.

want this to adversely affect his prospects of obtaining future employment at Chief Executive level.

27.41 Ms Lyn Simpson did not know Mr Chambers before she began helping him in September 2018. However, she had the following impression of him from her colleagues: "*Mr Chambers had quite a strong personality and was known for being very demanding and at times could be perceived as somewhat arrogant.*"[62] She stated this did not cause her to be concerned about moving Mr Chambers to another leadership role because there were metrics which demonstrated that he was a good leader. She pointed out that, in 2016, CQC graded the Countess as 'good'. That was more than two years earlier, and in the intervening two years, it had become clear that there were serious problems within the hospital, as I have set out in this Report.

27.42 Facilitated moves can be beneficial where issues have arisen that are not the fault of the person for whom a move is being arranged. This is particularly the case where the loss of an individual's skills and experience would be detrimental to an organisation. But such moves cost public money and should never be used to avoid going through normal

employment procedures in circumstances where there are concerns about the individual's skills, conduct or behaviour. In this case, it is not clear that there was any focus on the reasons for proposing such a move. Ms Lyn Simpson did not consider it necessary to question whether a facilitated move was justified, even though she knew that the purpose of it was to avoid the proposed vote of no confidence. She was also aware of the police investigation.

27.43 Mr Chambers confirmed he told Ms Lyn Simpson that he wanted to maintain his status as a Chief Executive and that he did not want the facilitated move to be at the expense of his career. He remarked he had heard facilitated moves for senior leaders described as "*rehabilitation*" or a "*donkey sanctuary*". From his perspective, he considered that he and Sir Duncan were taking a pragmatic step to help the organisation move forward. Mr Chambers asserted: "*I had done nothing that was in breach of that contract, so therefore I had a contractual right as a minimum to serve six months' notice.*"[63] He explained he could not be made redundant because the Chief Executive role still existed and he could not stay at the Countess under the circumstances; thus he sought a move

to another organisation where he could reset and rebuild his career.[64] He denied leaving in the circumstances he did to avoid scrutiny of his leadership via the vote of no confidence. That was undoubtedly the effect of what he did, and I am satisfied that was at least part of his motivation for leaving.

27.44 I can see that there may be situations where a senior manager needs support and help to move on when problems have arisen for which they have little responsibility. That was not the case here. The breakdown in relationships and the impending vote of no confidence were the result of Mr Chambers' approach to the consultant paediatricians. Moving elsewhere was an appealing prospect to Mr Chambers and appealing to the Trust, which avoided a vote of no confidence and could then recruit a new Chief Executive. Ms Lyn Simpson discussed various posts in various NHS settings and pursued them on Mr Chambers' behalf. He accepted a role that she had identified in another NHS Trust. She was unaware that Mr Chambers was also pursuing alternative placements on his own account. In the event, he secured a position with the Northern Care Alliance NHS Foundation Trust. His salary was paid by the Countess at the rate for a Chief Executive for

six months (his notice period). In the three months before that, he was paid his salary by the Countess while he sought an alternative post – again, something to which he was contractually entitled.

27.45 This meant that, for nine months, the Countess, part of a Foundation Trust, funded Mr Chambers' salary package, which, including pension contributions and benefits in kind, amounted to £290,000 to £295,000, with no benefit to the Countess.

27.46 Sir Duncan confirmed the financial arrangement. He said that this "*was approved by the RemCo* [Remuneration Committee] *of the Countess* [which Sir Duncan chaired] *and also by the national body, which has to approve exceptional provider remuneration*".[65]

27.47 Whilst I can understand that the organisation that had the benefit of Mr Chambers' services may have been pleased to have an extra pair of hands at no cost for a period of six months, it is troubling that public money could be spent in this way without any analysis of the reason for the move from the Countess and no consideration of whether Mr Chambers was a fit and proper person for the role he was taking on.

## Announcement of Mr Chambers' departure

27.48 On 19 September 2018, the Countess published an announcement about Mr Chambers' departure from the Trust. Mr Chambers said in evidence that he and Sir Duncan had collaborated on this.[66] The third paragraph read: "*Tony's stepping down as CEO at the Countess is as a result of extraordinary circumstances and is not a judgement on his ability as a CEO but more a reflection of his integrity as a leader.*"[67] That was pure spin. He was stepping down to avoid a vote of no confidence. It had nothing to do with integrity and everything to do with the preservation of his career.

27.49 Mr Chambers' view was that this was an accurate statement. He asserted that events on the neonatal unit did not define his time at the Countess and expressed the view that, overall, he had a successful tenure. The announcement contained a sentence that "*investigations into neonatal deaths at the trust have escalated over the past 2 years and inevitably put relations between senior management and paediatricians under exceptional strain*".[68] There was nothing inevitable about the "*exceptional strain*", as Sir Duncan accepted. Mr Chambers was

invited to reflect on whether relations would have "*inevitably*" worsened or whether that was as a result of the way he had managed the concerns of the consultant paediatricians. Mr Chambers said: "*I stand by the decisions that we made.*"[69] That is quite a statement, failing, as it does, to acknowledge any responsibility for any part of the deterioration in relationships. It is striking that he characterised his tenure as successful overall. The lack of reflection and the failure to take any responsibility for the delays and the heartache caused to the families by his approach to the concerns about the deaths of their children is indefensible.

27.50 Mr Chambers stepped down from his role on 19 September 2018 and his employment at the Countess terminated on 30 June 2019 (he was on secondment to his new role for six months from 1 January 2019 to 30 June 2019).

27.51 Dr Gilby stated that it was "*something of a shock*" to find herself having to act as interim Chief Executive "*after only seven weeks in the role*" of Medical Director and Deputy Chief Executive.[70]

27.52 She explained that Sir Duncan had asked her to step up to the Chief Executive role: "*I did say to him that I felt that my time in the organisation hadn't been long enough to act into the role, and I didn't feel confident that in such a challenged organisation, I would be able to deliver what they needed.*"[71] However, she felt she had the full support of Sir Duncan and the Non-Executive Directors.[72]

27.53 Sir Duncan stood down as Chair of the Trust on 31 March 2020.

27.54 Ms Kelly remained in her role as Director of Nursing until she left the Trust in June 2021.

## Charges

27.55 Letby was charged with offences of murder and attempted murder in November 2020. She was later removed from the Nursing Register (see Chapter 18).

## Events since August 2023

27.56 The Inquiry was announced in Parliament by the then Secretary of State for Health and Social Care, the Rt Hon. Steve Barclay MP, on 4 September 2023. The Terms of Reference were set by the Secretary of State, after consultation with me and with the parents of the babies who died or were injured and

with other Core Participants. The Inquiry was formally established on 19 October 2023. The Terms of Reference are on the Inquiry's website and in Appendix 1.

## The Inquiry hearings

27.57 The Inquiry's process is set out in Appendix 6. The substantive hearings began on 1 September 2024. All Core Participants were invited to contribute to the selection of witnesses to be called and to indicate whether they wished to ask questions in addition to the questions asked by Counsel to the Inquiry, Ms Langdale KC, and her team. Wherever Counsel for Core Participants wished to ask questions themselves, they were permitted to do so. All witnesses who gave evidence, 134 in total, are listed in Appendix 4. All the oral evidence was transcribed and is on the Inquiry's website. I am grateful to all Counsel for observing all time limits and for sitting extended hours whenever necessary to complete the evidence within five months, with closing submissions a month later in March 2025.

27.58 As I indicated I would, when giving my ruling in March 2025, I have kept under review the question of whether I should pause the

publication of my Report. I have read the documents from those speaking at the press conference in February 2025, provided to me by Counsel for the executives and by a journalist. I was urged by Counsel for the executives not to consider them but to acknowledge there was a real possibility that the convictions may be referred to the Court of Appeal and there quashed. Counsel for the families agreed that I should not consider the documents and they set out the countervailing position in respect of the effect of the documents produced at the press conference. Mr Baker KC subjected them to a rigorous and detailed critique. Mr Skelton KC referred to them as "*full of analytical holes*".[73]

27.59 I have endeavoured to keep abreast of press reporting, documentaries and other programmes about the criminal case.

27.60 I have also kept myself informed of the numerous developments within the NHS since the Inquiry began in September 2024, as set out in my Report.

27.61 At the end of the last Parliamentary session in July 2026, the Rt Hon. Sir David Davis MP suggested that the Terms of Reference of this Inquiry should be widened in light of the findings of a number of reviews of maternity

care in hospitals in England, some of them recent. I have not thought it appropriate to ask the Secretary of State either to pause the Inquiry or to extend the Terms of Reference.

# Endnotes

1 **INQ0012734/4-5**

2 **Witness statement of Prof. Neena Modi INQ0102753/3/para 5.1**

3 **Witness statement of Prof. Neena Modi INQ0102753/2/para 4.1**

4 **Witness statement of Prof. Neena Modi INQ0102753/3/para 5.1**

5 **INQ0012734/2**

6 **INQ0012734/2**

7 **Witness statement of Professor Neena Modi INQ0102753/3/para 5.1**

8 **INQ0012734/1**

9 **INQ0012748/1**

10 **Witness statement of Professor Neena Modi INQ0102753/3/para 5.1**

11 Employment Tribunals Judgment Case Number: 2402398/2023; 2408654/2023 (**https://www.judiciary.uk/wp-content/uploads/2025/02/Dr-Susan-Gilby-v-Countess-of-Chester-Hospital-NHS-Foundation-Trust.pdf**)

12 **Dr Susan Gilby 24 February 2025 28/1-3**

13 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); Dr Susan Gilby 24 February 2025 29/7-19

14 Dr Susan Gilby 24 February 2025 26/10-22

15 Dr Susan Gilby 24 February 2025 64/7-10

16 Dr Susan Gilby 24 February 2025 71/16-18

17 INQ0102361/78-81

18 INQ0102361/78-81; INQ0006198

19 Dr Susan Gilby 24 February 2025 65/2-3

20 Dr Susan Gilby 24 February 2025 65/14-18

21 Dr Susan Gilby 24 February 2025 65/21

22 Dr Susan Gilby 24 February 2025 66/8-16

23 Dr Susan Gilby 24 February 2025 67/1-2

24 Dr Susan Gilby 24 February 2025 67/2-4

25 Dr Stephen Brearey 19 November 2024 217/13-14

26 Dr Susan Gilby 24 February 2025 17/19 to 18/5

27 Dr Susan Gilby 24 February 2025 72/21-24

28 Dr Susan Gilby 24 February 2025 73/6

29 Dr Susan Gilby 24 February 2025 72/25 to 73/3

30 Dr Susan Gilby 24 February 2025 92/22 to 93/6

31 Dr Susan Gilby 24 February 2025 67/9-13

32 Dr Susan Gilby 24 February 2025 93/14-16

33 Dr Susan Gilby 24 February 2025 77/6-10

34 Dr Susan Gilby 24 February 2025 77/19-22

35 **Dr Susan Gilby 24 February 2025 81/10-11**

36 **Dr Susan Gilby 24 February 2025 78/6 to 79/6**

37 **Dr Susan Gilby 24 February 2025 81/1-7**

38 **Dr Susan Gilby 24 February 2025 70/8**

39 **Dr Susan Gilby 24 February 2025 69/19-21**

40 **Dr Susan Gilby 24 February 2025 70/16-25**

41 **Ian Harvey 29 November 2024 50/18 to 51/4**

42 **Dr Susan Gilby 24 February 2025 74/16-23**

43 **INQ0099064/18**

44 **Ian Harvey 28 November 2024 75/10-14**

45 Voluntary erasure is the process by which a doctor applies to the GMC to be removed from the Medical Register, ending their registration and ability to practise medicine in the UK, subject to the GMC's approval.

46 **Dr Susan Gilby 24 February 2025 90/13-15**

47 **Dr Susan Gilby 24 February 2025 91/4**

48 **Dr Susan Gilby 24 February 2025 91/5-7**

49 **Dr Susan Gilby 24 February 2025 91/20-22**

50 **Dr Susan Gilby 24 February 2025 92/4-5**

51 **Dr Susan Gilby 24 February 2025 92/11-19**

52 **Dr Paul Jameson 8 October 2024 174/3-6**

53 **Dr Susan Gilby 24 February 2025 94/1-21**

54 **Dr Susan Gilby 24 February 2025 95/14 to 96/25**

55 Sir Duncan Nichol CBE 2 December 2024 110/22 to 111/2

56 INQ0002935

57 Sir Duncan Nichol CBE 2 December 2024 105/8-13

58 Lyn Simpson 21 November 2024 19/1 and 18/21-24

59 Lyn Simpson 21 November 2024 14/15-19

60 Lyn Simpson 21 November 2024 64/13-17

61 Sir Duncan Nichol CBE 2 December 2024 105/24 to 106/1

62 Witness statement of Lyn Simpson INQ0101414/7/para 22

63 Tony Chambers 27 November 2024 189/8-11 and 190/12-13

64 Tony Chambers 27 November 2024 189/15 to 190/3

65 Sir Duncan Nichol CBE 2 December 2024 108/19-21

66 Tony Chambers 27 November 2024 192/11-12

67 INQ0015683/31

68 INQ0015683/31

69 Tony Chambers 27 November 2024 194/8

70 Dr Susan Gilby 24 February 2025 16/2-6

71 Dr Susan Gilby 24 February 2025 16/7-11

# Chapter 28. The current position

## The Countess

28.1 In 2025, the Countess opened an impressive combined facility for women and children.[1] It includes the current neonatal unit, opened in 2021, which occupies a larger, modern space where family integrated care is facilitated. Parents are encouraged to attend ward rounds, and babies' cots are next to their mothers.

28.2 The Countess has a Safeguarding and Promoting the Welfare of Children Policy dated 1 September 2022, in which the Trust commits to ensuring that all staff have access to expert advice, support and safeguarding supervision and training in relation to safeguarding children. The policy specifically addresses the possibility that a member of staff may have harmed a child, committed a criminal offence or displayed behaviours which may indicate that they are not suited

to work with children. In such circumstances, the Associate Director of Safeguarding is directed to ensure that a referral is made to the LADO.[2] This is a welcome and important improvement.

## Intercollegiate document

28.3 In their submissions, the RCPCH refer to a framework for all healthcare staff published in November 2025: 'Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff'.[3] The document brings together and updates two previous documents (*Safeguarding Children and Young People: Roles and competencies for healthcare staff* (2019) and *Looked After Children: Roles and competencies of healthcare staff* (2020)).[4] It sets out a system of five different levels, with an additional level for senior managers and executives. Level 3, the level for healthcare professionals and staff who deliver a clinical service to children, makes a passing reference under the heading 'Underlying knowledge' to the LADO process.[5] The streamlining of guidance is welcome, but the resulting document is neither clear nor concise.

28.4 The competencies, resources and references do not include mention of learning from previous inquiries or reference to the possibility that healthcare professionals may be responsible for deliberate harm to a child.

28.5 Appendix 5 provides a 'comprehensive' list of safeguarding and children and young people in care legislation, and statutory and non-statutory guidance.[6] There are 13 links to separate documents for England alone.

28.6 I am sorry to say that, whilst the effort taken to produce this guidance is no doubt significant, the effort and time required to read it are too great when something needs to be dealt with immediately. What is needed is clear, focused guidance. The guidance produced for use in schools, as well as providing background and context, is clearer and more direct about what to do in a variety of situations, including when a member of staff has a safeguarding concern or an allegation about another staff member.[7]

28.7 I acknowledge that, whilst it is useful for everyone working in healthcare to have an understanding of the importance of safeguarding and the reasons for it, including an understanding of the context in which children live, such information should be provided by way of guidance. What is at least

as important is that there be a short, clear document setting out what to do when there are suspicions that a member of staff may be harming children.

28.8 In a world bristling with frameworks and competencies, short, clear documents are essential.

## Memorandum of Understanding

28.9 On 17 December 2024, guidance was issued on investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm. This Memorandum of Understanding between regulatory, investigatory and prosecutorial bodies sets out at paragraph 2.1 that it "*has been produced to help deliver early, co-ordinated and effective action following incidents where there is* ***reasonable suspicion*** *that a patient/service user's death or* ***serious life-changing harm*** *occurred as a result of an incident where there is suspected criminal activity in the course of healthcare delivery*".[8]

## Neonatal Mortality Governance framework

28.10 BAPM published its Neonatal Mortality Governance framework in February 2026.[9] Dr Eleri Adams, BAPM President and NHS England Getting It Right First Time (GIRFT) Clinical Lead for Neonatology, led the development of the guidance with a working group that includes Dr Ngozi Edi-Osagie, NHS England National Clinical Director for Neonatology, who has also provided a statement to the Inquiry.[10]

28.11 The framework provides detailed operational guidance on mortality governance in neonatal services and is intended to complement existing national and statutory guidance across the UK. It is aimed primarily at perinatal healthcare professionals but may also be relevant to coroners and medical examiners. It sets out expectations for: governance and leadership of neonatal mortality processes; investigation and review of deaths; engagement with coronial and statutory processes; and support for families and staff, including bereavement care. It does not include a mechanism for ensuring the guidance is complied with nor the consequences of failure to do so. I address these issues later in this chapter.

## Post-mortem examinations

28.12 The Neonatal Mortality Governance framework makes clear that all parents should be offered a post-mortem examination following a neonatal death, recognising its importance for establishing cause of death, supporting learning, and providing understanding and closure for families. In coronial cases, a post-mortem examination may be mandated.

28.13 There are only 43 paediatric pathologists in England.[11] Without a successful programme to train more, this cannot be achieved (see paragraphs 28.24 to 28.31). I acknowledge the commitment that has already been made. I recommend a clear timetable (see paragraph 28.31).

28.14 The framework links post-mortems to:

- Child Death Review meetings
- escalation to coronial authorities where appropriate
- thematic review and system-wide learning, including identification of clusters, trends or unexpected findings.[12]

## Sudden unexpected neonatal deaths (SUDIC, SUDI, PRUDiC, SUPC)

28.15 This section of the framework points out that, whilst such deaths are uncommon in neonatal units and post-natal wards, they require prompt and structured responses.

28.16 BAPM states that deaths meeting the criteria for sudden unexpected death (including SUDIC, SUDI, Procedural Response to Unexpected Death in Childhood (PRUDiC) and Sudden and Unexpected Postnatal Collapse (SUPC)) should follow national statutory guidance, including a JAR/PRUDiC process or equivalent, with arrangements tailored to the circumstances and place of collapse or death.[13]

28.17 The framework gives neonatal-specific examples of circumstances in which a JAR/PRUDiC process should be considered, including:

- a baby born at home without medical professionals present who subsequently dies or is thought to be stillborn
- a sudden death with no immediately apparent medical cause

- circumstances raising suspicion that the death may not have been natural.

28.18 BAPM states that a JAR/PRUDiC should also be triggered where a baby is successfully resuscitated following such events but is expected to die in the following days. In those circumstances, the response should be considered at the point of presentation, rather than at the point of death, to allow accurate history-taking and, where necessary, a 'scene of collapse' visit. Where there is uncertainty, the framework advises discussion with the designated doctor for child death as part of immediate decision-making.

28.19 The framework also refers to BAPM guidance on SUPC, noting that it may be used in specific circumstances but should not be relied upon in isolation.

## Child Death Review meetings and investigation

28.20 The framework sets out expectations for Child Death Review meetings and associated investigations, including:

- review of individual neonatal deaths and identification of unexpected findings
- investigation of clusters of deaths or increased mortality rates

- notification to the coroner where investigations identify previously unknown factors that may have contributed to a death
- alignment between local reviews, statutory notifications and national safety processes.

28.21 The framework includes a timeline covering actions before death and up to at least three months afterwards, encompassing family-focused actions, staff actions, investigations, and statutory or national notifications.[14]

## Governance, leadership and resourcing

28.22 BAPM sets out expectations for leadership and resourcing of neonatal mortality governance, including:

- designated consultant and senior nursing leads for mortality governance with dedicated time for Child Death Reviews, thematic reviews and dissemination of learning[15]
- recommended job planned time for medical, nursing and administrative roles, scaled according to unit type (NICU, LNU or SCU)[16]
- training requirements for staff involved in end-of-life care, including completion

of Sands neonatal bereavement care pathway training as a minimum standard.[17]

28.23 All of this may be very sound. It should be assessed by Trusts and NHS England. It should inform decisions about leadership and resourcing. Compliance should be part of any CQC inspection.

## Paediatric and perinatal pathologists

28.24 A long-standing staffing shortage has become a crisis in the provision of paediatric and perinatal pathology services.

28.25 Perinatal pathologists study disorders of the placenta, problems affecting unborn babies' development, and causes of miscarriage, stillbirth and neonatal (newborn) death. Paediatric pathologists investigate illnesses affecting children up to 18 years of age. Paediatric pathologists are experts in unique childhood diseases. Their work includes post-mortems.[18]

28.26 The latest *Paediatric and Perinatal Pathology Workforce Report*, published by the Royal College of Pathologists in November 2025, declares a "*workforce crisis*".[19] The key findings are:

- The UK has 52 paediatric and perinatal pathology consultants working as 46.35 whole-time equivalents (WTE): 43 in England, 7 in Scotland and 2 in Wales.[20]
- There are no paediatric and perinatal pathology consultants working in Northern Ireland. In England, in the South West and the Midlands, shortages have led to total service collapses.[21]
- Currently, 37% of paediatric and perinatal pathology consultant posts in the UK are vacant.
- Recruitment is almost impossible due to a national shortage of qualified candidates; 83% of paediatric and perinatal pathology consultants report issues with recruitment in their departments.
- Only 3% of paediatric and perinatal pathology consultants believe that current staffing levels are adequate to ensure the long-term sustainability of their service.
- Within the next five years, 25% of the consultant paediatric and perinatal pathology workforce are expected to retire.
- There are only 13 resident doctors in paediatric and perinatal pathology specialist training posts. This is insufficient to address any of the following: long-

standing vacancies, expected retirements and future needs.

- Bereaved families are facing a major increase in waiting times – and/or transfer out of their region – for post-mortem examination of their babies and children: 1 in 5 are now waiting 6 months or more, and some longer than 12 months.

28.27 As well as a shortage of consultants, demand for services has increased over the last six years.[22]

28.28 In its report, the Royal College of Pathologists calls for:

- phased expansion of training posts up to 37 by 2030
- increased protected time and funding for professional development so consultants have time to train the next generation
- increased workforce support with dedicated biomedical scientists, anatomical pathology technicians (assistants to pathologists) and administrative support in each paediatric pathology unit
- committed funding and resources to continue the development of ten fellowships

- an advanced training programme in paediatric and perinatal pathology
- upskilling of scientists and histopathologists to engage in placenta reporting and commitment to resource and prioritisation of the specialty.

28.29 The government response in April 2026 points to the launch of a national programme to strengthen perinatal and paediatric pathology services and to improve service capacity and resilience. A £20,000 recruitment incentive for new trainees has been introduced, a fully funded international recruitment campaign has been launched, and a new National Training Programme Director has been appointed.[23]

28.30 On 8 April 2026, in answer to a written question in Parliament about the steps taken in light of the report, Gillian Merron, Baroness Merron, said this:

> "*The paediatric and perinatal pathology workforce report highlights the extent of the workforce crisis in paediatric and perinatal pathology and the impact this can have on turnaround times and families.*

> *NHS England has launched a national programme to strengthen perinatal and paediatric pathology services and to improve service capacity and resilience.*
>
> *A £20,000 recruitment incentive for new trainees has been introduced, a fully funded international recruitment campaign has launched, and a new National Training Programme Director has been appointed.*
>
> *Further initiatives are underway to review the training pathway, develop advanced practitioner roles, and implement a retention strategy for existing staff.*"[24]

This looks very promising, assuming the £20,000 incentive will attach to all new trainees with the aim of reaching 37 training posts by 2030. There is no commitment to the latter number. I also note that the Royal College of Pathologists' workforce report stated: "*A previously introduced £20,000 recruitment incentive for new residents has now stopped.*" The incentive must not be removed until workforce requirements are met.

28.31 I recommend that a clear timetable is set and followed so that, by June 2030, there are 37 doctors in training posts as paediatric and perinatal pathologists. Funding must be

made available to pay the £20,000 incentive to each new trainee with clear provision for the repayment of the £20,000 in the event the trainee does not complete training or takes up employment outside the NHS within five years of completing training.

# Endnotes

1 **Written Closing Submissions on Behalf of the Countess of Chester Hospital NHS Foundation Trust 17 March 2025 83/para 313(d)**

2 **Written Closing Submissions on Behalf of the Countess of Chester Hospital NHS Foundation Trust 4 March 2025 89/paras 334 and 338**

3 RCPCH, 'Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff', November 2025 (**https://child-health-safeguarding.rcpch.ac.uk**)

4 RCN, *Safeguarding Children and Young People: Roles and competencies for healthcare staff*, January 2019 (archived) (**https://child-health-safeguarding.rcpch.ac.uk/wp-content/uploads/sites/25/2025/09/ARCHIVED-Safeguarding-Children-and-Young-People-Roles-and-Competencies-for-Healthcare-Staff.pdf**); RCN and RCPCH, *Looked After Children: Roles and competencies of healthcare staff*, December 2020 (archived) (**https://child-health-safeguarding.rcpch.ac.uk/wp-content/uploads/sites/25/2025/09/ARCHIVED-Looked-After-Children-Roles-and-Competencies-of-Healthcare-Staff.pdf**)

5 RCPCH, 'Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff', November 2025 (**https://child-health-safeguarding.rcpch.ac.uk**)

6 RCPCH, 'Intercollegiate document (2025) Safeguarding children and young people & children and young people in care: Competencies for health care staff', November 2025, Appendix 5 (**https://child-health-safeguarding.rcpch.ac.uk/appendices/appendix-5**)

7 Department for Education, *Keeping Children Safe in Education 2025: Statutory guidance for schools and colleges. Part One: Information for all school and college staff*, September 2025, page 18 (**https://assets.publishing.service.gov.uk/media/68b02d1efef950b0909c1734/Keeping_children_safe_in_education_2025_part_one_Information_for_school_college_staff.pdf#page=18**)

8 DHSC, *Investigating Healthcare Incidents Where Suspected Criminal Activity May Have Contributed to Death or Serious Life-Changing Harm: A Memorandum of Understanding between regulatory, investigatory and prosecutorial bodies*, 17 December 2024, page 3, paragraph 2.1 (**https://assets.publishing.service.gov.uk/media/67604bbd239b9237f0915471/**

**investigating-suspected-criminal-activity-in-healthcare-mou.pdf#page=5**)

9 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf**)

10 **INQ0108888**

11 Royal College of Pathologists, *Paediatric and Perinatal Pathology Workforce Report*, November 2025, page 10 (**https://www.rcpath.org/static/798eba01-0ddc-47ce-90b3932f7a3d9312/fce53e2f-178f-474c-9f0c92c3d403590c/Report-RCPath-paediatric-and-perinatal-pathology-2025.pdf#page=10**)

12 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026, page 15 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf#page=15**)

13 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026, page 15 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf#page=15**)

14 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026, page 8 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf#page=8**)

15 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026, page 24 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf#page=24**)

16 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026, page 25 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf#page=25**)

17 BAPM, *Neonatal Mortality Governance: A BAPM framework for practice*, February 2026, page 24 (**https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/4060/BAPM_Neonatal_Mortality_Governance_FEB_26.pdf#page=24**)

18 Royal College of Pathologists, 'Become a paediatric and perinatal pathologist' (**https://www.rcpath.org/discover-pathology/careers-**

**in-pathology/careers-in-medicine/become-a-paediatric-and-perinatal-pathologist.html**)

19 Royal College of Pathologists, *Paediatric and Perinatal Pathology Workforce Report*, November 2025 (**https://www.rcpath.org/static/798eba01-0ddc-47ce-90b3932f7a3d9312/fce53e2f-178f-474c-9f0c92c3d403590c/Report-RCPath-paediatric-and-perinatal-pathology-2025.pdf**)

20 Royal College of Pathologists, *Paediatric and Perinatal Pathology Workforce Report*, November 2025, page 7 (**https://www.rcpath.org/static/798eba01-0ddc-47ce-90b3932f7a3d9312/fce53e2f-178f-474c-9f0c92c3d403590c/Report-RCPath-paediatric-and-perinatal-pathology-2025.pdf#page=7**)

21 Royal College of Pathologists, *Paediatric and Perinatal Pathology Workforce Report*, November 2025, page 7 (**https://www.rcpath.org/static/798eba01-0ddc-47ce-90b3932f7a3d9312/fce53e2f-178f-474c-9f0c92c3d403590c/Report-RCPath-paediatric-and-perinatal-pathology-2025.pdf#page=7**)

22 Royal College of Pathologists, *Paediatric and Perinatal Pathology Workforce Report*, November 2025, page 11 (**https://www.rcpath.org/static/798eba01-0ddc-47ce-90b3932f7a3d9312/fce53e2f-178f-474c-9f0c92c3d403590c/**

Report-RCPath-paediatric-and-perinatal-pathology-2025.pdf#page=11)

23 Baroness Merron, Written answer, Pathology: Vacancies, UIN HL15826, 8 April 2026 (https://questions-statements.parliament.uk/written-questions/detail/2026-03-20/hl15826)

24 Baroness Merron, Written answer, Pathology: Vacancies, UIN HL15826, 8 April 2026 (https://questions-statements.parliament.uk/written-questions/detail/2026-03-20/hl15826)

# Chapter 29. Bereavement care

## Accommodation

29.1 Mother D and Mother E and F both acknowledged that after their babies had died they were given the use of a family room; it is likely that this room was intended to give grieving parents some privacy in the aftermath of the death of their child. Mother D commented on the location of the room; it was situated within the labour ward,[1] and from here the deliveries and cries of newborn babies could be heard. This was, although wholly unintended, further cause of desperate heartache, emphasising in the most intense way possible the loss of their babies. Mother E and F expressed regret that she was not given the opportunity to take her baby, Baby E, to the family room and spend some time with him.[2] I acknowledge that arrangements are now different, but the accounts of these mothers should serve as a reminder to all those in the NHS who

deal with the allocation of space to particular uses always to be informed of, and take into account, the circumstances of the people likely to be using the room – and adjacent rooms and corridors. These are matters upon which the expert advice of bereavement support groups should also be sought.

## Support

29.2 A number of parents spoke about their experiences immediately after the death of their babies. I have set out in detail the experience of Mother and Father C in the time leading up to and after the death of their son. I do not repeat it. That Ms Taylor was acting empathetically and with kindness is not in doubt. In contrast, Letby's interventions following the death of Baby C were unnecessary and unprofessional, intervening when she should have been caring for her allocated baby. Her behaviour was the subject of criticism from the nursing shift leader at the time.[3]

29.3 Mother E and F spoke of Letby's actions at the time of Baby E's death, bathing him and preparing a memory box which is now tainted by the knowledge that Letby killed Baby E and tried to kill Baby F. She was unkind in the way

she responded to Mother E and F's shock at seeing her child still in his incubator next to his brother: "*You haven't told us to take him*."[4]

29.4 As I observed elsewhere (see paragraph 10.59, Chapter 10), having endured the excited behaviour of Letby as she prepared a memory box, Parents O, P and R were left with no support and their son Baby R was moved to another hospital, with all the additional anxiety that entailed. I repeat: this was unacceptable. 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*."[5]

29.5 Several parents spoke about being given leaflets about bereavement, but no other recognition of their situation, and no support. This was not good enough. Ms Jane Tomkinson OBE, the current Chief Executive of the Countess, acknowledged that bereavement care in 2015 and 2016 was inadequate.[6] It may well be that some of the nurses had not previously experienced the

death of a baby and did not know what to say. Some people, nurses amongst them, have a high level of empathy, and some have had personal experience of bereavement. They often know what to do. Help is needed for those who do not know what to do, particularly when facing the death of a patient for the first time.

29.6 Mother E and F's experiences of bereavement care at the Countess led her to re-train as a bereavement counsellor. One can only admire and pay tribute to her capacity for generosity and her determination to make sure that the experience of bereavement for others is quite different from hers.

29.7 Sir Stephen Powis said in his statement to the Inquiry:

> "[I]*n 2022/23 NHS England provided £2.26m of national funding to support trusts to expand the number of staff being trained in bereavement care and increase access to specialist bereavement services.*
>
> *In 2023/24, NHS England are investing £5.9m in bereavement care to enable all trusts to implement a seven-day provision … and increase the number of staff trained in bereavement care.*"[7]

These are relatively modest sums of money and very good intentions. What is essential is that bereaved parents have access to support that goes beyond the mere handing out of a leaflet, and that nurses and medical professionals have access to training where this is relevant to their roles.

29.8 It was encouraging to hear the evidence of Ms Fiona Murphy MBE, former Corporate Director of Nursing for End-of-Life Care and Bereavement at the Northern Care Alliance. One of the first points she raised was the need for nurses (for it is usually nurses) who may deal with bereavement to have training in advanced communication. It is training in how to communicate with people whose loved one has died. Here, a baby. The responsibility on medical and nursing staff is first not to make a terrible situation worse, and second for the parents to know that they care. The SWAN (Sign/Words/Actions/Needs) model of care used by the Northern Care Alliance starts from the premise that there is no harm in simply asking a family what matters to them at a particular moment, rather than following any lengthy written protocol. The model sets out four key principles: the provision of private space, sensitive communication with the family, stepping 'outside the box' to

facilitate what is important to the family, and considering whether the needs of the family are being met, documented and reviewed regularly. Ms Murphy spoke about the SWAN model providing prompts to help nursing staff with "*difficult*" conversations where they are "*fearful … to distress the family further*".[8] In fact, having conversations about what matters to the family (such as spending time with their baby after death) can help give the family some control. Ms Murphy said that about another 50 organisations in the UK now use the SWAN model.[9]

29.9 I heard evidence from a number of witnesses in person and also received witness statements, including from Sands, a UK charity that leads the National Bereavement Care Pathway. This includes specific guidance related to neonatal deaths. A summary of that evidence was read into the transcript.[10] I am encouraged that all Trusts have signed up to the National Bereavement Care Pathway. I recommend the National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.

29.10 The evidence from the Countess about the current position is that there are now two full-time bereavement midwives whose job is to support the bereaved for as long as and to the extent that they wish, and wherever they wish – home, hospital or elsewhere, as the bereaved person prefers. It is a service that can be accessed at any point following the death of a baby and referrals can be made to other support services, such as talking (psychological) therapies.[11]

## Medical records

29.11 It is relatively recently that there has been acknowledgement of the importance of marking the medical records of parents with a note of the fact of (as here) the death of their baby. The death of a new baby is relevant both to the parents' mental health and the care of a further pregnancy, to name two obvious points. No one should have to repeat their experience each time they go to the GP. It should be flagged in the notes with an alert on the outside of the file, digital or otherwise, so that the GP (or other professional) sees it before they see the patient. This will make a difference to bereaved parents.

29.12 It would appear that both nationally and at the Countess steps have been taken to improve bereavement care. However, perhaps most important is this final reflection, one that was well made in the statement submitted to the Inquiry by the UK charity Sands: "*Listening to the voices and experiences of bereaved parents will help to drive a change in culture and must be at the heart of all policies developed to save babies lives and improve future care*."[12]

# Endnotes

1 **Mother D 17 September 2024 24/5-7**

2 **Mother E and F 18 September 2024 54/9-11**

3 **Nurse W 14 October 2024 93/4 to 94/9**

4 **Mother E and F 18 September 2024 54/1**

5 **Mother O, P and R 25 September 2024 27/6-10**

6 **Jane Tomkinson OBE 13 January 2025 24/10-12**

7 **Witness statement of Prof. Sir Stephen Powis INQ0017495/242/para 905 to 906**

8 **Fiona Murphy MBE 14 January 2025 147/12-13**

9 **Fiona Murphy MBE 14 January 2025 148/7-10**

10 **Clare Brown 14 January 2025 185/18 to 193/21**

11 **Written Closing Submissions on Behalf of the Countess of Chester Hospital 4 March 2025 81/paras 305-307**

12 **Witness statement of Clea Harmer INQ0017151/17/para 55**

# Chapter 30. Parents' further recollections

Mother A and B: "*After losing* [Baby A]*, not only were we absolutely traumatised at what had happened, we were riddled with fear for* [Baby B]*.*"

"*What should have been the happiest time of our lives had become our worst nightmare.*"

Mother C: "*We have suffered immeasurably from the moment our son collapsed. The trauma that we faced from then until now is thoroughly incomprehensible to anyone who has not endured it.*"

"*Following on from the criminal trial, we have had to try to rebuild life and regain some normality for ourselves and our family, which has been very difficult. As a family, we have endured years of anxiety and stress … the knowledge we gained about the events leading up to our son's murder and the methods that were used by Lucy Letby has been indescribably traumatising*."

Mother D: "*I feel not only I lost* [my daughter]*, but lost all those years of my life too. Since* [she] *passed away I live beside my own shadow.*"

"[T]*he heavy load constantly on my mind has deeply changed me. My heart broke into a million pieces the second* [our daughter] *lost her battle against evil and that is when hell broke loose for us … I felt so guilty and questioned if any of this was my fault. Did I miss something? Did I do something wrong? Did I fail my daughter?*"

Mother E and F: "*The impact that* [the murder and the attempted murder of our sons] *has had on us has been enormous. It changed the course of our life completely and we've had to try and grieve in so many different ways. We tried to grieve at the time, and then we had to endure what was going to be happening when that* [the RCPCH] *report arrived on our doorstep, and then that brought everything back up. We had to grieve for the life that we thought we were going to have with* [our son]*, with his learning difficulties.*"

"*I feel guilty for not requesting* [a post-mortem]*, because if that had been requested and that had come back and something -- well, something would have been on it, you know, there's a lot of babies that could have not been involved in this case and it could have stopped there. And that weighs very, very*

*heavily on me, because that decision was ultimately ours, and that's painful to think about. So I carry our grief, but the sadness of the other families, because it should never have gone past that point.*"

Mother G: "*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.*"

Father G: "*We now know that the attacks by Lucy Letby caused a lack of oxygen to our daughter's brain resulting in a massive brain injury. Prior to the attacks, our daughter's repeated brain scans looked OK and her brain was seen to be maturing well. After the attacks, her brain scans changed and clearly showed a brain injury which had wiped out most of her brain … She can't be left unattended due to the risk of her choking. My wife and I provide the majority of her care and do so lovingly. She is our little girl, our fighter and our star. I have been besotted with her ever since the day she was born.*"

Mother H: "[The impact of the events at the Countess] *changed me fundamentally as a person. Among other things, it has really affected my ability to trust people, especially when it comes to anyone taking care of my*

*children. You know, they -- the people in the neonatal ward, you put your whole trust into them to take care of your baby and that has been completely abused.*"

Mother I: "*The first year after our baby's death was a blur and I don't know how we as a family got through it. I wore sunglasses constantly to hide the pain and tears from my other kids as I didn't want to upset them as they were also struggling.*"

"[My husband] *wished that he was dead instead of our baby. We even separated for a while as neither of us could deal with what happened. Our other kids also suffered. They gave up things they enjoyed and my older daughter stop*[ped] *speaking. Eventually we got back together.*"

Mother J: "*I cannot emphasise enough the impact of this on our whole family. Who we are as people, parents, work life, spouses, children.*"

Father J: "*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 and then you have an unexplained collapse, that stress is almost incomprehensible.*"

Mother K: "*For myself and my husband, the ripples are unbelievable … it's scarred your life, it's changed you. You look back and you don't only just grieve your daughter, you're grieving who you were. I grieve who*

*we were as a husband and a wife. It just completely destroys what's around you and you have to pick yourself up and find out who you are again in this new world and it just doesn't stop, it doesn't go away and we live with it every single day.*"

"*I only hope that I do* [our daughter] *proud within this statement and raising her siblings with her name continuing to be a great part of our family unit and remembering that she was the one that made me a mum for the first time.*"

Father K: "*They brought our baby in and handed her to me as she took a breath. That was it. Child K only took one breath on her own in my arms … I wish I could have held Child K for a little bit longer. I can't talk about what happened to Child K, it scares me to remember and I don't want to think about it.*"

Father L and M: "*I was first on the scene when one of my* [sons] *had his collapse, and that image has been forever etched in my mind and this case has been going on for … years.*

…

*The stress and strain has been unbearable at times and my mental health has suffered as a consequence of this case. I had to take time out of work and seek counselling. I have also had to take a course of anti-depressants to help me cope with this … 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.*"

Mother N: "*The 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. We have often heard of people dying from a broken heart, this is how we can describe how we felt that day the pain was immeasurable and we didn't want to leave that hospital without our son, we both relive this every day because not a day goes by without thinking about that day.*"

Father N: "*This has caused us massive trust issues which have remained with us to this day and we don't think will ever leave us.*"

Father O, P and R: "*I have visions and nightmares approximately every other night, of being back at the hospital. They tend to be about the boys and are a mix of specific things I remember happening at the time; the colour of their veins and their veins pulsating is something which comes up a lot. I also have angry*

*dreams where I tell myself I should have done more. I have also had angry dreams about Lucy Letby. I cry a lot more than I used to before all of this happened.*"

Mother Q: "*This has left me with massive anxiety with a lot of health professionals … over the years the slightest thing with Child Q has caused me to panic … I am in* [a] *constant state of worry and panic, I'm hyper vigilant with him and it is so draining for me.*"

I repeat my thanks to all the parents. As is plain from the pages of this Report, their insightful and thoughtful contributions to the Inquiry have been invaluable.

E03297534
978-1-5286-5451-7