Thirlwall Inquiry

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

Volume III

September 2026

HC 597-III

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
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Correction:

Appendix 8. Core Participants and legal representation, page 496

Text currently reads:

Families of babies named on the indictment – Family Group 2 & 3	
Counsel	Richard Baker KC Alex Jamieson Sara Sutherland Rochelle Rong

Text should read:

Families of babies named on the indictment – Family Group 2 & 3	
Counsel	Richard Baker KC Alex Jamieson Sara Sutherland Rochelle Rong Simon Driver

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Part Two

Chapter 31. Implementation of recommendations of inquiries

31.1 The first detailed work carried out by this Inquiry was a review of all recommendations made in all inquiries into the NHS in the last 30 years. It was published in May 2024, and updated in April 2025 to incorporate further comments from DHSC and NHS England in respect of 19 of the 33 inquiries listed, and three further inquiries.[1] The review is structured so as to lead the reader to the source material on every topic and I do not repeat either the source material (reports, recommendations and responses from government) or the commentary, all of which are self-explanatory. The review, although focused and concise, runs to 818 pages. Recommendations have been divided into four types, reflecting the four predominant themes of this Inquiry: patient safety, improving culture and governance, improving the ability to raise complaints and concerns, and regulation and oversight of managers.

31.2 The review shows that, whilst some significant changes have been introduced in response to Inquiry recommendations over the last 30 years, most have not been implemented. In very short summary: many of the recommendations made by Dame Janet Smith DBE in the Shipman Inquiry have been implemented. This required years of determined effort by many people in DHSC backed by political will. The last remaining change to be implemented, the introduction of medical examiners, occurred 20 years after the government proposed the medical examiner system in response to Dame Janet's recommendation that there should be a medical coroner system (which was not accepted). Her wide-ranging recommendations about changing the way coroners were arranged and operated were implemented much earlier, beginning with the passing of the Coroners' and Justice Act in 2009. I deal with the history of the introduction of medical examiners at Chapter 32.

31.3 In respect of most other reports, some of the recommendations have been implemented. Some have been implemented in part. Most have not been implemented, either because government did not accept them, as they are entitled to do, or for other reasons. The

reasons for not implementing are set out in the review in so far as the Inquiry was able to establish them. I should add that, as explained in the review, which has been scrutinised and responded to by DHSC and NHS England, it is not always clear whether something has been implemented. Where that is the case, it is reasonable to infer that, whatever has been done, if anything, has not been effective in addressing the issue to which the recommendation was directed.

31.4 In September 2024, the House of Lords Statutory Inquiries Committee (to whom the Inquiry provided the findings of our initial review) published its review of public inquiries that had taken place since the Inquiries Act 2005 came into force: *Public Inquiries: Enhancing public trust*. It was not restricted to inquiries into the NHS. The committee recognised the partial successes achieved by public inquiries but pointed out that recommendations, whilst accepted by government, were often not subsequently implemented. The committee described this as "*inexcusable*". The committee wrote that this "*risks the recurrence of a disaster and undermines the whole purpose of holding an inquiry in the first place*".[2] I agree. By way of example, the committee said that they had

been told that, had the recommendations from the public inquiry into deaths at the Bristol Royal Infirmary in 2001 been implemented, patient deaths investigated by the Mid Staffordshire inquiry in 2013 "*may have been less likely to occur*". The committee concluded that the 2005 Act and the wider governance structure of public inquiries "*must be improved*".[3]

31.5 I accept that the government has a choice about whether to accept recommendations but where the same failings are being identified in different places, repeatedly, effective action must be taken – by implementing recommendations or otherwise. It is inexcusable to ignore such failings. Even where recommendations are accepted, there is no mechanism to track progress or enforce implementation.

31.6 On the day before closing submissions were made by all Core Participants in this Inquiry, the government announced the abolition of NHS England. During closing submissions on 17 March 2025, I asked DHSC and NHS England for details of who would be responsible for implementing recommendations from this Inquiry. I was told that responsibility would lie with DHSC. I

pressed for further details. On 20 May 2026, I received a response in which DHSC and NHS England confirmed that the Inquiry's recommendations will be considered by DHSC "*in the usual established way*", and it is usual to constitute a programme board to coordinate the government's response. In addition, the National Maternity and Neonatal Taskforce will "*address recent developments … including recommendations*" from this Inquiry. DHSC and NHS England were unable to provide detail on how this will work in practice. This is very disappointing. Given the track record of DHSC and its predecessors to date, knowing that things will be done in the usual way is not reassuring. There are no specifics about how things will work in practice. The reference to the National Maternity and Neonatal Taskforce is important, not least because there is no neonatal expertise in the taskforce membership. This was raised by the Inquiry on 8 May 2026. In answer to a question from the Inquiry, DHSC indicated that BAPM would provide a suitable representative on the taskforce. DHSC and NHS England again were not able to set out how neonatal-specific issues will be addressed in practice. I note that Baroness Amos has also produced her

report and recommendations for maternity and neonatal services, and a Maternity and Neonatal Commissioner will be appointed.[4]

Reasons recommendations are not implemented

31.7 I heard evidence on a number of topics from Dr Rosie Benneyworth, Interim Chief Executive at the Health Services Safety Investigation Body (HSSIB). At the request of DHSC, she conducted a review of safety and risk in the NHS. Her report reviews recommendations made by national organisations but I accept her view that it is equally applicable to recommendations made by inquiries and local investigations.[5]

31.8 The nature of the findings is evident from the title of the report: 'Recommendations but No Action: Improving the effectiveness of quality and safety recommendations in healthcare'.[6] The report concluded that "*the sheer number* [of recommendations] *being made and the variance in their quality means that they can be a burden to an already pressured healthcare system which is expected to digest, prioritise, pay for and implement actions in relation to them*".[7] This echoed the evidence of Professor Dixon-

Woods[8] and Dr Penny Dash (lead for two independent reviews).[9] Dr Benneyworth's report observed that "*failure to implement actions following recommendations can impact public confidence in the healthcare system and compound harm to patients*".[10] The reasons for the failure, in addition to the sheer numbers, were given as follows:

a. The noise created by the significant volume of recommendations being made to the healthcare system means that providers struggle to prioritise and implement recommendations. This echoes Professor Dixon-Woods' reference to "*priority thickets*".[11]

b. Some recommendations duplicate or contradict others. The development of a searchable repository, which includes recommendations made across the healthcare system, may help to reduce this.

c. There is currently a lack of visibility of ongoing work across arm's-length bodies that would enable collaborative working on related workstreams.

d. Few recommendations require a formal response from the recipient organisation

and there is a lack of monitoring of the actions planned or taken to address the recommendations.

31.9 Dr Benneyworth added that some recommendations are not evidence based and do not provide a clear path to implementation. Some recommendations are too prescriptive and do not account for the fact that, when individual providers are implementing the recommendations, they also need to take into consideration their local needs.[12]

31.10 She concluded: "*I think it's about visibility, I think it's about being clear about how these are going to be tracked and monitored and it's about mechanisms for escalation when things aren't happening.*"[13]

31.11 Sir Robert Francis made the point in his evidence that the volume of structural change within the NHS over years makes it extremely difficult to follow through the implementation of Inquiry recommendations.[14] Mr Vineall, a highly experienced and long-serving director at DHSC, had considered the Inquiry's review before providing his evidence, written and oral, to this Inquiry. His assessment was more positive than mine.[15] I acknowledge that, in recent years, there have been significant changes within the NHS as a

result of inquiries: medical examiners and the introduction of the fit and proper person test for board members and senior executives. But, whatever the perspective, there is a lot that has not been done, as has been recognised in a number of reports.

31.12 Sometimes recommendations are implemented, but the change is not maintained and so progress is not made. It is instructive to look in this context at the report of the public inquiry into events at Bristol Royal Infirmary cardiology department between 1984 and 1995. Sir Ian Kennedy, the Chair, presented his excellent report to Parliament in 2001.[16] The response of the government in 2002 was detailed and positive.[17] It acknowledged that the NHS needed fundamental reform. A new plan for the NHS, of which Sir Ian approved, was already in place.[18] Of particular relevance to the Bristol inquiry was that the then government acknowledged that children's services had not been accorded appropriate priority. It instituted changes within the NHS and across government departments to improve the health of children. This plan was put into operation and met with some success, not least in lifting children out of poverty.

31.13 It is, however, inescapable that now, over 20 years later, paediatrics is once again considered to be at the back of the queue in terms of resources in hospitals. Dr Kingdon referred in her evidence to a "*significant problem*" of "*lack of resource*", noting that the lack of workforce in paediatrics was a particular issue.[19] The National Clinical Director role for neonatology was introduced only in 2024. Although welcome, it is part time and underfunded.

31.14 More urgently, from the standpoint of those working in neonatology, the current government's 10 Year Health Plan for England, whilst encouraging in many respects, has not, yet, identified where additional nurses and doctors are to come from for children's wards (including neonatal units). I recognise that poor maternity care is in many places a huge and very long-standing problem, which must be dealt with – but fixing that must not lead to babies and children being overlooked. Sir Stephen Powis was asked about the provision for further staff for neonatal units. His response was that it was recognised that staffing of neonatal units has been an issue and that this was a focus of neonatal delivery plans, and progress had been made in increasing staffing in neonatal

units. However, he accepted that, in terms of the 2023 NHS Workforce Plan, there was no specific commitment in terms of any sub-specialty of medicine, save for a commitment to increase GPs. Whilst he said this was the next step of the plan, he was unable to give any commitment as to timings.[20] This must be addressed urgently. I note the new 10 Year NHS Workforce Plan, due in Spring 2026, is still awaited.

31.15 As well as reorganisations and structural change, as identified by Sir Robert Francis, and the sheer number of recommendations, there are at least two other important reasons for not implementing recommendations that have been accepted. The first is lack of political will. There is a broadly held view that an inquiry serves its primary purpose when it is set up by taking the heat out of a difficult political situation. By the time it reports, there has often been at least one change of government, probably more than one change of Secretary of State, priorities have changed and, once the story of what happened has been told, the media and the public gaze generally move elsewhere and recommendations are quietly forgotten.

31.16 Both Sir Rob Behrens CBE (Parliamentary and Health Service Ombudsman from April 2017 to March 2024) and Sir Robert Francis pointed to a further reason, namely the absence of effective oversight or enforcement.[21] This chimes with the findings of Dr Benneyworth's group in respect of recommendations and guidance from within the NHS.

Establishment of a public inquiries committee?

31.17 The House of Lords Statutory Inquiries Committee's report from September 2024, *Public Inquiries: Enhancing public trust*, recommended that the House of Commons Liaison Committee facilitate the formation of a joint committee of Parliament to ensure that inquiry recommendations are followed up and implemented.[22] The committee would oversee public inquiries, monitor the publication of government responses to inquiry recommendations and hold the government to account for implementing accepted recommendations. The government responded in April 2025 that this recommendation would be a matter for Parliament.[23] However, it committed to providing Parliament with a further update on its intentions regarding

potential "*wider reforms*" to the policy and operational frameworks governing public inquiries.[24] Whilst reform of the system of public inquiries is not within my Terms of Reference, the question of implementation of recommendations is. I see the force of the Committee's recommendation. My only question (and this is surely something that could be worked on) would be whether such a committee would have the time, resources and flexibility to carry out its functions effectively. Provided those issues were addressed this could and should work.

31.18 The Committee also recommended, and the government indicated it would support, better resourcing for the Cabinet Office Inquiries Unit. This would allow greater sharing of good practice and learning from the experience of those who have been and are involved in public inquiries. It ought to remove the need for every chair of a public inquiry to reinvent the wheel. It should not, of course, cut across the Chair's independence.[25]

Independence of the monitoring and enforcement body

31.19 The Cabinet Office Inquiries Unit launched their Inquiry dashboards in July 2025, as a record of public inquiry recommendations made since 2024. The dashboards track the government's commitments in response to these recommendations, and update on implementation.[26] So far only six inquiries, not covering all modules and report phases, have been included. Keeping the dashboards up to date relies on government departments providing progress reports to the Cabinet Office. The dashboards do not provide further information on the implementation of 'in progress' recommendations. The Cabinet Office Inquiries Unit, however well resourced, is not the right body to monitor (with a view to enforcement) inquiry recommendations because it is independent neither of government nor of the civil service. A joint committee of Parliament would be both.

National Quality Board?

31.20 DHSC and NHS England's plans for a "*revitalised*" National Quality Board are set out in the 10 Year Health Plan.[27] I have been informed since the hearings that this

board will be responsible for a repository of recommendations and act as a "*clearing-house function to prioritise existing and new recommendations*". The board was to be refreshed "*from September 2025*" but there has been no further public update about that. I am told the "*recommendations hub*" will provide enhanced oversight and accountability for recommendations from multiple sources and provide an efficient system for prioritising, implementing and evaluating recommendations at the national level. There is no clear information on how prioritisation decisions will be made and by whom. I understand the hub will be implemented in a phased approach, with rollout starting in 2027. This does not lead me to expect great speed or urgency, nor is it clear where, if at all, this will work with the dashboards produced by the Cabinet Office Inquiries Unit. Finally, I am not persuaded that this board will be adequately resourced for the size of the task. It is not independent of government or the Civil Service and I am not at all confident of its practical effect.

National Audit Office

31.21 There is an alternative option which could be introduced more quickly. Sir Rob Behrens advised that the National Audit Office would be the ideal body to carry out this task.[28] I agree with him. The National Audit Office has a wide range of skills, expertise and experience. They audit programmes across the public sector and they report to Parliament. Importantly, they are independent of Government and of the Civil Service. They are held in high regard and are trusted.

31.22 I do not doubt that the National Audit Office would prefer not to add to their programme of work, but adding responsibility for monitoring the implementation of recommendations of the reports of statutory inquiries into NHS bodies, together with appropriate additional staffing, would transform the approach to recommendations and the effectiveness of public inquiries (even without any further changes as envisaged by the House of Lords Statutory Inquiries Committee). I am confident of this because the National Audit Office, and the House of Commons Public Accounts Committee through which it reports, have continued political clout.

31.23 I return to the question of recommendations in Chapter 45.

Endnotes

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8 **Prof. Mary Dixon-Woods 26 September 2024 20/1 to 21/2**

9 Dr Penny Dash, *Review of Patient Safety Across the Health and Care Landscape*, DHSC, July 2025 (**https://assets.publishing.service.gov.uk/media/686bd5d52cfe301b5fb6780c/dhsc-review-of_patient-safety-across-the-health-and-care-landscape.pdf**)

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11 **Prof. Mary Dixon-Woods 26 September 2024 20/6**

12 **Dr Rosie Benneyworth 8 January 2025 42/1-13**

13 **Dr Rosie Benneyworth 8 January 2025 44/21-24**

14 **Sir Robert Francis KC 30 September 2024 98/23**

15 **William Vineall 15 January 2025 179/6 to 181/7**

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17 Department of Health, *Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, 17 January 2002 (**https://assets.publishing.service.gov.uk/media/5a7c743540f0b62aff6c1c71/5363.pdf**)

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20 **Prof. Sir Stephen Powis 17 January 2025 63/5 to 65/16**

21 **Sir Rob Behrens CBE 10 December 2024 31/13-21** and **40/17-24**; **INQ0101079/2/para 1.1 and 12/para 1.18**; **Sir Robert Francis KC 30 September 2024 96/21-24**

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27 UK Government and NHS, *Fit for the Future: 10 Year Health Plan for England*, July 2025, page 91 (**https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf#page=93**); NHS England, 'National Quality Board' (**https://www.england.nhs.uk/ourwork/part-rel/nqb**)

28 **Sir Rob Behrens CBE 10 December 2024 40/17-23**

Chapter 32. Medical examiners

Introduction

32.1 The statutory system of medical examiners came into effect on 9 September 2024. The system could and should have been introduced at least a decade earlier, as I shall explain.

32.2 Dr Alan Fletcher was the National Medical Examiner for England and Wales until September 2025. He was involved for decades in the effort to introduce medical examiners into the NHS. He provided the Inquiry with detailed evidence about the purpose of medical examiners and the circumstances in which they came to be introduced as well as a review of their efficacy. During his career as a medical examiner from 2008 to 2025, he reviewed more than 22,000 deaths. Dr Fletcher had very extensive

experience as a working clinician, as a medical examiner, and latterly as National Medical Examiner.

32.3 Dr Fletcher explained that the purpose of the medical examiner system is to "*ensure that an independent person reviews the documents and circumstances of every person who has died in England and Wales whose death is not subject to coronial investigation*".[1]

History

32.4 In July 2003, Dame Janet Smith published her third report of the Shipman Inquiry.[2] She identified a number of flaws in the system in England and Wales for certifying deaths, a system which had remained unchanged since its introduction in 1926. It depended on the accuracy and integrity of a single doctor who certified the cause of death. As a result, Harold Shipman was able to murder approximately 250 patients and certify the cause of death without fear of contradiction. Dame Janet recommended a system which operated an effective cross-check of the account given by a doctor who had treated the patient and who had given a cause of death. The government of the day proposed a medical examiner system in the UK which

would provide an independent medical review of all deaths that were not reviewed by the coroner. As Sir Robert Francis explained, the system has a much wider effect than potentially identifying a doctor who kills, although it does of course do that. It operates as an early warning system when a person or several people die.[3] It is the role of medical examiners to identify patterns of poor care, including care which is negligent or deliberately harmful. As intended, they review deaths which a coroner has not taken for investigation. In some cases, where appropriate, they refer a case to the coroner.

32.5 The system of medical examiners was implemented 22 years after it was recommended. Mr Hunt, Secretary of State for Health between 2012 and 2018, said in evidence: "*I think of all the things that could have potentially meant that what happened at the Countess of Chester was spotted earlier and the dots were joined up would have been having Medical Examiners.*"[4]

32.6 In 2008, pilot schemes of medical examiners were set up in several cities. The most comprehensive and long-running pilots were in Sheffield and Gloucester, which tested the

operation of medical examiners in Primary Care Trusts for many years, from 2008 to 2019.* [5]

32.7 The Coroners and Justice Act 2009 was passed six years after the publication of Dame Janet's recommendations. Section 19 of the Act placed upon Primary Care Trusts (in England) and Local Health Boards (in Wales) an obligation to appoint medical examiners.[6] It also gave the government the power to appoint a National Medical Examiner.[7] In 2009, it was assumed, reasonably, that funding for medical examiners would come from the NHS budget.[8] The sections in the Act dealing with funding were not brought into force and for some years no progress was made on the national scheme.

32.8 As part of the reforms to the NHS introduced by the Rt Hon. Andrew Lansley CBE, Secretary of State for Health between 2010 and 2012, the sections of the Coroners and

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* Primary Care Trusts were abolished under the Health and Social Care Act 2012 and commissioning responsibilities handed over to Clinical Commissioning Groups; as of July 2022, CCGs were dissolved and replaced by Integrated Care Systems.

Justice Act 2009 dealing with funding (which are still not in force) were amended so as to shift the cost burden of medical examiners onto local authorities.[9] The pilot programmes continued to run during this time, with funding coming from local authority budgets.

32.9 Sir Robert Francis's inquiry into the failings at Mid Staffordshire NHS Foundation Trust published its report in February 2013.[10] Sir Robert Francis supported the use of independent medical examiners. This and many other recommendations were accepted by the government in 2014.[11]

32.10 Another ten years passed before the statutory scheme was set up. In the meantime, various approaches to funding were considered and the pilot schemes continued. In response to a consultation in 2016, the then Department of Health decided that medical examiners would be better funded through central NHS funding (rather than via local authorities).[12] This approach should have been taken in the first place. It is regrettable that even after the decision had been taken that funding should come from the central NHS budget, that did not happen. Instead, the Department of Health decided to devote some of the NHS budget to a non-statutory scheme.[13] It also changed the

process for the completion of Cremation Form 5, which until then could be completed only by a GP. The change moved responsibility for completing the form from GPs to medical examiners. The money saved by not paying GPs to fill in the form was diverted to fund the position of medical examiners.[14] One can only admire the ingenuity deployed by those in the Department of Health who were endeavouring to bring in medical examiners by finding ways around the failure to fund a system that had been agreed by government. This was a waste of the time of civil servants and of public money.

32.11 In 2019, the UK government laid primary legislation before Parliament to place medical examiners under the control of the NHS. The Bill received a second reading but was overtaken by a general election and the onset of the Covid-19 pandemic.[15] As a result, the ad hoc arrangements which had become referred to as ‘non-statutory arrangements’ continued. Medical examiners reviewed deaths across the UK but there was no statutory requirement for a medical examiner to be involved in the certification of death. Trusts were asked by NHS England to appoint medical examiners who would review deaths in hospitals. Many did, but there was no requirement to do so.

32.12 In 2022, after a government spending review, NHS England advocated for the statutory medical examiner scheme to be centrally funded.[16] It was Mr Hunt's evidence that having been Secretary of State for Health and now Chancellor, he was motivated to ensure that the scheme was properly funded and worked to ensure that the scheme was allocated central government funding.[17] He had been Secretary of State for Health from 2012 to 2018, during which time there was a failure to fund a statutory system of medical examiners. He conceded that the medical examiner system "*is something that I look at as being one of the things that we took too long to implement*".[18] He spoke about the "*NHS's reluctance to implement Medical Examiners*".[19] He explained that "*what lay behind the institutional reluctance*" was: (a) the cost associated with implementation; (b) that it was not initially clear who the medical examiners would be; and (c) that there was a shortage of doctors in the NHS and the focus was on using doctor time to treat patients as opposed to examining deaths.[20] That latter point rather overlooks that one of the purposes of examining a death is to understand what happened while the patient was alive and whether, had something

different been done, the outcome may have been different. This is essential learning for the effective treatment of live patients. In its closing submissions, DHSC accepted that it had taken a long time to implement the statutory scheme.[21]

32.13 Coinciding with the effort to ensure the scheme was centrally funded was the passage of the Health and Care Act 2022, section 169 of which re-established medical examiners as funded and appointed by NHS bodies.[22] It placed a duty on the Secretary of State to ensure that there were sufficient medical examiners to discharge their responsibilities across England, with a similar provision placing responsibility on Welsh ministers.[23]

32.14 It was not, however, until 9 September 2024 that the full statutory scheme of medical examiners was fully operational. That it was rolled out just before this Inquiry started hearing evidence was, I was told, a coincidence. DHSC gave three reasons for the further delay to the full scheme: first, to get the scheme to "*bed down*";[24] second, to try to get more engagement from GPs, who at that point had not been asked to engage with the medical examiner system;[25] and

third, because NHS England needed time to introduce the system and embed the logistical arrangements.[26] In other words, more preparation was needed.

32.15 In my view, it took far too long to implement this system. It should have been in place at the latest by mid-2014. This would have been 11 years after the recommendation was made, 10 years after it was accepted, 5 years after the Coroners and Justice Act 2009 was passed, and shortly after the reinforcement by the Francis Inquiry of the need for medical examiners. The system of 129 medical examiners' offices in England and Wales currently costs approximately £50 million to run each year, alongside £7 million of central administrative costs,[27] out of an NHS England annual budget of £179 billion in 2024/25.[28] Given the efforts of DHSC to find ways to put some sort of system into place, the absence of funding for this necessary measure was the result of a failure of political will. The most recently available (September 2025) information is that the funding for medical examiners is no longer ring-fenced but ICBs are funded on the basis that they will provide the medical examiner service.[29] I need hardly say that there should be no question of a failure to fund this important service. Ring-

fenced funding makes sure of that. When, as I recommend later in this chapter, the operation of medical examiners is next reviewed, the question of the adequacy of funding must be addressed.

Current system

32.16 There are 129 medical examiners' offices in England and Wales, each of which serves about two NHS Trusts.[30] Typically, each office employs a number of senior doctors as part-time medical examiners, one of whom will be the Lead Medical Examiner, with a team of medical examiner officers.[31]

32.17 All medical examiners receive training. Importantly, the possibility of deliberate harm comes at the beginning of the training. Dr Fletcher said: "[I]*n the first line of the e-learning, Medical Examiners are reminded that their role had the germination from the murders committed by Harold Shipman, the issues at Morecambe Bay,* [and] *Gosport War Memorial Hospital.*"[32] The report into the events at Morecambe Bay by Dr Kirkup was published in 2015.[33] I am satisfied that had the system been up and running in 2015, it would have included this same information.

32.18 Mandatory training includes the safeguarding of children and young people.[34] Dr Fletcher said, however, that he would normally expect safeguarding to be raised as an issue by the treating clinician, but he recognised that safeguarding is everyone's responsibility. He stated that he would prefer medical examiners to engage in a conversation with the clinical team and ask whether they have raised a safeguarding concern. If the response is no and the medical examiner considers it needs to be done, they should then do it themselves.† [35]

32.19 The role of the medical examiner officer is to help the medical examiners discharge their statutory functions effectively.[36] As permanent members of staff, officers run the office and keep records so that there is an institutional memory and oversight of the work of the examiners. Most importantly, they are often the first contact with the bereaved and need the skills to communicate appropriately. Whilst responsibility to discharge the duty to take reasonable steps to speak to the family rests with the medical examiner, in most cases this

† Dr Fletcher stated that this aligns with the medical examiners' approach to a referral to the coroner.

is done by the medical examiner officer.[37] Most families do speak to either the medical examiner or the medical examiner officer.[38]

32.20 Fundamental to the system is that the doctors carrying out the reviews are independent from the primary, treating physician. This removes the risk of the treating doctor's professional and emotional investment in the treatment, life and death of the patient affecting their judgement as to the cause of death. For the same reason, medical examiners cannot review a patient whom they have treated or where there is a conflict of interest – for example, where a death has occurred in the unit in which they work.[39]

32.21 Medical examiners have the power to access the medical records of the deceased under the Access to Health Records Act 1990 and must review them within five days of the death.[40] The review should be "*proportionate*".[41] As a matter of course, the medical examiner discusses the case with the attending practitioner, who is responsible for completing the medical certificate of cause of death.[42] They will also speak to the relatives of the deceased to establish whether they have any particular concerns about the quality of the care that was provided.[43] It was plain from

the evidence given during the Inquiry that parents and relatives can provide important information to clinicians – and, it follows, to medical examiners – about the condition and care of their babies.[44]

32.22 In the case of neonates, the medical notes are usually very much shorter than those of older children and adults. It is likely, therefore, that a medical examiner would look at all the medical records when examining the death of a neonate. This would be proportionate to the task.

32.23 Dr Fletcher said that medical examiners should answer three questions:

- What is the cause of death and has it been accurately recorded?
- Does the case need to be referred to the coroner?
- Are there any clinical governance concerns that need further review?[45]

32.24 The guidance to medical examiners makes it clear that they are not expected to carry out in-depth reviews or investigations.[46] They have neither the resources nor the expertise to do so. Their role is to identify any issues and pass them on to the coroner, where appropriate, or, if the issues are about clinical

governance, refer them either to established clinical governance processes[47] or to the National Medical Examiner.[48] Where the concerns require immediate action, they should be passed on to the Executive Team of the Trust concerned.[49] It goes without saying that, from that point on, the quality of the work done depends on the expertise and judgement of the Executive Team.

32.25 A decision to involve the police would occur after multi-agency discussions, probably involving the medical examiner, the coroner and the Trust's executives, after a concern had been identified and raised by the medical examiner.[50]

Developments in medical examiners' guidance on neonatal deaths

32.26 In the spring of 2024, Dr Fletcher commissioned three medical examiners, two of whom are neonatologists and one a paediatric pathologist, to work with BAPM to develop updated guidance on neonatal and child deaths for medical examiners. The resulting guidance was published in March 2025 and I was grateful to receive it, as promised by Dr Fletcher.[51] The same group

is creating an e-learning module that informs neonatologists and paediatricians about the medical examiner system and vice versa.

32.27 The recent guidance (2025 update) makes clear that where there is a sudden unexpected death of a child or neonate and there is "*no immediately apparent medical cause*", the medical examiner should "*actively consider whether unnatural events … may have caused or contributed to the death*".[52]

Medical examiners' areas of expertise

32.28 Whilst medical examiners are senior doctors, there is currently no requirement for the medical examiner to have knowledge or experience in the area of medicine relevant or potentially relevant to the death. For instance, neonatal deaths can be reviewed by medical examiners who have no experience of neonatal or paediatric care. Dr Kingdon, who gave evidence in her capacity as a past President of the RCPCH, explained the limitations of the system from the perspective of neonatology, which is now very specialised: "[W]*hen I am really troubled about what could have happened that triggered this child's death I think* [it] *is expecting quite a lot of* [adult trained] *clinicians who are dealing with*

all deaths in a busy … general hospital."[53] Dr Fletcher considered that the absence of specialist knowledge is not a barrier to effective review and suggested it may be a strength.[54]

32.29 I asked Dr Fletcher about a situation where a baby dies suddenly and unexpectedly and a medical examiner, who is not trained in paediatrics or neonatology, approaches the paediatrician to discuss the case. The paediatrician states that they have a cause of death, but without the appropriate expertise the medical examiner cannot challenge the paediatrician's view. Dr Fletcher agreed that this scenario could arise, but he emphasised that if a medical examiner has doubts they are encouraged to challenge the practitioner. Dr Fletcher stated that, whilst he accepted a medical examiner may accept a paediatrician's diagnosis on the first occasion, if there is another sudden and unexpected death, the situation would be very different.[55] He also said – and I accept – that there is support and accessible expertise in the local and regional structure for medical examiners to obtain advice regarding neonatal cases.[56] However, at present there is no funding or

the resources to provide a full network of neonatal experts.
I shall return to this later.

32.30 Dr Fletcher made the point that "*the Sudden and Unexpected Death of a baby in a neonatal unit is an outstanding and remarkable matter. So in* [and] *of itself I would expect that occurrence to generate a level, a heightened sense of concern about what happened.*"[57] He also said that, in these circumstances, there is an "*extremely low threshold for notifying the Coroner*".[58] In addition to contacting the coroner, he thought the JAR and Child Death Review process would also be followed. He explained that the medical examiner would review the records, speak to the attending practitioner about the case and ask the family questions. He said that, where a family member raised concerns, such as "*I don't understand what happened … we were told everything was fine*", these comments would be a trigger to review and escalate the case further.[59] The importance of speaking to the parents cannot be overestimated. The evidence of Mother E and F makes that clear.

Had the medical examiner system been in place in 2015 and 2016, would any deaths have been avoided?

32.31 The deaths of Baby A, Baby C and Baby D were reported to the coroner, so the medical examiner would almost certainly not have been involved. Although Dr Newby, when reporting the death of Baby D, alerted the coroner's office to the fact that there had been three deaths within a short period and a collapse of a twin, Dr McPartland did not recommend a forensic post-mortem. Given Dr Fletcher's view of the significance of the unexpected death of a neonate, it may well be that, had the medical examiner been informed of the death and the nature of the referral, they would have suggested that there should be a forensic post-mortem. However, I do not have the evidence to make a finding that this would have happened, nor can I say what the consequences would have been.

32.32 Baby E died at the beginning of August and his brother, Baby F, was poisoned with insulin shortly afterwards. Although not examined, Baby E's death was also reported to the coroner. I have set out the facts in Chapter 5. Had the medical examiner system been in place, it may be that Dr ZA would have turned

first to the medical examiner, although at that time the Senior Coroner, Mr Rheinberg, had in place a rule that all deaths of babies should be reported to the coroner (a policy that Dr Fletcher felt was likely to lead to overloading of the coroner's office and was probably unnecessary).

32.33 Had the medical examiner been involved, they may have held discussions with Dr ZA and, if appropriately experienced, may have challenged her view of the cause of death (see Chapter 5). However, I bear in mind that Dr Brearey, the lead for neonatology at the Countess, accepted her view at the time. Whether the medical examiner would have understood the significance of the X-ray findings I cannot tell. The medical examiner may have spoken to Mother E and F. Had she been asked about her experiences on the evening of Baby E's death, it is likely that she would have told him. I cannot say whether the significance of her information would have been understood at that time but it may have been.

32.34 In October 2015, Baby I was the fifth baby to die suddenly and unexpectedly on the neonatal unit. Dr Gibbs referred the case to the coroner. The involvement of the coroner

would have precluded the involvement of a medical examiner. The post-mortem returned a natural cause of death.

32.35 Had there been in place a hospital-based record of all deaths on the neonatal unit which was accessed as a matter of course by the medical examiner whenever a death on the unit was referred to them, that would have enabled the medical examiner to identify or at least ask about, for example, an unusual rise in the number of deaths. It would also have allowed the clinicians to talk about their concerns to someone external to the Trust. The results of the Inquiry questionnaire sent to 120 Trusts show that, by December 2023, most (112) had in place processes for medical examiners to identify trends or patterns in deaths across the Trust.[60] Had this been in place at the Countess in 2015 and 2016, as it should have been, the discussions should have led to action to protect babies by May 2016. By that stage, a baby had died each month from December 2015 to March 2016 (deaths not on the indictment). In respect of two, there was no post-mortem. In April 2016, Ms Powell had moved Letby to day shifts, as set out in Chapter 8. Whether other action to protect babies would have occurred would have depended on whether the medical

examiner's external voice persuaded the senior managers that the time had come to take action.

Conclusions

32.36 The introduction of medical examiners is a very positive development. For the first time, bereaved families have a voice in establishing what happened to their child or other family member. This is emphasised in the version of the 'Medical examiners' pages on the NHS website.[61] Importantly, there is a hospital-based record of all deaths on a neonatal unit which should be accessed by any medical examiner tasked with reviewing the death of a new baby. In most hospitals, the record is held on BadgerNet. I say more about that in Chapter 35. I would just add that all 120 Trusts that completed the Inquiry questionnaire confirmed that they had access to a medical examiner.[62]

Recommendations

32.37 Dr Fletcher made and agreed with a number of suggestions on how to improve the medical examiner system, including the following:

a. There should be a checklist of steps that medical examiners must take when dealing

with the death of a neonate. It should include consideration of whether they should make a safeguarding referral to the LADO.[63] I agree. When a medical examiner or any other doctor or nurse is dealing with the death of a neonate, what to do should be set out clearly and simply, in no more than one page.

b. The SUDIC guidelines should be set out within the Good Practice Series for medical examiners, not merely signposted.[64] I agree. Simplicity of process is imperative.

c. Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or if there is a safeguarding concern.[65] I would add that, where there may be such a concern, the medical examiner should ensure that there is a record made immediately of the contact details of every doctor or nurse who attended the baby during their life. This is not too much to ask. Sudden unexpected death on neonatal units is rare. The number of doctors and nurses who will have looked after neonates during their short lives is usually low. The details should be held on the child's records

and by the medical examiners' office and provided by the medical examiners' office to the hospital's safeguarding team. Where deliberate harm is suspected, these steps are proportionate to the risk to patient safety.

32.38 Dr Fletcher suggested that consideration should be given to the possibility of medical examiners having unique specialties in the future.[66] In light of Dr Kingdon's evidence, I am sure that this should be done at least for paediatrics and neonates. It is too easy to say, as was done for years after the Coroners and Justice Act 2009 came into force, that medical examiners would reduce the number of doctors available for other things. Now that they are in place, if medical examiners are not specialists in the relevant area of medicine, time is wasted while they get up to speed and seek advice from an appropriately skilled expert. It would be quicker to have a medical examiner who is appropriately skilled in the first place. It requires careful organisation. Specialists may be regional or, rarely, national. These are details to be worked out.

32.39 I note that NHS England is working on a time-limited survey of medical examiner offices in England to evaluate the impact of medical

examiners on causes of death.[67] I suggest it be reviewed two years after that. It should include a review of the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC.

Endnotes

1 **Dr Alan Fletcher 12 December 2024 3/6-9**

2 Dame Janet Smith DBE, *The Shipman Inquiry. Third Report: Death Certification and the Investigation of Deaths by Coroners*, July 2003 (**https://assets.publishing.service.gov.uk/media/5a7b99ae40f0b645ba3c55db/5854.pdf**)

3 **Sir Robert Francis KC 30 September 2024 47/1-8**

4 **Rt Hon. Jeremy Hunt MP 9 January 2025 175/2-5**

5 **Witness statement of Dr Alan Fletcher INQ0014570/2/para 4**

6 Coroners and Justice Act 2009, section 19 (**https://www.legislation.gov.uk/ukpga/2009/25/section/19**)

7 Coroners and Justice Act 2009, section 21 (**https://www.legislation.gov.uk/ukpga/2009/25/section/21**)

8 **William Vineall 15 January 2025 157/16-17**

9 **William Vineall 15 January 2025 157/19 to 158/1**; Health and Social Care Act 2012, section 54(2) (**https://www.legislation.gov.uk/ukpga/2012/7/section/54**)

10 Sir Robert Francis KC, *Report of the Mid Staffordshire NHS Foundation Trust Public*

Inquiry, February 2013 (**https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry**)

11 **Rt Hon. Jeremy Hunt MP 9 January 2025 175/10-13**

12 **William Vineall 15 January 2025 136/20-24** and **162/22-24**

13 **William Vineall 15 January 2025 158/13-15**

14 **William Vineall 15 January 2025 158/13 to 159/6**

15 **William Vineall 15 January 2025 138/1-8**

16 **William Vineall 15 January 2025 160/3-18**

17 **Rt Hon. Jeremy Hunt MP 9 January 2025 175/21-24** and **239/13-16**

18 **Rt Hon. Jeremy Hunt MP 9 January 2025 175/15-17**

19 **Rt Hon. Jeremy Hunt MP 9 January 2025 175/25 to 176/1**

20 **Rt Hon. Jeremy Hunt MP 9 January 2025 176/4-19** and **181/8-13**

21 **DHSC 17 March 2025 24/13-15**

22 **William Vineall 15 January 2025 138/9-12**

23 See Coroners and Justice Act 2009, sections 18A(2) and 18B(2) (**https://www.legislation.gov.uk/ukpga/2009/25/part/1/chapter/2**)

24 **William Vineall 15 January 2025 138/17**

25 **William Vineall 15 January 2025 138/18-21**

26 **William Vineall 15 January 2025 138/21-22**

27 **William Vineall 15 January 2025 161/13-22**

28 NHS England, 'Planning guidance and budget for 2024/25', 28 March 2024 (**https://www.england.nhs.uk/long-read/planning-guidance-and-budget-for-2024-25/#background**)

29 NHS England, *National Medical Examiner Report 2024*, 11 September 2025 (**https://www.england.nhs.uk/long-read/national-medical-examiner-report-2024**)

30 **William Vineall 15 January 2025 162/11-14**

31 **Witness statement of Dr Alan Fletcher INQ0014570/17/para 61**

32 **Dr Alan Fletcher 12 December 2024 25/20-24**

33 Dr Bill Kirkup CBE, *The Report of the Morecambe Bay Investigation*, March 2015 (**https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf**)

34 **Dr Alan Fletcher 12 December 2024 27/15-18**

35 **Dr Alan Fletcher 12 December 2024 27/18 to 28/8**

36 **Dr Alan Fletcher 12 December 2024 11/9-11** and **14/14-23**

37 **INQ0108962/8/para 35**

38 **INQ0108962/8/para 36**

39 **Dr Alan Fletcher 12 December 2024 5/21 to 6/10**

40 **Dr Alan Fletcher 12 December 2024 17/18-23**; Access to Health Records Act 1990, section 3 (**https://www.legislation.gov.uk/ukpga/1990/23/section/3**)

41 **Dr Alan Fletcher 12 December 2024 16/6-24**

42 **Dr Alan Fletcher 12 December 2024 45/1-10**

43 **Dr Alan Fletcher 12 December 2024 45/11-15**

44 **Rt Hon. Jeremy Hunt MP 9 January 2025 182/17 to 183/6**

45 **Dr Alan Fletcher 12 December 2024 3/5-18**

46 Dr Alan Fletcher, *National Medical Examiner's Good Practice Series No. 6: Deaths of children and neonates*, March 2022, updated March 2025, page 4 (**https://www.rcpath.org/static/7fa7a9d6-ada5-4597-b16f4602c93d3e91/054c6e3b-d6fd-472e-a2f0bbe13f179adb/good-practice-series-deaths-of-children-and-neonates.pdf#page=4**)

47 Dr Alan Fletcher, *National Medical Examiner's Good Practice Series No. 6: Deaths of children and neonates*, March 2022, updated March 2025, page 4 (**https://www.rcpath.org/static/7fa7a9d6-ada5-4597-**

b16f4602c93d3e91/054c6e3b-d6fd-472e-a2f0bbe13f179adb/good-practice-series-deaths-of-children-and-neonates.pdf#page=4)

48 **Dr Alan Fletcher 12 December 2024 5/18-20** and **11/15 to 12/1**

49 **Dr Alan Fletcher 12 December 2024 10/5-7**

50 **Dr Alan Fletcher 12 December 2024 39/8-20**

51 Dr Alan Fletcher, *National Medical Examiner's Good Practice Series No. 6: Deaths of children and neonates*, March 2022, updated March 2025 (**https://www.rcpath.org/static/7fa7a9d6-ada5-4597-b16f4602c93d3e91/054c6e3b-d6fd-472e-a2f0bbe13f179adb/good-practice-series-deaths-of-children-and-neonates.pdf**)

52 Dr Alan Fletcher, *National Medical Examiner's Good Practice Series No. 6: Deaths of children and neonates*, March 2022, updated March 2025, page 7 (**https://www.rcpath.org/static/7fa7a9d6-ada5-4597-b16f4602c93d3e91/054c6e3b-d6fd-472e-a2f0bbe13f179adb/good-practice-series-deaths-of-children-and-neonates.pdf#page=7**)

53 **Dr Camilla Kingdon 12 December 2024 183/8-12**

54 **Dr Alan Fletcher 12 December 2024 22/22 to 23/1**

55 **Dr Alan Fletcher 12 December 2024 70/13 to 72/10**

56 **Dr Alan Fletcher 12 December 2024 24/14-24**

57 **Dr Alan Fletcher 12 December 2024 44/15-19**

58 **Dr Alan Fletcher 12 December 2024 44/25**

59 **Dr Alan Fletcher 12 December 2024 44/23 to 46/5**

60 **INQ0018076/154**

61 NHS England, 'Medical examiners' (**https://www.england.nhs.uk/patient-safety/medical-examiners**)

62 **INQ0018076/152**

63 **Dr Alan Fletcher 12 December 2024 26/15-22 and 28/9-12**

64 **Dr Alan Fletcher 12 December 2024 50/18 to 51/16**

65 **Dr Alan Fletcher 12 December 2024 60/4-14**

66 **Dr Alan Fletcher 12 December 2024 63/3-14**

67 NHS England, *National Medical Examiner's Report for 2025*, 6 July 2026 (**https://www.england.nhs.uk/long-read/national-medical-examiner-report-2025**)

Chapter 33. CCTV and monitoring

33.1 From a time well before the Inquiry hearings began, the parents were firmly of the view that CCTV would protect babies on the neonatal unit. It would be a visible and clear deterrent to those who intended harm to babies. In the course of her evidence, Mother C made the point that in-cot cameras would be particularly useful, so that parents (or others) who wanted to observe the babies could do so from a different location.[1] It would also act as a deterrent to anyone who intended harm to a baby.

33.2 On behalf of Family Group 1, Mr Skelton KC and his team submitted that all neonatal units should have individual cameras in each cot/incubator. This would enable real-time monitoring of actions by staff and allow parents to monitor their babies when they were not present at the hospital. They asserted it would also have a significant deterrent effect.[2]

33.3 On behalf of Family Groups 2 and 3, Mr Baker KC maintained that the provision of CCTV within the unit would:

> "*provide greater security to the vulnerable patients who are cared for there. In cases where deliberate harm is suspected its presence would either confirm the occurrence of crimes or exonerate the individual accused of them. It would act as a deterrent to an individual intent on causing harm to vulnerable patients, whether that individual was a healthcare worker or another individual present on the unit. At the very least, it would make the act of causing harm to babies considerably more difficult*."[3]

This group added: "*Families would say that CCTV covering each cot/incubator but not the wider spaces within the NNU* [neonatal unit] *would limit the risk of intrusion into private or intimate moments.*"[4]

33.4 Mr Harvey considered that CCTV would have a deterrent effect but would not completely remove the risk. Ms Hodkinson thought it could have a deterrent effect and it could help Trusts better monitor activity on neonatal units.

33.5 The Countess recognised that CCTV can be important to help parents feel reassured about their babies' safety, particularly when parents cannot readily access the ward, although acknowledged that there may be some privacy issues. Live cot or incubator cameras could help advance that aim. They expressed their support for any recommendations intended to provide for better contact and engagement between parents and their child while they are on the neonatal unit.[5]

33.6 The RCPCH was neutral on the CCTV proposal, although described it as "*surveillance*" and submitted that "*the key question was whether the increased level of protection justifies the breach of a child's right to privacy*".[6] The RCPCH did not deal with the question of in-cot cameras.

33.7 CQC did not deal with in-cot cameras. As to CCTV, it "*considers whether or not it is appropriate for hospitals to deploy CCTV to be a fact-specific question that falls to be addressed by each Trust in light of the specific circumstances at that Trust. In cases where CCTV is appropriate, the CQC has issued guidance to support its lawful use*."[7] In my view, it would be unfortunate were there

disparities in approach between different Trusts and I can see no justification for different approaches in different places.

33.8 Having raised privacy issues about CCTV in respect of breastfeeding and close contact with babies, Sir Stephen Powis informed the Inquiry that a different form of CCTV, such as in-cot cameras, was being explored and pilots were due to take place, and that this may be a more appropriate way forward.[8] Before those pilots took place, NHS England performed a U-turn. Their final position was: "[H]*aving sought the views of neonatal experts and reviewed the published scientific literature on the issue, our view was that a pilot of cot cams would not be appropriate taking into account other priorities to improve neonatal services and the findings of the scientific research on this topic to date*."[9]

33.9 The change of position is disappointing and puzzling. On behalf of NHS England, Mr Jason Beer KC explained that the scientific literature relied on by NHS England was a pilot at University College London Hospitals, in addition to learning from abroad of which no details were provided. Mr Beer KC explained the outcomes of the pilot to the Inquiry. He stated that there was not an

identifiable gain in patient safety by having in-cot cameras, by which he meant that there was no change to the outcomes for babies when the cameras were there. I infer that the cameras did no harm.[10] I also infer that there was no question of anyone being seen trying to harm babies. He summarised that, whilst families felt reassured and it gave them a feeling of greater safety, the cameras led to an increased workload because parents believed that they could see issues on the cameras that required a clinical response. I suggested to Mr Beer KC that, had the parent been present next to the cot and seen something they were concerned about, they would be entitled to raise the issue with staff. Mr Beer KC, rightly, did not seek to persuade me that there was any difference between the two situations. Parents do worry about their babies. Part of the job of the nursing and medical staff is to reassure them. I acknowledge that, if absent parents are in a position to raise a concern about something that would otherwise have gone unnoticed, it will make more work for nurses and doctors. There are two ways of dealing with that: the first is not to allow cameras. The second is to expect nurses and doctors to respond to the concerns of parents. Where a mother or father

in a neonatal unit expresses concern about their baby, a nurse attends. I do not accept that, because a parent expresses concern as a result of something seen on a baby monitor, it is less worthy of attention.

33.10 The number of babies for which nurses are responsible is not changed by the fact that baby monitors are in place. They are all being looked after. Very tiny babies are often linked to monitors of various kinds, such as oxygen monitors. When the alarm sounds, someone has to attend. It may be said that those alarms make work for nurses and doctors (and sometimes unnecessary work), but no one suggests the answer is to get rid of the monitors.

33.11 Nurses manage parents' concerns as a matter of course. The risk of something being missed is reduced if the baby is being observed more often.

33.12 NHS England also asserted that there were significant training, supervision and resource demands because of the in-cot cameras. There is nothing technically complex about a baby camera/video monitor. Parents use them at home all the time. Training, if any, would

be minimal. If it really was thought necessary, short rules could be drafted to govern the use of monitors by parents and staff.

33.13 In submitting that there was no difference in outcome for the babies when in-cot cameras were in place, NHS England overlooked the deterrent effect of the monitors. I accept that attacks by healthcare professionals on babies are very very rare. In-cot cameras will make them rarer. NHS England cannot operate on the basis that harm is unthinkable. It is not. The total cost for approximately 3,500 monitors – to cover all neonatal cots – is minimal in the scheme of NHS expenditure. It is easily justified by the fact that it will certainly reassure parents and will act as a deterrent.

33.14 Finally, there is no suggestion that the presence of the camera would pose any risk to the baby.

Conclusion

33.15 I do not think that fixed CCTV cameras would add sufficient extra deterrent to outweigh the privacy concerns and the practical problem of who is to watch the footage, where it is to be stored and for how long. I am sure that all cots and incubators in all neonatal units should be fitted with in-cot cameras with livestreaming

video, so that parents may observe the baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. I have no doubt that parents of very young babies will find this reassuring. That will be its principal effect. It is inescapable and important that it will also be a deterrent to those rare people who seek to harm babies. Everyone will get used to it.

Endnotes

1 **Mother C 16 September 2024 123/4-13**

2 **Written Closing Submissions on Behalf of Family Group 1 4 March 2025 89/paras 274-275**

3 **Written Closing Submissions on Behalf of Family Groups 2 and 3 7 March 2025 140/para 610**

4 **Written Closing Submissions on Behalf of Family Groups 2 and 3 7 March 2025 141/para 613**

5 **Written Closing Submissions on Behalf of the Countess of Chester Hospital NHS Foundation Trust 4 March 2025 86/paras 319-321**

6 **Written Closing Submissions on Behalf of the Royal College of Paediatrics and Child Health 26 February 2025 56/para 120**

7 **Written Closing Submissions on Behalf of the Care Quality Commission 4 March 2025 27/para 56**

8 **Prof. Sir Stephen Powis 17 January 2025 53/2 to 56/25**

9 **NHS England 17 March 2025 46/19-24**

10 There was a trial of the AngelEye CameraSystem in a Level 3 neonatal unit in the UK in 2020,

which found that the impact of webcams on nursing workload in the neonatal unit was low per camera-related task and the benefits for parents were recognised. More recently, in a clinical study in 2026, a research team has also trialled a calibrated RGB, depth and infra-red camera system at Addenbrooke's Hospital neonatal unit, which picks up medical information as well as live video stream for parents. The use of webcam technology is prevalent in neonatal intensive care units in the United States. This all proves that in-cot cameras with live video streams for parents are possible.

Chapter 34. Insulin

34.1 On a few occasions over decades nurses have killed patients by poisoning them with insulin. UK examples include the cases of Beverly Allitt, Victorino Chua and Colin Norris. It was one of the methods of killing discussed by the RCPCH report team during their investigation at the Countess.

34.2 There are two separate issues: first, access to insulin; second, how tests are sought and how results are reported.

Storage and access to insulin

34.3 Insulin is not a controlled drug and not subject to the same very tight processes and procedures. No one in this Inquiry has suggested that it should be. All accept, however, that there should be effective systems to prevent and detect unauthorised access to and use of insulin.

34.4 On behalf of Family Group 1, it was submitted that access to the administration of insulin on neonatal units should be restricted and more effectively controlled. It should not be left to individual hospitals to institute controls over access to insulin. If this happens, it will result in inconsistent or non-existent safety standards.[1] It was submitted that CCTV should cover drug dispensary areas within the hospital, so dispensing insulin can be monitored at all times to deter and catch malevolent use.[2]

34.5 Family Group 1 also submitted that the relevant unit in DHSC (that takes over policy responsibilities for the administration of insulin from NHS England) should mandate that hospitals implement standard safety measures, such as electronic access and records. This will ensure that everyone who accesses insulin in hospitals can be identified and their actions can be checked where necessary.[3]

34.6 On behalf of Family Groups 2 and 3, it was submitted that the storage areas should be monitored to ensure that those who access them can more easily be traced.[4]

34.7 NHS England suggested automated access to drug dispensaries by the submission of biometric data, such as fingerprint or retina scans, rather than CCTV covering those areas.[5]

34.8 On behalf of the Countess, support was expressed for the expansion of systems designed to encourage best practice in the administration of medications and the storage of drugs on neonatal units.[6]

34.9 Mr Dzikiti, principal witness for CQC, acknowledged that it would be beneficial were there to be electronic access to medicines, but made it plain that, as before, CQC did not take a position on this or any other recommendations.[7]

The guide to safe insulin use in neonatal services

34.10 The guide, issued in January 2026, sets out a delivery checklist for safe access, storage, handling, prescription, administration and disposal of insulin.[8] This includes individually identifiable and auditable access control (probably swipe card access), locked medicine fridge or cupboard (the expectation of an automated drawer with digital access on units within six months to two years).

It also covers professional practice – the need for a local policy and clinical guidance, appropriately trained staff who complete specific neonatal insulin training every three years, mandating two-person checking for insulin preparation and administration, with at least one checker having completed neonatal nurse specialty training (QIS), a documented standardised approach for preparing and administering insulin infusions, and working towards implementing 'closed loop' administration systems. It states there should be "*appropriate pharmacy staffing support as per NPPG* [Neonatal and Paediatric Pharmacy Group]*/ BAPM standards and … network pharmacists as recommended in GIRFT Neonatology national specialty report*".[9]

Technology

34.11 There is broad agreement about this issue. Technology allows us to be tracked in every aspect of our lives – transport, health, work, school, shopping, entertainment. It can easily be used to track who has access to which cupboard in a hospital and when. It requires only the installation and proper operation of the right technology. I recommend that digital devices be used to: restrict access to authorised people; and record access to

insulin storage units. I acknowledge that steps are being taken to achieve this. It should be mandatory for all neonatal units to meet the expected requirements for access control and storage of insulin on neonatal units set out in the NHS's Getting It Right First Time guide within six months.[10]

34.12 Until such time that access requires the provision of biometric data, there is always a risk that a swipe card or similar device may be swapped, inadvertently or deliberately, so each Trust should install a CCTV camera focused on the storage cupboard or unit. The camera should store recordings for at least 28 days. A visible camera is a very powerful deterrent and I see no argument against it. It is no more invasive than the digital tracker, the requirement to provide biometric data, or the cameras monitoring the entrances to hospitals or Accident and Emergency departments or other wards.

34.13 The provision of biometric data by someone accessing an insulin storage unit will combine restriction and record of access, obviating the need for CCTV. If that were in place, then such a system would comply – in spirit and practice – with my recommendation.

High insulin low C-peptide results: Laboratory handling guidance

34.14 Sir Stephen Powis was asked, directly, if there was a need for "*regulation or some sort of direction to be given to laboratories by NHS England about how they should react in circumstances where a low C-peptide is found corresponding with a high insulin level … and a corresponding direction to doctors*". He took the point and undertook to discuss it with the Chief Pharmaceutical Officer.[11] This is now addressed in the laboratory handling guidance published in October 2025, which I welcome.[12] The document contains "*best practices for establishing standards around the measurement, reporting, and timely communication of insulin and C-peptide test results*". This includes "[*t*]*he critical identification and communication of red flag scenarios where hypoglycaemia occurs with elevated insulin but low C-peptide levels*". It is aimed at Trusts, biochemists/pathologists/scientists, endocrinologists, paediatricians, neonatologists, clinical and medical directors and pharmacists. The key recommendation is "[m]*echanisms must be put in place to ensure that the red flag scenario of hypoglycaemia,*

elevated insulin and low C-peptide can be rapidly and readily identified".[13] To that I would add 'and immediately acted upon'.

34.15 This 12-page document sets out the red flag scenario on three occasions. There is no doubt that the significance of high insulin low C-peptide in the presence of hypoglycaemia should be well understood. When it is found, something must be done and each person in the chain from patient to laboratory and back has responsibility for doing something. The guidance is detailed and ends by directing that local protocols be set up. I suggest that serious consideration be given to producing a single step-by-step protocol for use as a template when high insulin low C-peptide is found. The protocol can be adjusted to local conditions, if necessary, but the fundamental requirements will always be the same. That would be a much less labour-intensive way of producing guidance for use in all Trusts.

34.16 I recommend that all guidance, local and national, applying to the high insulin low C-peptide situation mandates immediate discussion between laboratory and treating clinician (which must be recorded) and between laboratory head and the medical director of the hospital (which must be

recorded). Senior managers must inform NHS England and CQC. In the absence of a complete explanation for the finding, a senior manager must contact the police. Where a member of staff is suspected of being responsible, they should be removed from all patient contact pending investigation.

34.17 On behalf of the Countess, Mr Andrew Kennedy KC supported the evidence of Dr Brearey, who suggested that a nationally agreed process for the testing and reporting of insulin and C-peptide results should be developed. Mr Kennedy KC suggested that asking whether a patient had received insulin at the time of the insulin/C-peptide test would be enough to establish the significance of any result.[14] This is an important point. I am encouraged to see it taken up in the guidance issued in October 2025.[15] I recommend the current guidance be made mandatory and of national application.

Endnotes

1 **Family Group 1 18 March 2025 88/16 to 89/9**

2 **Written Closing Submissions on Behalf of Family Group 1 4 March 2025 89/para 276**

3 **Family Group 1 18 March 2025 89/9-16**

4 **Written Closing Submissions on Behalf of Family Groups 2 and 3 7 March 2025 141/para 614**

5 **NHS England 17 March 2025 47/7 to 48/8**

6 **Written Closing Submissions on Behalf of the Countess of Chester Hospital NHS Foundation Trust 4 March 2025 87/323**

7 **Chris Dzikiti 14 January 2025 115/2-3**

8 NHS England Getting It Right First Time, *GIRFT Neonatology: Guide to safe insulin use*, January 2026 (**https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf**)

9 NHS England Getting It Right First Time, *GIRFT Neonatology: Guide to safe insulin use*, January 2026 (**https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf**)

10 NHS England Getting It Right First Time, *GIRFT Neonatology: Guide to safe insulin use*, January 2026 (**https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in-neonatal-services-FINAL-January-2026.pdf**)

11 **Prof. Sir Stephen Powis 17 January 2025 210/10-24**

12 NHS England Getting It Right First Time, *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia*, October 2025 (**https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/07/Laboratory-handling-of-insulin-requests-in-the-investigation-of-hypoglycaemia-guidelines-FINAL-November-2025.pdf**)

13 NHS England Getting It Right First Time, *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia*, October 2025 (**https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/07/Laboratory-handling-of-insulin-requests-in-the-investigation-of-hypoglycaemia-guidelines-FINAL-November-2025.pdf**)

14 **Written Closing Submissions on Behalf of the Countess of Chester Hospital NHS Foundation Trust 4 March 2025 87/para 324**

15 NHS England Getting It Right First Time, *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia*, October 2025 (**https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/07/Laboratory-handling-of-insulin-requests-in-the-investigation-of-hypoglycaemia-guidelines-FINAL-November-2025.pdf**)

Chapter 35. Data – reading the signals

Evidence obtained

35.1 The Inquiry obtained statements from a number of organisations and individuals concerned with the collection and analysis of data about neonates. These include:

a. Professor Richard Feltbower, Professor Elizabeth Draper and Dr Sarah Seaton on behalf of the Paediatric Intensive Care Audit Network (PICANET)[1]

b. Professor Modi on behalf of the National Neonatal Research Database[2]

c. Professor Karen Luyt on behalf of the National Child Mortality Database[3]

d. Dr Edile Murdoch on behalf of the Maternity and Neonatal Outcomes Group[4]

e. Professor Marian Knight MBE on behalf of MBRRACE-UK.[5] Professor Knight also gave evidence to the Inquiry.

35.2 The Inquiry also obtained written and oral evidence from Sir David Spiegelhalter.[6] Sir David is Emeritus Professor of Statistics at the University of Cambridge. His work has been principally as a medical statistician, focusing in particular on methods for monitoring and comparing performance in health services. Amongst other important and far-reaching projects, he led the statistical team on the inquiry into deaths of babies with congenital heart disease at the Bristol Royal Infirmary, and worked on the statistical team for the Shipman Inquiry. He was also a frequent presence on radio and television during the Covid-19 pandemic in 2020 and 2021.

Retrospective audit and real-time prospective monitoring

35.3 In his first statement, Sir David drew attention to the value of "*formal statistical process control*" as a means of monitoring "*adverse clinical outcomes*" and detecting "*clusters of failures*".[7] He described two broad types of system: (a) retrospective audit and (b) real-time prospective monitoring. Retrospective audit involves data collection and aggregation over a period of time, comparison of centres, and results being fed back to centres for

further analysis. The advantages of such monitoring include quality control of data and centralised scrutiny. The disadvantages are that retrospective audit involves historical data, and is not designed to detect "*clusters of failures*".[8] Real-time prospective monitoring, meanwhile, is based on the continuous monitoring of accumulated experience. Sir David describes the advantages of real-time prospective monitoring as a "*strong feeling of local ownership*",[9] the use of accumulated data, and rapid response, with formal monitoring systems to trigger investigation. The disadvantages are that it requires buy-in from centres, rapid access to high-quality data, care in setting parameters and thresholds, and explanation and acceptance of more complex monitoring.[10]

35.4 In practice, real-time prospective monitoring may only report monthly or even quarterly, but still uses methodology that monitors events without regard to annual boundaries. In his second statement, therefore, Sir David said that it might be clearer to label the two types of system as (a) fixed-period monitoring and (b) continuous monitoring.

35.5 Sir David spoke highly of the PICANET system, which is used in paediatric intensive care units in various hospitals. Units submit data to PICANET's online system. In PICANET's written statement to the Inquiry, Professor Feltbower explained that PICANET *"undertakes outlier analysis of risk-adjusted excess mortality compared to the expected mortality based on disease severity at the time of admission using funnel plots"*.[11] Professor Feltbower said that any provider who falls above the upper line of the funnel plot is considered a potential negative outlier, and this triggers an established management process set out in PICANET's Outlier Policy.

35.6 The PICANET system combines fixed-period and continuous monitoring. The results from retrospective audit are provided to units in an annual report that contains data from the previous three-year reporting period.[12] In real time, the system produces resetting sequential probability ratio test (RSPRT) plots, which show the odds of mortality over variable time periods alongside two thresholds. PICANET reviews the plots quarterly in comparison with the thresholds and categorises each unit as either 'satisfactory', 'cause for close monitoring' or 'cause for concern indicating internal review'. Professor Feltbower tells us

that *"RSPRT plots can be accessed at any time by each paediatric intensive care unit and PICANet",* with units supported by guidance to assist them in identifying and responding to potential issues with the quality of care in a time-sensitive fashion.[13]

The role and limitation of monitoring systems in identifying criminal acts

35.7 In oral evidence, Sir David told the Inquiry that the events at the Countess were "*exactly the situation where real-time monitoring … is so vital*".[14] It is common sense that, when it comes to the early detection of a member of staff causing deliberate harm, it is real-time monitoring or continuous monitoring that will be of the most value.

35.8 The case of Harold Shipman provides a stark example. In 2005, Dame Janet Smith DBE found in the Report of The Shipman Inquiry that the GP Shipman killed approximately 250 patients. A major reason for his popularity was his willingness to visit his elderly patients at home. Mr Justice Forbes remarked when sentencing Shipman that none of his victims had realised that Shipman "*brought death; death which was disguised as the caring attention of a good doctor".* Sir David was part

of the statistical team for the public inquiry that examined how events might have been monitored at the time, and whether Shipman's crimes could have been stopped earlier.

35.9 Sir David explained in his oral evidence that, if a continuous monitoring system had been in place at the time, it would have sounded "*a very strong alarm*" after Shipman had killed 40 people.[15] Sir David is clear about the significance of a very strong alarm (or any alarm) and the limitations of statistics. He told the Inquiry that a "*statistical monitoring system cannot say why something has happened … a signal can only indicate that someone should look carefully at what is going on*".[16]

35.10 In 2022, Dr Kirkup's investigation into maternity services in East Kent led to the publication of his report, *Reading the Signals*. Dr Kirkup's first recommendation was the establishment of a taskforce "*to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use*".[17]

35.11 This recommendation led to the creation of the Maternity and Neonatal Outcomes Group. In a statement to the Inquiry, Dr Murdoch

stated that the group's task was to develop a tool that could identify signals about potential critical safety issues in maternity care that could lead to adverse outcomes.[18]

35.12 Dr Murdoch describes a data-driven early warning system in this way:

> "*Safety signal systems work through monitoring real time changes in the trends of defined critical safety outcomes. A signal prompts an early critical review to understand the causes of the signal change.* ***It is the subsequent assessment and review that will identify if there are safety issues to be acted upon*** [emphasis added]."[19]

35.13 As Dr Murdoch says later in her statement, "[a] *safety signal system demonstrates unusual changes in signals* ***but cannot explain why the signal has changed*** [emphasis added]".[20] In the course of insightful oral evidence, as before, Professor Knight similarly pointed out the need for narrative-based medicine alongside statistical analysis. She told the Inquiry: "[**W**]***e have to have both the statistics and the stories*** [emphasis added]."[21]

MOSS and MBRRACE-UK: what data do they collect?

35.14 The safety signal system being developed by the Maternity and Neonatal Outcomes Group is called the Maternity Outcomes Signal System (MOSS).* As with any data system, MOSS has set parameters in terms of the data it is analysing. The data used by MOSS is taken from that gathered by MBRRACE, together with data from the Neonatal Data Analysis Unit in relation to hypoxic ischaemic encephalopathy at birth. The agreed parameters for MOSS exclude pre-term babies (i.e. those born before 37 weeks' gestation) and those who died more than 28 days after birth.[22] Accordingly, in its current form it would not be capable of capturing or identifying any anomalies in relation to the deaths of Baby A, Baby C, Baby E, Baby I, Baby O or Baby P, who were all born pre-term.

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* Its standard operating procedures were updated on 25 November 2025; see NHS England, 'Maternity Outcomes Signal System (MOSS) standard operating procedures', 25 November 2025.

35.15 In her statement to the Inquiry, Dr Murdoch said: "*While there may be benefit in a neonatal outcome signal system, this was not part of Recommendation 1 and based on our current knowledge, there is a good tool already available (the MBRRACE-UK real time data monitoring tool).*"[23]

35.16 MBRRACE undertakes surveillance of all stillbirths, late foetal losses and neonatal deaths (up to 28 days of age).[24] Accordingly, all the babies named on the indictment who died, except Baby I, fell within the parameters of the data that MBRRACE considers.

35.17 Reports are made online to MBRRACE, with responsibility for reporting the deaths sitting within the Trust in which the death occurs. The data provided is analysed and then presented as both a 'crude mortality rate' and a 'stabilised mortality rate' or a 'stabilised and adjusted mortality rate'.

MBRRACE data signals in respect of neonatal deaths at the Countess from 2015 to 2016

35.18 Professor Knight provided written and oral evidence to the Inquiry. Two figures within her written statement (reproduced below as Figures 4 and 5) set out the crude mortality rates and stabilised and adjusted mortality

rates for babies born at the Countess between 2013 and 2016.[25] Professor Knight said that the crude mortality rate reflects the number of deaths over the total number of births in a year.[26] The stabilised rate considers random variation in the rate.[27] She explained that, because perinatal deaths are relatively rare, the numbers are small. This means there can be random fluctuation in the data, which results in big changes in the rate.[28] The adjustment rate, meanwhile, considers differences in the population of women giving birth and the population of babies at different hospitals based on national statistics.[29]

Figure 4: MBRRACE-UK chart – crude mortality rates for babies born at the Countess of Chester Hospital NHS Foundation Trust at 24 weeks or later gestational age, 2013 to 2016

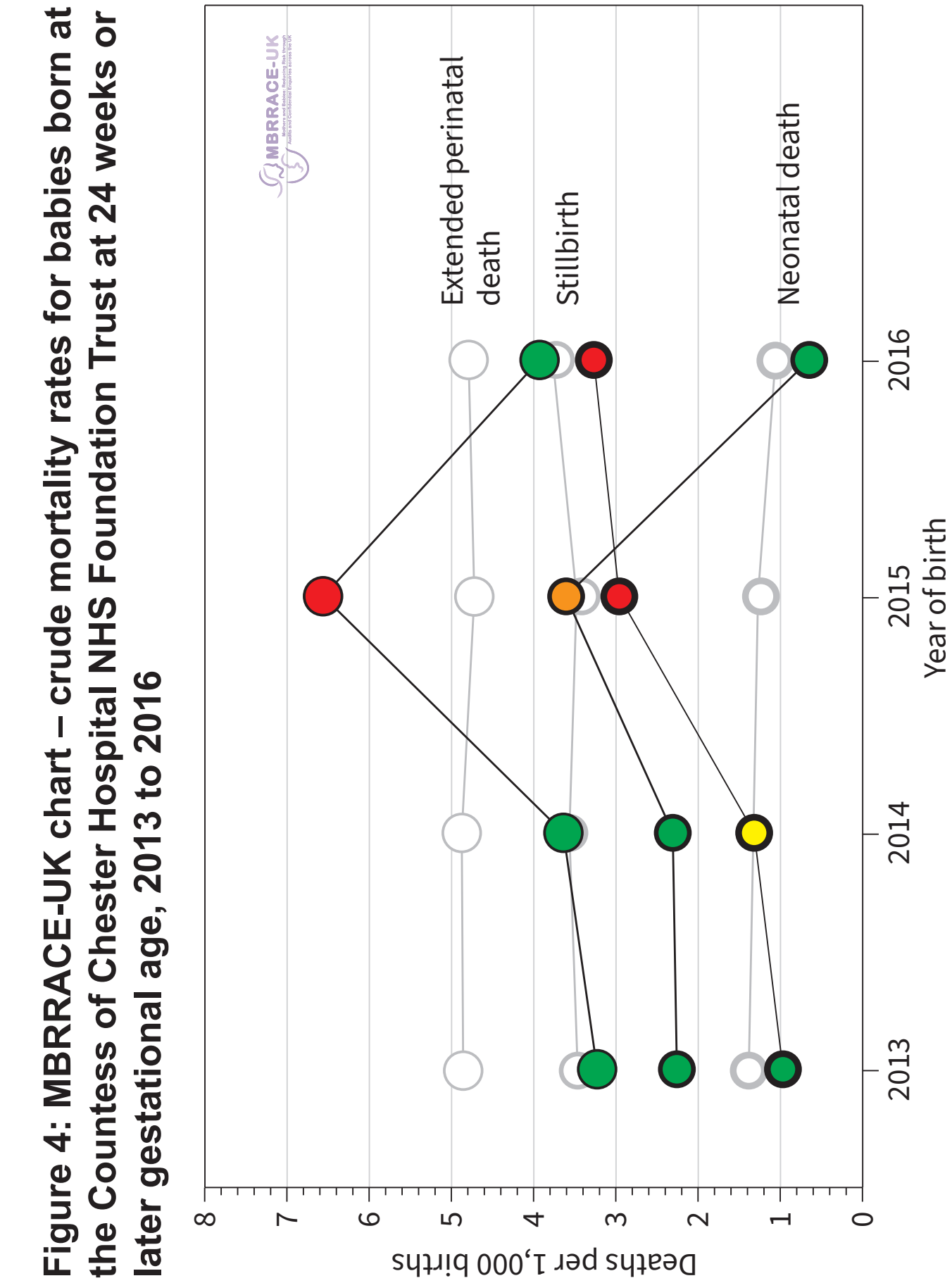
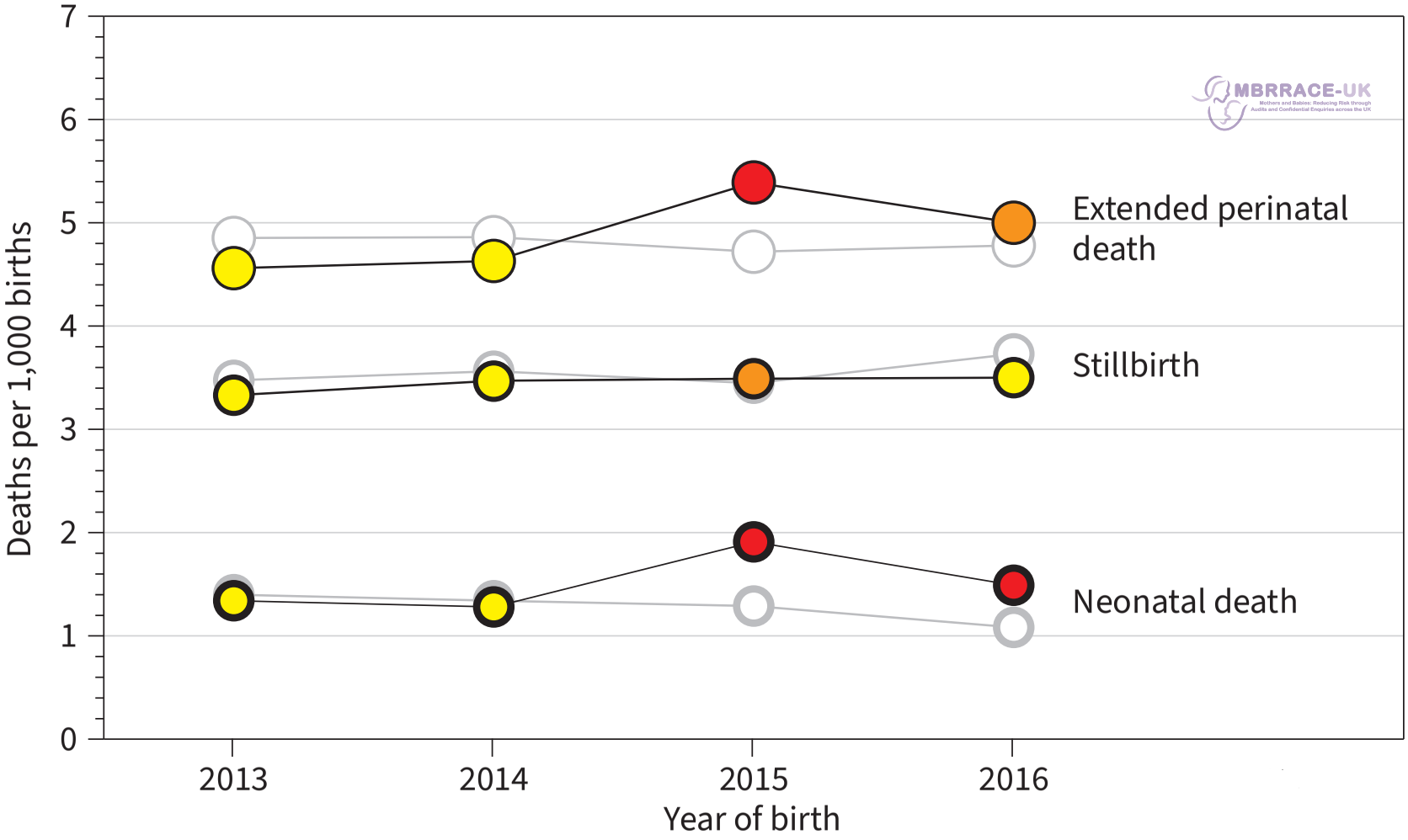


Figure 5: MBRRACE-UK chart – stabilised and adjusted mortality rates for babies born at the Countess of Chester Hospital NHS Foundation Trust at 24 weeks or later gestational age, 2013 to 2016



Source: **Witness statement of Prof. Marian Knight MBE INQ0006757/8/paras 28-30, 20/12/2023**

35.19 Professor Knight explained to the Inquiry that in 2015 and 2016 "*the rate at the Countess of Chester for neonatal deaths* [was] *more than 10% higher than the average for hospitals with similar characteristics in terms of the neonatal care and their birth population*".[30] She characterised this as a signal that the Countess "*should be reviewing in detail the deaths of the babies that occurred in their care*".[31] Likewise, Sir David said of Figures 4 and 5: "[W]e *are particularly interested in red, which means they are estimating it's 10% higher than the average for their -- for their tier for their group. And so for 2015 it concluded more that it was red, more than 10% higher; 2016 up to 10% higher.*"[32] This placed the Countess as the highest in its tier group, which Sir David stated "*would be sufficient to generate a signal and alert warranting investigation*".[33]

35.20 Before he gave evidence, Sir David was sent a document prepared by the Inquiry legal team titled 'Countess of Chester Evidence about the Number of Deaths on the Neonatal Unit Pre-2015'.[34] Sir David considered the numbers of recorded deaths from 2010 to 2016. He explained: "*So the number of deaths between 2010 and 2014, 1, 3, 3, 2, 3, it*

actually shows surprising consistency. I would have expected more variability … Anyway, it went up to 8 in 2015."[35] Sir David concluded:

> "[T]*he probability of getting eight or more deaths in 2015 I assessed to be around 0.008 … that would generally be considered sufficient to trigger an alert signal, someone should look at this locally. But not extreme enough to be considered an outlier and I think this is very useful to put this in perspective.*"[36]

35.21 There was no obvious explanation for the unusual pattern of deaths in 2015 that the data highlighted, and there was a requirement to understand and investigate each death.

35.22 However, the figures provided by neonatal units and hospitals for the year 2015 were analysed and reported by MBRRACE in June 2017.[37] The figures provided for 2016 were reported in June 2018.[38] In oral evidence, Sir David emphasised this "*substantial delay*".[39] Leaving aside for a moment what they were told by medical staff about neonatal deaths at the hospital, in 2015 and 2016 it follows that neither the executives nor the Board at the Countess were aware of the need to investigate neonatal deaths as a result of MBRRACE's monitoring system.

However, by June 2017, when the MBRRACE 2015 report was received (and the unusual rise to eight neonatal deaths was identified), they were.

Current reporting and viewing arrangements

35.23 In oral evidence, Professor Knight explained why MBRRACE's monitoring system takes the time that it does. MBRRACE receives data from a Trust about the deaths of babies in a particular year at the end of that year. It then cross-checks the information provided with data available from the Office for National Statistics. MBRRACE then sends the cross-checked data back to the Trust for data confirmation. Once confirmation has been received, MBRRACE produces stabilised and adjusted mortality rates and prepares its own report. In 2015 and 2016, this process took 18 months; it now takes 14 months.[40]

35.24 In 2019, MBRRACE provided all NHS Trusts and Health Boards with access to a real-time or continuous data viewer, enabling immediate and ongoing monitoring of the stillbirths and neonatal deaths reported to it. In her written evidence, Professor Knight states that this provides a means for responding immediately to any concerning trends.[41] It permits a user to

log on and to look at the most recent figures for their hospital. It enables comparisons with its own previous data to be made. The system is reliant upon timely data being provided by each Trust or Health Board in respect of all baby deaths.

35.25 Professor Knight informed the Inquiry that MBRRACE has no power to mandate that organisations use this tool.[42] She described use of the tool and monitoring of the data as variable. Some organisations use it several times a week; others once every couple of months.

35.26 In September 2021, the Maternity Incentive Scheme was introduced. This scheme includes requirements to notify MBRRACE of all neonatal deaths, stillbirths and foetal losses within 7 days, and to provide additional surveillance data within 30 days. Professor Knight explained that each hospital has a lead neonatal reporter and a lead maternal reporter who are tasked with reporting deaths via the online notification system.[43] Since the introduction of the Maternity Incentive Scheme, Professor Knight says "*we now see nearly 100% of deaths notified within that time*".[44]

35.27 Dr Kingdon (former President of the RCPCH) gave evidence to the Inquiry about the difficulties experienced by clinicians when entering data, because the various hospital systems do not all communicate with each other.[45] When asked about the practicalities, Professor Knight confirmed that, although many hospitals use the electronic patient record system, there is no universal system in the NHS. This makes it "*complex*" to automatically extract data from hospital systems.[46] Thus, MBRRACE uses a manual system, which Professor Knight acknowledged may be a burden for those reporting the data.[47] Professor Knight also confirmed that there had been a move away from the BadgerNet system, saying "[n]*ot everybody uses BadgerNet any more*".[48]

35.28 Sir David was told that the Inquiry had received evidence that the BadgerNet system was no longer being used in some hospitals because other systems could not communicate with it. He lamented the "*lack of [interoperability] of medical systems*" and labelled it as "*an utter disaster in this country*".[49]

Conclusions and recommendations

35.29 I have reflected upon the burden of reporting in respect of two monitoring systems that have an impact upon babies and neonates in hospital. In the end, it is not for me to decide whether two systems are necessary. MBRRACE's remit involves pre-term and term babies. MOSS's remit involves term babies and babies with severe brain injuries. Each monitoring system has set its own parameters with specific, clinical purposes in mind. They have each been designed to identify areas of risk to babies and to highlight where there is any need for investigation. Where there is no clear agreement that one system can achieve the work of both, as appears to be the case, the need for both remains.

35.30 Professor Knight stated that it was a *"worry"* that hospitals will have two different signalling systems; that it may *be "confusing"* and too many signals could mean "*we are not going to be able to see … the most important signals amongst the noise*".[50] Sir David commented that it "*remains to be seen how* [the systems] *might complement each other*".[51]

35.31 Without data monitoring in respect of babies in hospital, trends and areas of safeguarding concern may be difficult to detect. The

collection, analysis and use of statistical monitoring tools is important in the context of highlighting the need to investigate events. Sir David's evidence in respect of Shipman's crimes demonstrates that monitoring tools can identify unusual patterns of deaths and prevent ongoing criminal acts. Despite the numbers being very much smaller, the MBRRACE system also raised a signal in respect of the number of neonatal deaths at the Countess in 2015, and the need for further, rigorous investigation of those deaths.

35.32 To be its most effective in a healthcare setting, data in respect of babies must be accessible in continuous time and should be analysed objectively and dispassionately, with proper regard for the protection of babies in hospital from risks of harm. Healthcare professionals need to understand the importance of data, and the damage to safeguarding if collection of data is slipshod or not prioritised. If data is difficult to input, and its analysis is not relevant or timely, it can too easily appear tedious or pointless for those clinicians who are required to input it.

35.33 It is not possible for me to make findings upon the evidence I have heard about the specific computer systems or technology

available in hospitals to ensure the smooth running of the MBRRACE and MOSS data-monitoring systems. It will be obvious to all that the ability to enter data and to retrieve it should be as simple and time-effective as possible. Systems need to be interoperable. I have heard evidence that a software patch can be put in place in the short term (within three months) to enable this.[52] On behalf of the NHS, it was said there are "*complex data questions*" and "*there's not a timetable for it because it's a national issue*".[53] It is my view that it is urgent precisely because it is a national issue.

35.34 I recommend that NHS England and/or DHSC undertake to provide by 31 March 2027 a clear and timed route to ensuring that computer systems are harmonised across the NHS, so that by December 2028 data relating to babies and neonates in hospital may be entered and reviewed in a timely manner and on a continuous monitoring basis. The timescales are long because of the cumbersome procurement process and the need to get this right first time. There have been too many wasteful NHS technology experiences.

35.35 Following commencement of the Data (Use and Access) Act 2025, both DHSC and NHS England now point to a future mandatory information standard for neonatal care as the solution to the lack of interoperability between data systems, but I have received no timeline for the development nor for the implementation of the standard. In May 2026, I was informed that the mandatory information standard for neonatal care remained at an "*early stage*" (with discovery work completing at the end of June 2026). In this correspondence, it was also reiterated that the Single Patient Record timeline set out in the 10 Year Health Plan still stands. The first stage of this started in April 2026, but again there was no confirmed timeline for the inclusion of neonatal records within the Single Patient Record.

35.36 This is not good enough. The position is urgent. Assuming the evidence I received about the software patch was accurate, that work must be completed to achieve interoperability. It is important that this work on the development of a mandatory information standard with requirements for interoperability between systems is taken forward and implemented as soon as possible.

35.37 Professor Knight suggested that training in the interpretation of the data produced by MBRRACE is necessary. MBRRACE has created training materials and has worked in partnership with MOSS to develop a governance process around the use of the real-time data viewer.[54] Professor Knight also suggested that there should be a pre-determined route to senior management in the event of any concern about trends or patterns, with a view to an action plan being developed.[55] I agree.

35.38 I therefore recommend that hospitals should name a lead reporter with responsibility for inputting data regularly (at least weekly) and logging into real-time data viewers on neonatal and maternity units. Whilst the lead reporter does not necessarily need to be a clinician, they should be someone trained to understand and interpret the available data.

35.39 Furthermore, I recommend that, save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise (a) whether any alerts or a need for investigation have arisen and (b) the investigation or action plan

in place. This should enable Trust Boards to address whether any safety issues identified through monitoring systems are being adequately interrogated.

Endnotes

1 **Witness statement of PICANET INQ0010439**

2 **Witness statement of Prof. Neena Modi INQ0006759**

3 **Witness statement of Prof. Karen Luyt INQ0017157**

4 **Witness statement of Dr Edile Murdoch INQ0106962**

5 **Witness statement of Prof. Marian Knight MBE INQ0006757**

6 **Witness statement of Prof. Sir David Spiegelhalter OBE INQ0008966**; **Witness statement of Prof. Sir David Spiegelhalter OBE INQ0108786**

7 **Witness statement of Prof. Sir David Spiegelhalter OBE INQ0008966/1/para 3**

8 **Witness statement of Prof. Sir David Spiegelhalter OBE INQ0008966/2/para 3**

9 **Prof. Sir David Spiegelhalter OBE 15 January 2025 20/25 to 21/1**

10 **Witness statement of Prof. Sir David Spiegelhalter OBE INQ0008966/3**

11 **Witness statement of PICANET INQ0010439/8/para 23**

12 **Witness statement of PICANET INQ0010439/8/para 23**

13 **Witness statement of PICANET INQ0010439/7/para 20**

14 **Prof. Sir David Spiegelhalter OBE 15 January 2025 45/9-10**

15 **Prof. Sir David Spiegelhalter OBE 15 January 2025 6/20-25**

16 **Prof. Sir David Spiegelhalter OBE 15 January 2025 7/7-8 and 8/24-25**

17 Dr Bill Kirkup CBE, *Reading the Signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation*, October 2022, page 167 (**https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf#page=167**)

18 **Witness statement of Dr Edile Murdoch INQ0106962/7/para 16**

19 **Witness statement of Dr Edile Murdoch INQ0106962/9/para 28**

20 **Witness statement of Dr Edile Murdoch INQ0106962/11/para 36**

21 **Prof. Marian Knight MBE 7 January 2025 31/22-23**

22 **Witness statement of Dr Edile Murdoch INQ0106962/20/para 68**

23 Witness statement of Dr Edile Murdoch INQ0106962/7/para 17

24 Witness statement of Prof. Marian Knight MBE INQ0006757/2/para 3

25 Witness statement of Prof. Marian Knight MBE INQ0006757/8/paras 28-30

26 Prof. Marian Knight MBE 7 January 2025 15/19-21

27 Prof. Marian Knight MBE 7 January 2025 16/4-5

28 Prof. Marian Knight MBE 7 January 2025 15/23 to 16/3

29 Prof. Marian Knight MBE 7 January 2025 16/7-19

30 Prof. Marian Knight MBE 7 January 2025 22/12-16

31 Prof. Marian Knight MBE 7 January 2025 22/19-20

32 Prof. Sir David Spiegelhalter OBE 15 January 2025 37/10-15

33 Prof. Sir David Spiegelhalter OBE 15 January 2025 39/4-5

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35 Prof. Sir David Spiegelhalter OBE 15 January 2025 42/18-22

36 Prof. Sir David Spiegelhalter OBE 15 January 2025 43/12-13 and 43/18-22

37 INQ0006749/91

38 INQ0006750/96

39 Prof. Sir David Spiegelhalter OBE 15 January 2025 38/25 to 39/2

40 Prof. Marian Knight MBE 7 January 2025 17/16 to 19/21

41 Witness statement of Prof. Marian Knight MBE INQ0006757/10/para 36

42 Prof. Marian Knight MBE 7 January 2025 34/1-2

43 Prof. Marian Knight MBE 7 January 2025 12/18 to 13/1

44 Prof. Marian Knight MBE 7 January 2025 8/19-20

45 Dr Camilla Kingdon 12 December 2024 150/19-23 and 151/1-14

46 Prof. Marian Knight MBE 7 January 2025 41/12

47 Prof. Marian Knight MBE 7 January 2025 42/9-10

48 Prof. Marian Knight MBE 7 January 2025 41/25 to 42/1

49 Prof. Sir David Spiegelhalter OBE 15 January 2025 68/4-8

50 **Prof. Marian Knight MBE 7 January 2025 40/1-9** and **36/24-25**

51 **Prof. Sir David Spiegelhalter OBE 15 January 2025 29/15-16**

52 **RCPCH 17 March 2025 139/11-23**; **NHS England 17 March 2025 52/1-8**

53 **NHS England 17 March 2025 52/9-19**

54 **Prof. Marian Knight MBE 7 January 2025 33/22-24**

55 **Witness statement of Prof. Marian Knight MBE INQ0006757/11/para 38**

Chapter 36. The NHS

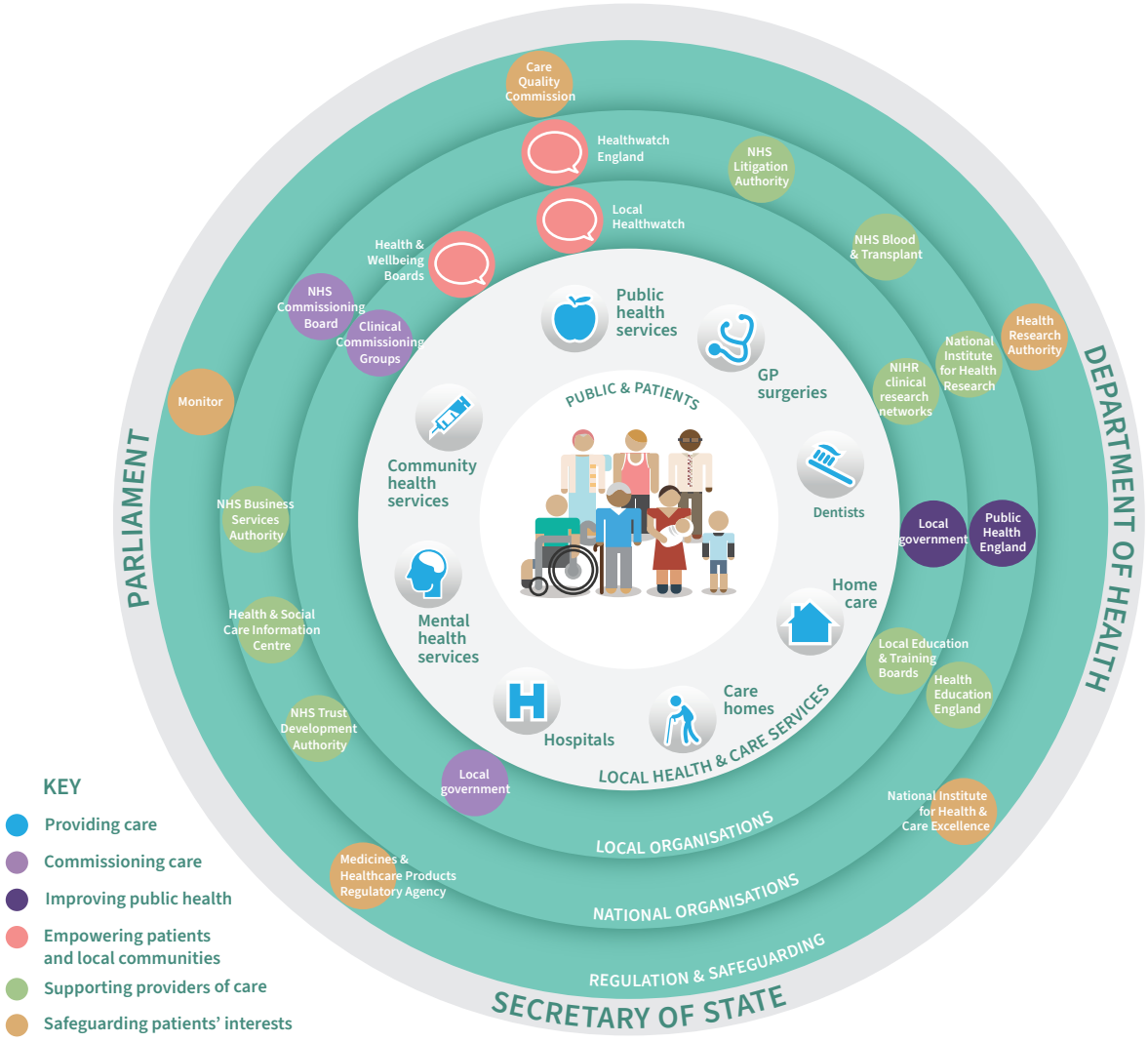
Size and complexity

36.1 The workforce of the NHS is one of the largest on earth: over 1.5 million people working in every healthcare setting, including hospitals, GP surgeries and pharmacies.

36.2 Sir Robert Francis has spent many years steeped in the NHS, including chairing the Mid Staffordshire NHS Foundation Trust Public Inquiry. I am grateful to him for his authoritative and detailed two-part report produced for this Inquiry, which provides a comprehensive overview of the NHS.[1] As many witnesses were later to say, and as Sir Robert Francis reminded the Inquiry at the outset, the NHS is not a single organisation. He described it as a "*series of planets … which together provide a service and I use the word 'together' somewhat loosely*".[2] The NHS was the subject of a large reorganisation in April 2013. The DHSC website hosted a

diagram of the UK's health and care system at that point (see Figure 6). As Sir Robert Francis observed, it placed patients at the centre of the diagram (a good thing) but the structure of the image exemplified the disconnected nature of the NHS: "[A]*ll these bodies seem to go round in an orbit but none of them seem to be connected with each other.*"[3]

Figure 6: The health and care system, April 2013



Source: **INQ0101079/7**

36.3 Further reorganisations had taken place by the time of the Inquiry hearings in 2024 and 2025. In March 2025, it was announced that NHS England was to be abolished, with enormous ramifications for the workforce and for the running of the NHS. It goes without saying that changes in the administrative arrangements of the NHS must always be directed to improving patient care.

A common purpose?

36.4 The NHS Constitution for England asserts that the NHS "*belongs to the people*" and that:

> "*It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.*"[4]

36.5 The constitution contains seven key principles:

a. The NHS provides a comprehensive service, available to all.

b. Access is based on clinical need, not an individual's ability to pay.

c. The NHS aspires to the highest standards of excellence and professionalism.

d. The patient will be at the heart of everything the NHS does.

e. The NHS works across organisational boundaries (i.e. with local authorities and other public sector and private sector organisations to provide and deliver improvements in health and well-being).

f. The NHS is committed to providing best value for taxpayers' money.

g. The NHS is accountable to the public, communities and patients that it serves.

36.6 There then follows a list of NHS values, developed with help from patients, the public and staff. The values "*inspire passion in the NHS and … should underpin everything it does*".[5]

36.7 The values are:

a. Working together for patients

b. Respect and dignity

c. Commitment to quality of care

d. Compassion

e. Improving lives

f. Everyone counts.

36.8 The document explains that, with the national position having been set, individual organisations are expected to "*develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.*"[6]

36.9 I have looked at the statements of values of three NHS Foundation Trusts in different parts of England: University College London Hospitals, The Newcastle Upon Tyne Hospitals and Great Western Hospitals. All three have neonatal units. I also reviewed a further statement of values, from NHS England.

University College London Hospitals

36.10 The short statement of vision and values reads: "*Our mission is to deliver top-quality patient care, excellent education and world-class research.*"[7] The values are: safety, kindness, teamwork and improving. All four values are listed in the NHS Constitution.

The Newcastle Upon Tyne Hospitals

36.11 The values are: care and kindness, high standards, inclusivity, innovation and pride. The last two are not listed in the NHS values but are not divergent from them.[8]

36.12 This Trust has also identified (through consultation with over 1,000 of their staff) 8 'Big Signals'. These are described as "*key issues to address*".[9] They appear to be strategic goals. They are to:

a. prioritise quality of care

b. be a great place to work

c. restore focus on excellence

d. ensure technology supports patient care

e. ensure buildings are fit for purpose

f. take responsibility as a public service seriously

g. develop our commitments to the communities who depend on us

h. be open, honest and transparent about challenges and progress.[10]

Great Western Hospitals

36.13 Great Western Hospitals' Quality Strategy includes the vision to "*deliver great joined up services for local people at home, in the community and in hospital, helping them to lead independent and healthier lives*".[11]

36.14 There are also four pillars, which the Trust aims to be known for. These are: outstanding patient care with a focus on quality improvement; staff and volunteers feeling valued; improving the quality of patient care with partnerships; and using funding wisely.[12]

36.15 There is further detail that aligns with values in the NHS Constitution.

NHS England

36.16 NHS England's statement of vision is "*high quality healthcare for all*".[13] The values listed are collaboration, inclusion, and learning and improvement. Again, these accord with the values stated in the NHS Constitution, despite some changes of language and the use of synonyms. NHS England also expressly endorses the NHS's core values from the constitution and provides a link to that document.

36.17 The values of the (very small sample of) three Trusts and NHS England are consistent with, if not identical to, those set out in the NHS Constitution. Whether the fact that the values in the constitution have not been replicated entirely by any of the organisations may indicate that some of the values are no longer considered relevant, I cannot say. This is something to be addressed when the constitution is reviewed after ten years, as required by section 3(3) of the Health Act 2009.[14]

36.18 It is clear that the excellent local statements of values require significant time and effort to prepare. What is not clear is whether the quality of care is different (and better) than it would have been had the hospitals simply adopted the values set out in the NHS Constitution. The same applies to the NHS England document.

36.19 At a time when the pressures on the whole workforce are enormous, I would suggest time (managerial, medical, nursing or other) should not be devoted to any task that does not improve patient care, or at least maintain it to a good standard. I suggest that the drafting of

mission statements/values/vision statements should be given lower priority than tasks that have been shown to improve patient care.

Too many targets

36.20 Hospitals are on the receiving end of a relentless flow of targets, directives, guidance and other documents from the centre – i.e. ministers, DHSC and NHS England. A number of witnesses expressed the view that there are too many targets. The Rt Hon. Jeremy Hunt MP, a former Secretary of State for Health, referred to "*too many targets*", noting that "*a Chief Executive of a hospital will be assessed against possibly 100 targets every year*" and expressing the concern that this "*crowds out the opportunity for longer term strategic changes*".[15] General Sir Gordon Messenger also referred to the large number of targets, many being politically driven, noting that whilst some consider them "*the stepping stone to better productivity*"[16] others take the view that there are too many targets and that when "*everything is important, then nothing is important*".[17] This is obviously correct. The Rt Hon. Professor the Lord Darzi of Denham OM KBE echoes these views in a 2024 report, observing: "*As the Hewitt Review pointed out, there are too many targets set*

for the NHS which makes it hard for local systems to prioritise their actions or to be held properly accountable."[18]

Too many regulators

36.21 A number of witnesses, including Dr Benneyworth, Sir Robert Francis and Professor Dixon-Woods, referred to a 2019 paper in the *British Medical Journal* titled 'Patient safety regulation in the NHS: Mapping the regulatory landscape of healthcare'.[19] This found that there are "*up to 126 organisations that exert regulatory influence*" on NHS providers.[20] That is an eye-catching number. Even for such a huge organisation as the NHS, it is unlikely that so many regulators are necessary. Dr Benneyworth put it more diplomatically: "[T]*he message from* [the paper] *is absolutely clear in that we have a very complex expansive landscape for patient safety.*"[21] She thought it is important to think about the impact that all the organisations collectively have on local systems. She asserted local systems need to be empowered to deliver good care, and this might require the "*rationalisation of organisations*".[22] However, she also stated: "[S]*omething we could do much quicker than* [rationalisation] *is about how*

we collaborate, how we work together, how we coordinate things much more formally across the system."[23] That is a commendable proposal and I support it. At the same time, the practical outcome of the abolition of NHS England should include a significant reduction in the number of regulatory bodies. To achieve that, an informed analysis of what they all do should be prepared then reviewed, and decisions taken about which bodies are necessary, which can be amalgamated and which can be abolished. Those that remain must be properly staffed.

36.22 Dr Benneyworth pointed out that Dr Dash had again been commissioned by DHSC to conduct "*a review into the patient safety landscape*".[24] Dr Dash, who qualified as a doctor, took up the post of Chair of NHS England in July 2025, but until then she was for many years an independent management consultant who produced a number of reports for the NHS (see Chapters 40 and 42). On this occasion, she was asked to consider the functions and future roles of six organisations: CQC, HSSIB, the Office of the Patient Safety Commissioner, the National Guardian's Office, Healthwatch England and Local Healthwatch, and the patient safety learning aspects of

NHS Resolution.[25] Dr Dash's report was published in July 2025, shortly after she took up the post of Chair of NHS England.

36.23 Notwithstanding the commission to review patient safety with particular reference to six organisations, Dr Dash stepped back and considered what she describes as "*the overall quality of care*". This, she explains, includes safety, effectiveness and patient experience, as well as accessibility, equity and efficiency. Safety means "*those who receive care are not harmed avoidably in the process*". Effectiveness means that "*evidence-based care is provided to those who need it, while low-value care is minimised*". Positive patient or user experience means that "*people have a good experience of care that is responsive to and respectful of their needs, values, preferences and cultural background*".[26] Perhaps assessment of the outcome should be included in that definition.

36.24 Strikingly, Dr Dash points out that there has been more focus – and therefore more funding – for safety, that is, more staff and more supervisors, particularly in hospitals. However, this has led, she says, to only a limited improvement in safety. Effectiveness and other aspects of the quality of care

have received "*relatively less attention or resource*".[27] She advises that money should be spent where it will have the most impact and says there should be greater focus on community care with a view to improving health and so reducing the need for acute care. These are complex issues and I can see the judgements that need to be made when planning for a future where there is (hopefully) a reduced need for acute care compared with the position now, where safe care (e.g. in maternity wards) is not a given in many hospitals. Throughout the evidence to this Inquiry, from every expert and every witness, there was an acknowledgement of the fundamental importance of the safety of the patient. If spending money on safety has not achieved greater safety then scrutiny is required of what the money was spent on and to what purpose, with a view to directing resources, of all types, to the things that do work. Staying with the maternity example, there are very few NHS hospitals where maternity services are rated outstanding by CQC and about one-third where they are rated good. However, over 60% of hospitals are in neither of those categories and require improvement.[28] As the recent reports of Baroness Amos LG CH and Ms Donna

Ockenden make plain, a great deal of urgent work is needed to keep mothers and babies safe in hospital.

36.25 CQC describes safety as their number one priority.[29] At a time of real concern about certain areas of care (maternity care in particular), people need to know that is the case. Given the history of CQC (as I have set out in Chapter 7), I am not confident that the statement that safety is their number one priority will lead automatically to a situation where safety is a reality. A great deal of sustained improvement is necessary. There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Select Committee, initially once a year and, once the committee is satisfied, it should move to once every three years, or such other frequency as may be agreed between the NHS and the select committee.

36.26 One of Dr Dash's recommendations that has now been taken forward is the abolition of the National Guardian's Office. I deal with this in Chapter 40.

Too many documents

36.27 As is very well known and is clear from this Inquiry, many thousands of hours are spent across the NHS on administrative tasks that make no difference to the quality of patient care, including the production of lengthy documents of questionable value that there is no time to read.

36.28 There is a multiplicity of guidance (clinical and non-clinical) which is sent out in large quantities. This is, I assume, essential for those carrying out clinical duties as they are expected to keep up to date with guidance as well as developments in their fields of practice. To that documentation may be added codes of conduct for medical and other professionals, reports and reviews (local and national), in addition to all the necessary documentation generated in the course of patient care. The fact that much of this is online disguises its volume. Everyone working in a hospital knows there is too much to read. A certain amount of documentation is required, of course, but a moment's thought reveals the time spent in producing a document: it is typed, proofread (although not always), approved and uploaded to the internet. When such documents were printed,

there was an inbuilt discipline to keep the length within reasonable bounds because of the cost of printing. The digital age means that documents can be as long as the writer wants them to be, with no concern for the reader.

Drafting by committee

36.29 It is not unfair to observe that too many documents are drafted by committee. The effect of that is this: a dozen people (stakeholders) spend several hours over several months talking about what the document should contain. Then they draft it. It will be many pages long. To shorten it would take more of the committee's time, so that rarely happens. Each hour saved by the committee leads to hundreds of hours spent by overstretched healthcare workers grappling with overlong and over complex documents. They are read 'in their own time' (i.e. outside of working and paid hours). It is an invisible subsidy of the NHS by its staff. Leaving aside the data centre requirements for the unrestricted production of documents to be distributed to thousands of people at the press of a button, information overload is real. The production of more documents than can be read is futile – and eye-wateringly extravagant of staff time.

36.30 I shall look at some current documents later in Part Two.

36.31 The focus in the reorganisation that is to result in the abolition of NHS England must be on identifying and then resourcing those tasks that will make a positive difference to the experience and outcomes of patients in hospital. Then there should be sufficient staff retained within the restructured DHSC/ NHS England and in Trusts to deal with those tasks, **and** sufficient support staff for all those (nurses, doctors and non-clinical staff) who have managerial and leadership roles as well as their clinical roles. Health professionals with managerial roles in addition to clinical duties must be given protected time – not just within their job plan, but in reality.

Endnotes

1 **Expert Report by Sir Robert Francis KC – Part 1 30 May 2024 INQ0101077**; **Expert Report by Sir Robert Francis KC – Part 2 30 May 2024 INQ0101079**

2 **Sir Robert Francis KC 30 September 2024 5/7-10**

3 **Sir Robert Francis KC 30 September 2024 23/7-8**

4 DHSC, *The NHS Constitution for England*, 17 August 2023 (**https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england**)

5 DHSC, *The NHS Constitution for England*, 17 August 2023 (**https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england**)

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8 The Newcastle upon Tyne Hospitals NHS Foundation Trust and Group, *Annual Report and Accounts 2024/25*, page 9 (**https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2025/07/The-Newcastle-upon-Tyne-NHS-Foundation-Trust-Annual-Report-and-Accounts-2024-25-FINAL.pdf#page=9**)

9 The Newcastle upon Tyne Hospitals NHS Foundation Trust and Group, *Annual Report and Accounts 2024/25*, page 9 (**https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2025/07/The-Newcastle-upon-Tyne-NHS-Foundation-Trust-Annual-Report-and-Accounts-2024-25-FINAL.pdf#page=9**)

10 The Newcastle upon Tyne Hospitals NHS Foundation Trust and Group, *Annual Report and Accounts 2024/25*, page 61 (**https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2025/07/The-Newcastle-upon-Tyne-NHS-Foundation-Trust-Annual-Report-and-Accounts-2024-25-FINAL.pdf#page=61**)

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12 Great Western Hospitals NHS Foundation Trust, *Quality Strategy 2022–2026*, page 2

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13 NHS England, 'What we do' (**https://www.england.nhs.uk/about/what-we-do/#:~:text=Our%20mission,population%20and%20the%20wider%20economy.**)

14 Health Act 2009, section 3(3) (**https://www.legislation.gov.uk/ukpga/2009/21/section/3**)

15 **Rt Hon. Jeremy Hunt MP 9 January 2025 228/11-23**

16 **Gen. Sir Gordon Messenger 8 January 2025 160/10-11**

17 **Gen. Sir Gordon Messenger 8 January 2025 160/14**

18 The Rt Hon. Professor the Lord Darzi of Denham OM KBE, *Independent Investigation of the National Health Service in England*, September 2024, page 126, para 31 (**https://assets.publishing.service.gov.uk/media/6a05a27e97000cb6073e4dd8/lord-darzi-independent-investigation-of-the-national-health-service-in-england-updated-14-May-2026.pdf#page=130**)

19 Eirini Oikonomou, Jane Carthey, Carl Macrae and Charles Vincent, 'Patient safety regulation in the NHS: Mapping the regulatory landscape of healthcare', *British Medical Journal*, 9:7

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20 **Dr Rosie Benneyworth 8 January 2025 39/3-4**

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22 **Dr Rosie Benneyworth 8 January 2025 53/11**

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Chapter 37. Training and regulation of managers

Managers in NHS Trusts

37.1 The pressure on the NHS now is probably greater than it was in 2016. Between then and now, the NHS has faced, and only just survived, the pandemic.[1] The pressures on many staff – clinical, management and otherwise – remain relentless. The population is ageing, rates of obesity are soaring. There is a shortage of doctors and nurses.

37.2 General Sir Gordon Messenger, co-author of the independent report *Leadership for a Collaborative and Inclusive Future*[2] (the Messenger/Pollard report), said in evidence that the NHS workforce faces "*eye-watering pressure*".[3] He said that people are working very hard, with a reduction in investment in managers and too many people working too hard with little support. It was his opinion that there were some very good leaders in NHS hospitals. He also said that there are too

many people who reach the top of the NHS without having the proven credentials or skills. At the same time, there are people within the NHS who do have the necessary skills and abilities to lead but who do not get to the top because they do not get the opportunity. Lord Darzi conducted a rapid review of the NHS in 2024.[4] He acknowledged the generally held view that there are too many managers in the NHS, but considered: "*The problem is not too many managers but too few with the right skills and capabilities*."[5] It may be that both statements are true. No one could argue with the proposition that the NHS needs but does not have sufficient managers with the right skills.

37.3 I refer in this chapter to chief executives and board-level directors in NHS Trusts as senior managers. I acknowledge that there is an element of leadership in many management roles at all different levels.

Core purpose of a hospital

37.4 In the multiplicity of mission statements, statements of values, visions etc emanating from all corners of the NHS and elsewhere, it is easy to lose sight of what a hospital is for. Stripped to its essentials, the core

purpose of a hospital is to diagnose accurately and treat effectively patients with illnesses, conditions and diseases, and to care for those patients with kindness and respect. Discussion between doctors/nurses and patients about appropriate treatment is part of effective treatment and respect. The need to keep patients safe is fundamental.

37.5 The purpose of a neonatal unit is to look after and, where necessary, treat babies who need more care than is ordinarily available in a post-labour ward. From the evidence to the Inquiry and from the public discourse, it is plain that parents want to be in partnership with the doctors and nurses, and expect to be – and should always be – consulted about the nature and duration of any treatment of their baby and kept informed of the baby's condition and progress. They, too, as well as their babies, should be treated with kindness and respect. A range of healthcare professionals provide diagnosis, treatment and care throughout the hospital.

Senior managers' responsibilities

37.6 For many years, much management time in the NHS was taken up with the workings of the NHS internal market. First introduced by

the National Health Service and Community Care Act 1990, this separation of health service purchasers (commissioners) from providers (hospitals) was intended to introduce competition, efficiency and patient choice. It continued to be developed as a model for the NHS up until the Health and Social Care Act 2012. These requirements are now significantly reduced.

37.7 Fundamentally, the role of the senior managers in a hospital is to make sure that the core purpose of the hospital is achieved. It is the responsibility of senior managers to make sure that those whose direct responsibility it is to treat and care for the patients (doctors, nurses and other healthcare staff) are sufficient in number and suitably qualified, and have the tools to diagnose, treat and care for patients. In brief, senior managers are responsible for the provision of clean and well-maintained buildings, properly equipped wards, operating theatres, medical supplies and administrative support, and must deal with problems that have an adverse impact on those core functions. This requires, particularly for the most senior managers and leaders, close collaborative working with clinicians, involving strategic thinking, planning, obtaining sufficient funds

from NHS England or elsewhere, identifying projects which require fundraising, careful stewardship of the hospital's financial resources, assessing priorities, leading improvement (digital and otherwise), leading teams, innovating, and making sure that the hospital is fit to meet its core purpose, both now and in the future. I acknowledge that this is an oversimplification of a complex role that is more than the sum of the tasks and outcomes. In addition, hospital senior managers must raise their heads above the hospital for which they are responsible, and consider and contribute to the broader NHS, for which senior managers within NHS England are responsible.

37.8 Decisions on how to spend (or save) money are difficult. The non-executive directors included accountants, and people with experience in business. The annual reports of the Countess make plain that there was a strong emphasis on finance.[6]

37.9 Sir Rob Behrens, former Parliamentary and Health Service Ombudsman, said in evidence that the Kirkup report on East Kent and the Ockenden report on Shrewsbury and Telford NHS Trust have shown unpleasant working environments where staff do not

feel leaders respect what they are doing. He pointed out that "*they don't feel that leaders actually have respect for what they are doing*" and "*the issues about staff welfare and about the culture of organisations have taken second or third place to issues around productivity, finance and staffing and while that is understandable, it's not acceptable*".[7] He suggested that the way to make people feel more valued comes down to leadership, resources and regulation.

37.10 Whilst being good at securing and controlling the money is an essential consideration when running any hospital, it is not the only one. A sound understanding by senior managers of what the people working in the hospital (doctors, nurses and all involved in clinical care) actually do – and why – is also essential. Without it, there can be no real collaborative working, which is essential for making properly informed decisions about spending. This should be part of management training (see below, paragraphs 37.20 to 37.23) and, consistent with this, every NHS Trust board should have amongst its non-executive directors at least one qualified doctor and one qualified nurse in addition to at least one of each profession as Executive Directors. Both Dr Gilby, who took over from

Mr Harvey as Medical Director and then from Mr Chambers as Chief Executive in 2018, and Ms Tomkinson, who took over as acting Chief Executive initially in 2022, and substantively from 2024, considered there should be senior clinicians on the Board.[8] I would add that there should be respect as between the different professions and between the professions and the managers. There is no place for unquestioning loyalty to your team.

Recruitment

Doctors

37.11 The standards for the qualification and recruitment of doctors are very exacting. High academic achievement, often an aptitude test, a proven record of volunteering and a demonstrable interest in health or social care are the minimum standards expected for entry to medical school. The competition is fierce. The same is true for the postgraduate medical degree. The university courses are demanding and lengthy (between four and six years). After that, the newly qualified doctors work for two ‘foundation’ years as resident doctors somewhere in the UK. Next, if they can secure a post, they embark on a training programme that lasts between six

and ten years. If successful, they will become first a registrar, then a senior registrar, and ultimately a consultant. Leaving aside the question of shortages of training places and consultant posts, which is outside the scope of this Inquiry, it is sufficient to say that not all resident doctors will obtain consultant posts, notwithstanding about 15 years of training.

Nurses

37.12 Nurses are generally expected to hold a degree in Nursing, as was the case at the Countess. Such a degree takes three or four years and its entry requirements include three good grades at A level and five GCSEs. Nurses in the NHS are expected to work shifts (including at night), to attend courses and to acquire specialist skills in order to progress.

Recruitment and training of managers

37.13 There is an NHS graduate management training scheme. It is acknowledged to be excellent and attracts good candidates.[9] This would be expected to produce very good managers and leaders over time, and I was told it does.[10] It is open to graduates with a 2.2 degree in any subject.

37.14 Until now, there have been 250 places a year on the NHS graduate training scheme, divided into various specialisms and areas of management.[11] There is stiff competition for places. The training takes two years, during which the trainee is paid, and is expected to study outside of working hours. All materials are paid for by the NHS. The 10 Year Health Plan for the NHS launched in July 2025 has promised an increase of 50% in the number of training places on this course.[12] That is to be welcomed. A job in the NHS for those completing the training is assured.

37.15 Other routes into management are available and well used. Many doctors have management roles at different levels. Some become medical directors and a few chief executives. Many nurses and some midwives also move up to board level, including becoming chief executives, with varying amounts of financial and other support and training from their employers. I note that the Royal Berkshire NHS Foundation Trust now has 150 staff members accredited through the Chartered Management Institute's Chartered Manager scheme.[13] Mr Chambers' path was not untypical. He trained as a nurse at Bolton College (before nursing was a degree-only profession). He nursed for a short period, then

took a degree in Media and Communications and a postgraduate diploma in Health Services Management, before becoming a hospital bed manager. He subsequently took on further and more senior management roles and eventually was appointed Chief Executive at the Countess. Over the years, he attended a number of professional development programmes run by the NHS.

37.16 Professor Judith Smith is Professor of Health Policy and Management at the Health Services Management Centre at the University of Birmingham. She has worked in health services, research, evaluation and development since 1995. Prior to that, she had been a senior manager in the NHS, having undertaken the NHS graduate training scheme.[14] She expressed the view that those who step onto the management ladder other than from the graduate training scheme do not receive the same quality of training as those on the scheme. In particular, she pointed to the lack of opportunities to work in different areas and the lack of networking available compared with those on the graduate training scheme.[15] Leaving aside whether, as Professor Smith explained, that is unfair to the trainees, if the outcome is that the non-graduate-scheme trainees are less

well trained, and likely to be less good at what they do, this is detrimental to the NHS. It may also lead, as Sir Gordon identified, to talented people not reaching higher-level management[16] – which is not good for the NHS and, ultimately, its patients.

Succession planning

37.17 The evidence from Sir Gordon and others was that the NHS is not good at identifying and developing future senior managers.[17] There must be a clear-eyed commitment to recruiting the best and then training them appropriately. Academic qualifications do not equate automatically (or sometimes at all) to the ability to manage and lead. As an NHS user and from the evidence heard during this Inquiry, it appears to me that any prospective senior manager must be able to demonstrate the ability to think analytically, to think and work strategically, to understand organisations and finances, to always be looking for ways of improving how things are done, to innovate – and, importantly, to get things done, including complex technology/digital programmes. At all levels, managers will need to be inspirational leaders, of small and then larger teams, progressing as they gain experience. These attributes should be assessed over

time. If managers in the most senior roles in a hospital are not up to the job, there will be no respect, no collaborative working and resentment. All of this destroys morale. It is imperative to recruit able people, train them properly and retain them.

37.18 There has to be a well-understood route to identifying and bringing on people of ability. This will include significantly increasing the opportunities for potential managers who do not arrive via the graduate training route, while ensuring that there is no decrease in opportunities for those on the graduate training scheme. It is all about providing the best managers in the interests of patients.

37.19 Where doctors and nurses take on management roles, they, too, ought to receive good-quality training. Dr Brearey made the point that he received none in his risk management role on the neonatal unit (nor was the 25% protected time for management a reality). This was the common position in many of the professions for decades, but it is not the position now, and it should not be the position in the NHS either. I understand that it is expected that the provision of the

NHS Leadership Academy will be expanded. I note that in two NHS regions there are two NHS leadership schemes.[18]

37.20 All doctors and nurses, irrespective of their management ambitions, should have a basic education in the workings of the NHS, how it is funded and, at least in their workplace, who does what. This should be part of the undergraduate training – and subject to examination. Continuing professional development should include this. This, too, will improve cohesion and collaboration.

37.21 All non-clinical managers should receive training about what the doctors, nurses and other health professionals in the hospital do, how they do it and what challenges they face. As I have said already, this understanding is fundamental to effective team working.

37.22 Effective and practical joint training should be provided to clinically qualified and non-clinically qualified managers and potential managers. With good will, this would bring down barriers between managers from different backgrounds and increase levels of trust.

37.23 Since references to 'them and us' attitudes continue to persist when people talk about the NHS, effective training must be directed towards changing the behaviours that perpetuate those divisions. It should be unthinkable that, as happened at the Countess, when a department is under strain, the nursing managers should turn on the doctors. The reverse would be equally unacceptable, as would managers turning on nurses or doctors and vice versa. The training will be successful if it is clearly demonstrated to be well thought through, capable of being effective and well delivered. It would have to be compulsory.

37.24 Sir Gordon suggested that there should be an induction guide for every new manager joining the hospital.[19] He also underlined the importance of putting an "*organisational arm around*" the shoulder of the new recruit.[20] I would suggest that, if such a guide proves to be useful to new recruits, it ought to be offered to all existing members of staff. It does no harm for staff to know what the new recruits are being told and to be reminded of what their hospital is all about. The purpose of the exercise would be to inform individuals and to improve cohesion: everyone receives the same message. As Sir Gordon put it,

the message to the new recruits is that you are "*embarking on a profession that matters a great deal to the organisation*".[21] That message should be given to all those working in the organisation, not just new managers. It should remind everyone of their common purpose, a statement that each individual is doing something important that matters to the NHS and the patients being cared for. It is about being part of something that matters.

Regulation

37.25 Doctors are regulated by the GMC and they are subjected to full revalidation, which is an onerous process, every five years. The regulator is funded by the doctors. Where a doctor is found to have committed serious misconduct, they are liable to disciplinary action, including dismissal, and to being referred to the GMC, where they may be found unfit to practise and so erased from the register. This prevents the doctor from pursuing their chosen profession anywhere in the UK.[22]

37.26 Nurses are regulated by the NMC (for which they pay a fee) and are required to renew their registration (currently described as revalidation; see Chapter 18) every three

years. In the case of serious misconduct, a nurse is liable to disciplinary action within the Trust, including dismissal, referral to the NMC, and removal from the register. This prevents the nurse from pursuing their chosen profession anywhere in the UK.[23]

Regulation while in a management role

37.27 Both nurses and doctors who move into management remain subject to regulation by their professional bodies when carrying out their management roles, as well as when carrying out their clinical roles. Managers who are not clinically qualified have never been regulated.

37.28 There is some law on the question of the extent of the applicability of *Good Medical Practice* (the code of conduct for doctors) when a doctor is acting in a managerial capacity or in the fulfilment of any managerial function they might have. In *Roylance v GMC [2000] 1 AC 311*, the Privy Council held that a doctor, who had been the Chief Executive of the Bristol Royal Infirmary, was liable to be erased from the profession for failing to respond appropriately to concerns that had been raised about increased infant mortality

in the performance of cardiac surgery, irrespective of the fact that he himself had not performed any of the care under scrutiny.[24]

37.29 Sir Robert Francis referred to this case in his oral evidence. He stated:

> "[T]*he sad thing is that if a doctor is brave enough to become a Chief Executive of a Trust and acts in a way which is contrary to the patient's interests, the GMC can, and occasionally has -- it happened to the Chief Executive of Bristol being hauled up before the General Medical Council for their conduct as the Chief Executive because they will be involved inevitably in a breach of the Code of Conduct of a doctor. There is … no such procedure for the non-clinical manager and the result I'm afraid is that people who haven't done terribly well, one way or the other, may leave one job. You will then find they crop up in another job because there is no overall certification as to whether someone is a fit and proper person at any given time to do these roles.*"[25]

37.30 The decision of the High Court in *R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin)* was that there are some roles that are so far

removed from practising medicine that the GMC's fitness to practise procedures do not apply to them. However, it points out that medical professionals are still accountable to the GMC when they are performing a wide range of clinical management roles (for example, as a Clinical or Medical Director) or other non-clinical roles (for example, as a medical educator or researcher), even if medical knowledge or expertise is not needed for the roles (for example, as the Chief Executive of a hospital).

37.31 Thus, where, for example, the Chief Executive (non-clinically qualified) of a hospital and the Medical Director both fail to act upon concerns about mortality in the hospital, only the Medical Director is subject to regulatory action. It is easy to understand why the current state of affairs is considered by many to be unfair. It is worth pointing out that, whilst the unfairness to the individuals is obvious, it is ultimately unfair to patients.

Unregulated managers

37.32 Those managers who are neither nurses nor doctors are not regulated. Part of the reason for this is historical. I heard evidence from Mr Ken Jarrold CBE, a health service

manager and the Chair of the working group that produced the *Code of Conduct for NHS Managers*. Now retired, he had vast experience of management within the NHS over decades. After graduating with first-class honours from the University of Cambridge, he joined the NHS in 1969 as an administrative trainee. He went on to hold increasingly senior posts and lived through the changes in posts from administrators, to general managers (after the Griffiths report – *NHS Management Inquiry*),[26] and then to leaders. He had been part of the system when competition and the internal market were introduced and when there began to be greater recruitment from outside the NHS. He was an impressive witness who had deep experience and understanding of the NHS. He explained that management, unlike nursing and medicine, is not a profession.[27] There are no necessary qualifications, no professional body, no code of conduct and, in most places, including the NHS, no regulation. It follows that, until now, there has been no difference between being a manager in the NHS and a senior manager or leader of a company, listed on the FTSE 100 or otherwise. Their work and conduct is

governed by their contracts of employment. The same applies to non-clinically qualified managers in the NHS.

Accountability and regulation

37.33 The Terms of Reference require me to consider whether, and if so how, the accountability of senior managers should be strengthened. One very effective way of improving accountability is to regulate. The question as to whether to regulate managers has been considered, ignored and reconsidered for decades.[28] Scores of recommendations have been made and mostly ignored.

37.34 The report of the inquiry into Bristol Royal Infirmary (the Bristol report) made comprehensive recommendations about the regulation and oversight of NHS managers in 2001.

37.35 Recommendations 39, 70 and 91 called for the regulation of staff, the formalisation and standardisation of training, and continuing professional development.[29]

37.36 Since 2001, far-reaching action has been taken in respect of clinical staff:

- The GMC and Postgraduate Medical Education and Training Board merged in April 2010 to create a single regulatory body overseeing all stages of medical education and training.
- Doctors' revalidation was introduced in December 2012. This process is considered the gold standard for professional revalidation.
- The civil standard of proof now applies in fitness to practise cases, and there is increased lay involvement in the regulatory process.
- Education standards for nurses changed in 2009 and revalidation (in fact, renewal of registration) was introduced in 2016.
- Professional standards for clinical staff have been updated to reflect learnings from reviews and inquiries.

37.37 The Bristol report's recommendations in respect of managers, although accepted over two decades ago, were not acted upon – in particular, the recommendations that there should be a senior managers' professional body (70)[30] and that managers' regulation should be aligned with that of healthcare professionals (39, 91).[31] Even the current

government proposals on regulation, to which I refer below, do not come near to meeting these important recommendations.

37.38 Recommendation 91 of the Bristol report stated: "*Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals, including being subject to a regulatory body and professional code of practice.*"[32]

37.39 DHSC responded at the time (20 years ago): "*We agree in part. We do not think it is practical to establish self-regulation for senior managers. We do agree that the standards expected of senior NHS managers should be explicit. We favour a code of conduct, stronger performance management and tighter contracts rather than regulation*."[33] All three of those matters – code, stronger performance management and tighter contracts – remain necessary, and the first is in its early stages (see paragraphs 37.92 onwards below).

37.40 Following publication of the report (in July 2001) and the government response (in January 2002), Mr Nigel Crisp KCB (later Lord Crisp), then Chief Executive of the NHS and Permanent Secretary to the Department of Health, asked Mr Jarrold to write the code of conduct for senior NHS managers. Mr Jarrold

was the right person to be invited to produce this. He did so having brought together a working group that included representatives of the British Association of Medical Managers, an organisation which, Mr Jarrold said, did excellent work in preparing clinicians for management roles.[34]

37.41 The code of conduct was launched in October 2002. The following are the central points:

> "*As an NHS manager, I will observe the following principles:*
>
> - *make the care and safety of patients my first concern and act to protect them from risk;*
> - *respect the public, patients, relatives, carers, NHS staff and partners in other agencies;*
> - *be honest and act with integrity;*
> - *accept responsibility for my own work and the proper performance of the people I manage;*
> - *show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;*
> - *take responsibility for my own learning and development.*"[35]

37.42 Simultaneously, Mr Crisp launched a wider piece of work, *Managing for Excellence in the NHS*. Mr Jarrold commended the work, which expressed strong support for the code, management development and management standards.[36] He considered at the time: "[I]*f we are going to help managers to behave differently and better, then we have to address the fundamental issue from the Kennedy* [Bristol] *Report.*"[37]

37.43 Mr Jarrold informed this Inquiry that the text accompanying the code stated it should be incorporated into the employment contracts of all senior managers at the earliest opportunity and that systems should be in place to fairly investigate any breaches of the code. This did not happen – and the NHS, as Mr Jarrold put it, became "*consumed with the awfulness of Stafford*".[38] As so often, the NHS moved on with business unfinished. Some 25 years have passed since then.

37.44 The code of conduct drafted by Mr Jarrold is clear and simple. It does not include reference to diversity, to candour or to the Nolan principles, all concepts that were not specifically recognised 25 years ago and could easily be added to the code as drafted, together with a section on the need for

reflection. I am not persuaded that anything more elaborate is needed by way of a code of conduct for managers of all backgrounds, clinical or otherwise.

37.45 Mr Jarrold's aim in writing the code was to make it clear that every senior manager should be able to say: "*I will make the care and safety of patients my first concern and act to protect them from risk and to put that ahead of personal interest, the reputation of the organisation, or protecting colleagues.*"[39] This is an apt, succinct expression of what is required of a senior manager and of managers at all levels in the NHS.

37.46 Recommendations 43 to 47 of the Bristol report spoke to the need for staff to be held to codes of conduct.[40] As before, although progress has been made with clinical staff regulation, the recommendations call for all staff, including non-clinical staff, to be held accountable through codes of conduct and contracts. After 25 years, there has been very recent movement on that.

37.47 Recommendations 57 to 68 call for the recognition of non-clinical skills and for education in these skills.[41] This includes investment in developing leadership skills, all clinical staff having education in management,

and funded training. The government agreed to these recommendations. Some action was taken – for example, the publication of the NHS Leadership Qualities Framework in 2002. But we know from the Messenger/ Pollard report and the work of Lord Darzi that, 20 years later, these skills are still often lacking. A new framework was produced in September 2025 in response to those reports. I deal with that below.

37.48 There are also recommendations in the Bristol report for a standard approach to the induction of non-executive directors and training for leaders (52–54). There was agreement that an NHS Leadership Centre would work on this. The focus of the NHS Leadership Academy is said to be on helping "*everyone in the NHS discover their full leadership potential*".[42] Unsurprisingly, NHS England and DHSC recognise that more is needed here; most recently, the 10 Year Health Plan acknowledged that the NHS has "*become less appealing to, and less able to retain, world-class leaders*".[43] The government's latest position, also included in the 10 Year Health Plan, is that it plans to establish a College of Executive and Clinical Leadership.[44]

Fit and proper person test

37.49 Sir Robert Francis sought views on options for regulating NHS managers and introducing a professional duty of candour in 2013. He also recommended a fit and proper person test,[45] which was introduced by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This came into force on 27 November 2014. It was intended to ensure those individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care, and can be held accountable if standards of care do not meet legal requirements.

37.50 The application of the fit and proper person test was reviewed in 2019 by Mr Tom Kark KC, co-author of *A Review of the Fit and Proper Persons Test* (the Kark Review), with a particular focus on the skills, competence and qualifications required of directors and the absence of a power to disqualify. In his enlightening and helpful evidence to this Inquiry, Mr Kark referred to some Trusts having a dearth of applications, such that the skills and competence requirement for the post of director "*became something of a sliding scale*" with "*no benchmark*".[46]

Regarding the lack of a power to disqualify, Mr Kark referred to situations where, as part of a settlement agreement, a Trust would provide an anodyne reference, thus avoiding expensive disciplinary hearings, but creating a problem for a future Trust.[47] The Kark Review recommended the extension of the fit and proper person test to board-level leaders.[48] Nothing was done about Mr Kark's recommendations until a Fit and Proper Person Test Framework was introduced by NHS England shortly after this Inquiry was announced. The framework applies to the board members of NHS organisations and was effective from 30 September 2023.[49] In February 2024, the NHS Leadership Competency Framework for Board Members was published. This framework is said to form part of the Fit and Proper Person Test Framework for board members.[50]

37.51 Mr Kark was asked for his views on the Leadership Competency Framework for Board Members.[51] He had a number of reservations about it, describing the language in the framework as "*very aspirational and frankly a bit fuzzy*".[52] He had hoped that there would be more specific competencies for each area of expertise on a Trust board. He also observed that, whilst the framework

mentions experience and competencies, it does not specify qualifications. Mr Kark said: "*I suggested that there should be … specific competencies or qualifications, that's what I thought we were going to see. And I think some of this language, as I have said, is either too wordy or quite woolly.*"[53] I agree with him.

37.52 Mr Jarrold made four criticisms of the framework:

a. "[I]*t does not specifically refer to the care and safety of patients being the first concern of managers.*"

b. "[I]*t appears to depend on self-assessment and that is obviously limited … any proper appraisal system needs to involve 360 degree feedback from colleagues.*"

c. "*Appraisal is often not done well …* [s]*o to rely so heavily on appraisal worries me.*"

d. "[T]*he fitness for practice work is also incredibly wordy*."[54]

37.53 The first point is telling, and is a fundamental flaw in the framework. I am confident that every person who has been treated and looked after by the NHS – that is, almost everyone – would agree that the care and

safety of patients should be the first concern of managers, as it is for nurses, doctors and other healthcare professionals.

37.54 When dealing with the Leadership Competency Framework for Board Members in his written evidence, Sir Stephen Powis wrote: "*NHS England expects … greater achievement across the competency domains over time*."[55] In other words, it was expected that performance against the framework would improve. Professor Dixon-Woods thought it was too early to assess its impact.[56] Whilst I acknowledge that, having spent so long devising a process, it would be reasonable to give it time to bed in, it is not clear to me how the absence of the fundamental duty could be remedied without the process being revised to include it, as was plainly necessary.

37.55 Be that as it may, after the Inquiry evidence hearings had been completed, a new framework was developed in September 2025. I shall review that while looking at the current proposals on regulation.

Current government proposals on regulation

37.56 On 26 November 2024, the government issued a consultation seeking views, not on whether there should be regulation of

NHS managers, but rather on how it should be done. I infer that is the intention. In their manifesto document 'Build an NHS Fit for the Future', issued before the 2024 general election, the Labour Party said: "*Labour will implement professional standards and regulate NHS managers, ensuring those who commit serious misconduct can never do so again. And we will establish a Royal College of Clinical Leadership to champion the voice of clinicians.*"[57]

37.57 The consultation in November 2024 sought "*views from all stakeholders, including health and care organisations, regulators, professional bodies, health and care managers and senior leaders, the public, patients and other health and care staff*".[58] In addition to views on regulating managers, views were sought on the wholly separate issue of introducing for managers a duty of candour, to which I refer in Chapter 38. The consultation closed on 19 February 2025.

37.58 The number of responses seems low: 4,907, of which 748 were from individual members of the public (including patients and carers)

and 110 from organisations.* Of the rest, 2,815 (57%) responses came from non-managerial members of the health and care workforce and 1,344 (27%) came from NHS managers. Such a low response rate from the public may have been expected if the topic is of interest only to those working in the NHS. I note that the 2024 NHS staff survey received 732,000 responses online and a further 43,000 on paper. Those responses represent half the workforce (which is over 1.5 million people). I bear in mind that the staff survey is sent directly to all staff and it is their opportunity to have their say. If this consultation was sent to all staff, as it should have been, the response rate is disappointing. However, in a statement to Parliament on 21 July 2025, Ms Karin Smyth MP, Minister of State for Health (Secondary Care), said that the consultation had had a "*high level of engagement*". Whilst this seems to me a rather generous assessment of the figures out of a workforce of 1.5 million people (and the general public),

* There is a difference between the total responses quoted in Hansard (4,924) and the online responses analysed in the consultation response document (4,907).

the number of responses was considered sufficient. Ms Smyth outlined the next steps to be taken by government as follows:

> "*Department officials will prepare draft legislation to provide the HCPC* [Health and Care Professions Council] *with the powers to implement a statutory disbarring regime for NHS managers. When parliamentary time allows, we intend to bring forward this legislation, which will be subject to a further public consultation. We will continue to engage with stakeholders throughout and we will work closely with NHS England to ensure alignment with the wider work underway to develop and professionalise NHS managers and leaders.*"[59]

37.59 According to the consultation document, concerns remain about managers' accountability when things go wrong.[60] This is correct. This reality underlies the Term of Reference requiring me to consider whether accountability should be strengthened. I have no doubt that it should.

Failure to deal with poor performance and the revolving door

37.60 There is a widespread view that NHS managers have no real accountability. I have heard and read enough to know that there are some excellent managers in the NHS.[61] However, it is inescapable that there is a culture of avoiding dealing with poor performance. I suspect that this avoidance is the result of three factors:

a. The shortage of staff at all levels (clinical and managerial) means that everything is done to keep people in post.

b. The time it takes to performance-manage means that it is not done, and poor performers remain poor performers, in post.

c. The potential expense in time and money if a decision is taken to dismiss a person means that HR advice is very risk averse.

All three lead to poor management and a degradation of morale within an organisation. The Inquiry questionnaire also sought views of senior managers on regulation (see Appendix 2).

37.61 I accept that, sometimes, a Chief Executive may be brought in to deal with an intractable problem, not be given the resources to allow them to resolve the problem, and then be blamed and moved out. Sir Robert Francis pointed to the very high risk of failure in the Chief Executive role. He described it as a job with a high turnover and said: "[T]*he easy lever to pull is to blame the Chief Executive.*"[62] In some situations, as was acknowledged by several witnesses, including Mr Chambers, failing managers would be moved, with the active assistance of NHS England, to an alternative post in a process referred to as rehabilitation. Mr Chambers said it is referred to as 'the donkey sanctuary'.[63] Whatever it was called, it allowed the movement of failed managers into new roles, irrespective of the reasons for their failure. This process is well known inside and outside of the NHS. Sir Rob Behrens said: "*Chief Executives or board chairs who have presided over unfortunate events in one Trust have moved to another without there being … appropriate training before they take on something else. And in other professions I don't think that would happen.*"[64]

37.62 Mr Kark informed the Inquiry that "*a problem in the NHS … for a very long time*" has been the "*revolving door of the NHS*". He said: "[W]*here people have potentially misbehaved or behaved very badly, they come to a settlement agreement with the Trust to save the Trust the bother of having to go through a full disciplinary process, part of that settlement agreement is a vanilla reference. The director moves on to the next Trust down the road.*"[65] This state of affairs is accepted with almost a collective shrug of senior shoulders. It should not be tolerated.

37.63 The government put forward three options in its consultation document:

a. **Statutory barring system:** A list of people who are unsuitable to practise, have committed offences or have been found unsuitable to practise, and a body (the Health and Care Professions Council) legally responsible for complaints, using a code of conduct to consider complaints against.

b. **Full statutory regulation:** Administrated through a regulator, a full set of professional standards and a professional register. This is the position for doctors and nurses.

c. **Accredited voluntary register:** As (b) above, but voluntary. I think it most unlikely that a voluntary register would be considered acceptable to many. It has already been rejected by government and I would not suggest it should be revived.[66]

37.64 The consultation document set out "*implementation considerations*". These are, effectively, 'reasons not to implement'. Tellingly, the first of these described as a potential "*barrier to entry*" for some individuals is the "*formalisation of training requirements and standards for professions*". This could make recruitment from other sectors "*much more difficult and deter external talent from joining management and leadership roles in the NHS*". It could also "*potentially be a barrier and/or have implications for ongoing employment of existing NHS managers*". I understand this to mean that there are in the NHS managers who do not meet the standards that ought to be expected of them.

37.65 On full statutory regulation, the document sets out:

- Support must be provided to help individuals meet standards.

- Transition is needed due to managers' diverse backgrounds and lack of a common entry qualification.

I shall return to this in paragraph 37.85.[67]

37.66 Implementation considerations include that regulation could increase fear of sanctions.[68] I do not accept that regulation could create unnecessary barriers to entry. It may well put off those who do not want to be regulated. We would be unperturbed if would-be doctors or nurses did not pursue their ambitions because they did not want to be regulated. The same applies to would-be managers. The fear of sanctions point is no more persuasive than the barrier to entry point. Doctors, nurses, dentists, lawyers, teachers and accountants are all regulated. People still apply for those roles. There is nothing in this objection.

37.67 The third implementation consideration was "*managers monitor risks and face challenging decisions to balance patient safety, operational performance, and financial sustainability*", and regulation may increase risk aversion.[69] The same point can be made about the practice of doctors, where exquisitely difficult clinical judgements have to be made with huge consequences for

individuals (the patient and the doctor). It is a reason for the regulation of doctors, not against it. The same applies to managers.

37.68 The fourth implementation consideration was that central regulation could reduce the need for local oversight and use of local performance management, encouraging referral rather than local resolution.[70] This is about the mechanism of regulation, not whether it is a good idea. It is not clear to me why the fact of regulation would remove oversight or local performance management. They would run in tandem with whatever systems support regulation.

37.69 The fifth implementation consideration does not require lengthy thought. The risk of spurious complaints is there, irrespective of whether people are regulated.[71] It is not a reason not to regulate. The key is to spot and dismiss the spurious complaint speedily.

37.70 The consultation document also said that there would be dual regulation issues for managers with clinical qualifications.[72] There are ways of dealing with those issues; the one I would favour, which has been suggested several times before now, is that there should be a common code of conduct for all managers. Whichever way that question is

resolved, it is necessary that all managers be regulated, not just those who are clinically qualified and subject to codes of conduct.

Summary of the consultation responses and the government's response

Consultation responses

37.71 92% of respondents agreed there should be regulation. There was some variation as to the preferred method, but overall the majority of respondents wanted:

- managers who commit serious misconduct never to hold a management role again, citing examples of unfit managers being moved between NHS roles currently
- NHS managers to be standardised to improve professionalism and trust and bring non-clinical managers in line with clinical professionals
- education and training to be available, accessible and an ongoing requirement for managers
- skills and competencies for NHS managers to include general management, people management, coaching and development of others, operational delivery (managers should understand the systems and

structures related to their role, effective governance, meeting targets and quality assurance procedures), financial knowledge and skills (budgeting, balancing costs and saving money are all important for NHS managers), the ability to receive feedback, and the importance of understanding clinical services and patient safety and engagement.[73]

37.72 The 4% who disagreed with regulation commented on the risks of overregulating and the need for proportionality, and the fact that learning and development opportunities are more likely to have an impact on quality of management than regulation is.

Government response

37.73 In its response to the consultation, the government expressed its intention to introduce a statutory barring system for board-level directors and their direct reports within NHS bodies. This will be managed by the Health and Care Professions Council, who will have statutory powers to disbar NHS leaders in senior roles who have committed serious misconduct from holding such roles. The response document seemed to accept the proposition from an overall

majority of stakeholders, who "*showed a slight preference for implementing a barring system*", arguing that "*this provides an effective and proportionate means of achieving the primary aim of regulation, enabling the removal of unsuitable managers who* ***have committed offences*** [emphasis added] *or who have been found to be unfit*".[74] I infer that the latter part of the sentence refers to a person who has committed serious misconduct but not a criminal offence.

37.74 The government explained that a further consultation will be necessary for legislation, with the aim of the bill being laid in the "*second half of 2026*", and regulation will commence "*within 12 months of legislation being laid*".[75] The proposed disbarring system is to apply to NHS bodies (NHS Trusts, Foundation Trusts and ICBs).

37.75 In its summary, the consultation response set out that "*regulating managers and leaders will help to professionalise NHS leadership and will ensure that NHS managers and leaders are professionally accountable, while improving patient safety and driving up performance*".[76]

37.76 It is not clear how regulating only the most senior managers – that is, board-level directors and their direct reports – within NHS bodies will help professionalise NHS leaders generally, save as a first step to wider regulation.

Profound change is necessary

37.77 Leaving aside criminal offences, the first step towards dismissing someone for serious misconduct is to investigate the misconduct and go through the hospital's disciplinary process. There is a well-known reluctance within the NHS to follow the HR process and a tendency to move people around with few questions asked (see Mr Kark's evidence above). Even when the person is being moved out, one of the reasons a disciplinary process is avoided and employees paid off is because it is cheaper to do that than to risk the costs of litigation and/or the payment of damages for a successful claim for wrongful or unfair dismissal.

37.78 A profound change is necessary in the NHS's approach to dealing with serious misconduct (and, separately, poor performance). First, the NHS must be prepared to dismiss senior managers for serious misconduct (after due

process). Second, it should follow that such managers would not secure employment as a manager in the NHS again. This would happen in any well-run company. NHS employment records must ensure that this is followed. If, worryingly, the reality is that people are currently being dismissed for serious misconduct but are able to return to employment within the NHS (because it is not possible to track people, given the size of the NHS), or worse, being moved around the NHS to different roles to avoid this outcome, then that system failing must be remedied. A barring system is a cumbersome way of achieving what ought to be achieved by effective disciplinary process, record keeping and management.

37.79 It ought to be understood that, if a hospital does not invoke the disciplinary process and dismiss for serious misconduct, then, on the current proposals, there would be no basis for barring the manager. Whilst I understand that barring is a cheaper option than full regulation, and certainly necessary, it will not be worth the money spent on it, or the bureaucracy that comes with it, without the prior change of approach set out above.

37.80 The government's rationale for choosing a barring system over other types of regulation is that a barring system achieves the primary purpose – that is, to focus on those who commit serious misconduct no longer being able to work in "*senior NHS management positions, preventing unacceptable behaviour and improving patient safety*".[77]

37.81 Failure to regulate at lower levels, combined with an unwillingness to deal with difficult behaviour, means that poor conduct will continue unchecked at all other levels. The government goes on to say that a barring system is intended to fill gaps in the current system without duplicating what is already in place.[78] I acknowledge that the mechanisms exist – the fit and proper person test, the Nolan principles, CQC and professional regulations and the Maintaining High Professional Standards framework. The most important gap in the current system is the one I identify above: the failure to use disciplinary process when there is misconduct. The barring system will not fill the gap, it will fall through it.

37.82 Doctors and nurses are regulated from the moment of qualification and throughout their careers. Teachers, dentists, the same. When

they are removed from the register, they cannot work in their chosen profession at all, either during a period of suspension or after removal from the register. Even were non-clinically qualified managers barred from working in the NHS, it would not follow that they could not be a manager outside the NHS. In other words, the effect of barring would be much less severe for NHS managers than for doctors, nurses and other professionals outside the NHS (teachers, etc).

37.83 The government document continues – barring is simpler than a full regulatory system because full professional standards and revalidation are not required, and there is no requirement for a new regulator, no need for a transition period or to deal with existing NHS managers who do not meet any new requirements set, and fewer issues with no dual regulation.[79]

37.84 All of that is true. The fact that full professional standards are not required for NHS managers (and that it is intended that this should continue) should ring alarm bells. The first and essential step is to raise standards. After more than 50 years of management in one form or another, the continued failure to achieve 'full professional standards' for all, or at least

most, managers is a significant failure by all those responsible for the NHS. I return here to the 'implementation considerations' first mentioned in paragraph 37.64. They make plain that which is common knowledge: many managers do not meet the standards that should be expected of them. This must be addressed now.

37.85 The same points are relied on again for not introducing full statutory regulation: it would be resource-intensive, the "*implementation of education standards and qualifications would be a major challenge for such a diverse profession*", and setting such standards would require "*significant additional regulator time*".[80] This is not new. If education standards and qualifications are not to be used when recruiting, then other standards have to be set and kept to. Once managers are in the system, there have to be clear standards that they are expected to meet; their potential to meet these should have been tested in the recruitment process. If they do not, after appropriate support and performance management, they should not remain in post. It is just not acceptable to say it is all too difficult, as has clearly been done for decades.

37.86 The suggestion that introducing full regulation risks putting individuals off applying for careers in the NHS because they may have to meet more requirements and evidence their continual learning, and because there may be more fear of sanctions with full professional standards, is all more of the same. I have already dealt with the latter point. The other points are not arguable.

37.87 Finally, the government position is that a barring system is much cheaper than a statutory regulation system. I do not doubt that. The question is, is a barring system sufficient? The answer is that it may be, but only if it is preceded by a sea change in the approach of the NHS to managing its managers.

37.88 Respondents to the consultation want the same standards, qualifications and expectations for all NHS managers. This is obviously right.

37.89 The government's response points to the then new draft Management and Leadership Framework, published in September 2025.[81] This draft, and a further draft in 2026, have been superseded by the final published version in July 2026.

37.90 The government acknowledges that there are matters still to be decided: how dual regulation will work, and how the barring system will work alongside the fit and proper person test and the Management and Leadership Framework. That this has to be worked out makes plain that the proliferation of tests and frameworks with the fit and proper person test is a recipe for more complication.

Final NHS Leadership and Management Framework

37.91 A 'final' version of the framework was shared with the Inquiry in February 2026, then published on NHS England's website in July 2026. It is now known as the Leadership and Management Framework and all references to managers have been changed to 'leaders and managers'.[82]

Leadership and Management Framework Code

37.92 At the outset, the code sets out the "*core principles and behaviours expected of every leader and manager within our health and care system*" and sets out "***for the first time*** [emphasis added] *the principles and characteristics that* ***all leaders and managers*** [emphasis added] *are expected to meet in the sector*".[83] Under the heading 'Why do we need

the code?' there are links to six documents: the Messenger Review, the NHS Constitution, 'Our People Promise', 'Our Leadership Way', the 7 Principles of Public Life (the Nolan Principles), and 'A Healthier Wales: Our plan for health and social care', with which the code is said to align.

37.93 Under the heading 'Be accountable', the code reads:

> "*As a leader or manager in health and social care, you must:*
>
> - *take responsibility for your actions and decisions*
> - *hold yourself and others to account for doing the job well, working together fairly and effectively and always looking for ways to improve.*"

That means "*following the relevant professional codes of conduct, including duty of candour where appropriate*".[84]

37.94 There is no professional code of conduct for non-clinicians, other than this one. The structure of the paragraph suggests that this is a duty imposed only on those who are subject to professional codes of conduct. This immediately differentiates between clinical and non-clinical managers. I note

the explicit reference to "*including duty of candour where appropriate*". I accept that the nurses and doctors (and other healthcare professionals) have a duty of candour under their professional codes. This paragraph suggests that, in the absence of a separate professional code for managers, non-clinically qualified managers are not bound by the duty of candour. If that is the intention, it is unacceptable and wholly unjustified, particularly in light of the provisions of the Public Office (Accountability) Bill requiring the establishment by all public bodies of a duty of candour for staff. I am in no doubt that there should be no exemption for non-clinical managers from this important duty, which should be clear on the face of this code of conduct and should apply to all managers (see also Chapter 38).

37.95 The code sets out six principles, which are defined and each followed by examples of effective and ineffective practice:

- Be accountable.
- Be collaborative.
- Be compassionate.
- Be curious.
- Be inclusive.

- Show integrity.

With the exception of inclusivity, these principles broadly follow Mr Jarrold's much shorter code (see paragraph 37.41).

37.96 I readily acknowledge that this code is an improvement on what went before, including the September 2025 document, but nowhere does it put front and centre Mr Jarrold's first principle, with which surely every manager must agree: "*I will make the care and safety of patients my first concern and act to protect them from risk.*" It is not enough to say that the reader should read the NHS Constitution or any of the other related documents. This omission rather undermines the document's credibility. I recommend an urgent review of the code so that this may be remedied.

Leadership and Management Framework Standards

37.97 The 'standards' are shorter than the draft version (see paragraph 37.89).[85] The vision and mission statements have been stripped out, along with other superfluity.

37.98 The standards are divided into three 'focus area' headings:

a. Personal impact

b. Managing people and resources

c. Delivering across health and care.

37.99 Under each focus area heading, there are three subsections – the 'standards' – each subdivided into further subsections. There are also standards for the 'fundamentals' stage – "*for every leader and manager regardless of their level*", and four further stages of management depending on your role.[86]

37.100 The first area of focus is the leader or manager personally, 'personal impact'. I assume that underpinning this is the belief that, if there is a well-functioning management team, that will be good for patients. The first requirement for the stage 1 'new leaders and first-time managers' is that they should "[p]*rioritise for personal productivity*"; the second, that they should "[d]*evelop personal safety and wellbeing strategies*". Leaving aside which priority matters more (and Professor Dixon-Woods' priority thicket comes to mind), it is not easy to see how the latter competency, in particular, is properly included as a professional standard. How will a failure to "*develop health and wellbeing strategies*" be assessed and managed? I note that the stage 2 ('mid level') leader or manager is required to "*make sure wellbeing*

is prioritised". If it is to be a manager's responsibility to prioritise well-being by promoting conversations about a healthy work culture and encouraging others to prioritise their health and well-being, how is success to be measured? By whether conversations take place? By whether people's health is protected or well-being improves? I acknowledge that it may be possible for managers (non-clinical or clinical) to protect their own health and wellbeing and those of others in a fully staffed hospital. However when, as now, there is a shortage of doctors, nurses and managers and the fundamental requirement is to keep patients safe, urging wellbeing strategies may feel somewhat removed from the reality of running a busy ward/department/hospital. However well meant, it may have the effect of increasing workload with no real benefit. This aspect of the framework should be kept under review.

37.101 The approach to patients is buried within the third of the three focus areas – 'delivering across health and care' – under the standard 'improving quality'. It should come first. This is not just about presentation, it is about the fundamentals. The patients/service users are the reason for the NHS. As above, I suggest

this is remedied swiftly. That may easily be done by leading with the standards under this heading (delivering across health and care).

37.102 The first and fundamental descriptor under this third standard is: "*I put patients first and report safety concerns and incidents*." This ought to feature more prominently in the standard and in the code (see above).

37.103 It is instructive to compare the standards with the code of practice for doctors and assistants (formerly physician and anaesthetist associates) now called *Good Medical Practice*. It is clear, practical and specific.[87] There is a separate leadership guidance document, 21 pages in length, including endnotes. It is concise and easy to understand. Like the main document, it is not a slide pack. It is written in prose and so is easier to absorb. The opening section makes it plain where the doctors' duties lie. It explains on the first page what it is, who it is for and how it is structured.[88]

37.104 Importantly, on the GMC website, as part of the 'Good Medical Practice' section, there is a webpage titled 'A patient's guide to good medical practice'.[89] There can be no doubt where the doctor's priority lies. There is an

easy read version too, which includes the most important information in a shorter, even clearer format.

37.105 The nurses' code of conduct can also be found on the website of the NMC.[90]

37.106 I do not doubt that both codes could be improved, but they are both focused on patients and make clear what is expected of nurses and doctors in the course of their work in the NHS.

37.107 I acknowledge that time and effort has been directed to producing the responses to the recommendations of the Messenger/Pollard report in 2022 but four years is too long. I hope that, when the required changes are made in response to my observations in this section of the Report, the first effective steps will be taken to raising the standards of conduct and behaviour of managers in the NHS.

37.108 To achieve real and enduring change, the issues I raise in respect of recruitment, retention and the enforcement of the terms of contracts must all be addressed. If that is done efficiently, then the proposed barring system has some chance of success.

37.109 The introduction of a barring system will not remove the urgent need to manage poor performance effectively. That too requires the attention of Trusts and NHS England.

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Chapter 38. Duty of candour

Statutory duty of candour for organisations

38.1 Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulations) sets out the statutory duty of candour for organisations. It provides that "*a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity*".[1] This regulation applied to NHS organisations from November 2014.[2] From April 2015, it applied to all health and social care providers registered with CQC.[3]

38.2 In her evidence to the Inquiry, Professor Dixon-Woods explained that, prior to the introduction of the Regulations in 2014, an open and well-run hospital would have been expected to be open with people

injured by the actions of people working in the hospital. That, however, was not generally the case.[4]

38.3 Regulation 20(2)–(4) requires that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person.[5] A notifiable safety incident is defined as:

> "*any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in–*
>
> *(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or*
>
> *(b) severe harm, moderate harm or prolonged psychological harm to the service user.*"[6]

A relevant person is the service user, or a person lawfully acting on the service user's behalf.[7]

38.4 The notification must:

> *"(a) be given in person by one or more representatives of the health service body,*
>
> *(b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification,*
>
> *(c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate,*
>
> *(d) include an apology*."[8]

The notification must also be recorded in a written record which is kept securely by the health service body. The oral notification must be followed by a written notification to the relevant person. This must comply with the same requirements as the oral notification. It should also include the results of any further enquiries into the incident. The health service body must also provide reasonable support to the relevant person in relation to the incident, including when giving such notification.[9]

38.5 The statutory duty of candour is also written into the NHS Standard Contract, which is published annually by NHS England for use

by NHS commissioners to contract for all healthcare services other than primary care services.[10]

38.6 The statutory duty of candour does not apply to individuals, but organisations discharge their duty through the actions of their staff. It follows that there is an obligation on those in charge of the organisation to make sure that they and all staff understand the duty and how it is to be discharged.

38.7 CQC provides guidance for providers on meeting the statutory duty of candour.[11] It has the power to enforce Regulation 20.[12] Its range of enforcement powers include warning and requirement notices, imposition of conditions and criminal prosecution.[13] Mr Dzikiti, corporate witness for CQC, told the Inquiry that, since 2020, CQC had successfully prosecuted seven organisations in relation to the duty of candour.[14]

38.8 CQC regulates the organisational duty of candour.[15] It has the task of checking that the hospital or other provider is discharging its responsibility in respect of all aspects of the duty of candour. CQC does not investigate every notifiable safety incident; this is the responsibility of the hospital or other provider.[16]

38.9 CQC looks at the duty of candour when considering whether the service being inspected is well led; this involves having an open and safe culture, and meeting the regulatory requirements of the duty of candour. When CQC holds monitoring calls, it assesses the data and information it receives. When conducting an inspection, CQC looks for evidence that all three requirements are met.[17]

Professional duty of candour

38.10 All clinical staff who are registered healthcare professionals have a professional duty of candour. Oversight is by the regulators of each profession, such as the GMC, the NMC and the General Dental Council. The professional duty of candour derives from codes of conduct, not from statute. Non-clinical staff are not usually registered with a statutory body, so are not subject to the same (or any) professional code.[18] See Chapter 37.

38.11 The GMC and the NMC published joint guidance: *Openness and Honesty When Things Go Wrong: The professional duty of candour*. This took effect on 29 June 2015.[19] This joint guidance specifies: "*Every health and care professional must be open and*

honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress."[20]

38.12 There are two aspects to the professional duty of candour. The first relates to patients. The guidance sets out a number of steps that health and care professionals must follow. They must:

"• *tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong*[*]
- *apologise to the person*
- *offer an appropriate remedy or support to put matters right (if possible)*
- *explain fully to the person the short and long term effects of what has happened.*"[21]

38.13 The second part of the professional duty of candour relates to colleagues, employers and other organisations. The guidance states:

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* Wherever 'the person' is mentioned, 'or, where appropriate, their advocate, carer or family' applies each time.

> "*Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.*"[22]

38.14 The guidance also specifies that, "*if you are in a management role, you must make sure that individuals who raise concerns are protected from unfair criticism or action, including any detriment or dismissal*".[23]

38.15 Breaches of the professional duty of candour can result in investigation and disciplinary action by the GMC or the NMC.

38.16 Speaking on the duty of candour, Sir Robert Francis said: "*I think that there has … developed a feeling that it's not working as well as it should do*" and "*anecdotally, I hear of worrying things*".[24] He described a case where a doctor who made a mistake and caused harm to a patient expressed to the hospital that he wished to meet the patient and discuss it with them. However, the doctor was told that he could not do so. Instead, he

was presented with a letter to send to the patient. The doctor was given no choice but to send the letter, and the contents upset the patient. The letter was not inaccurate, but it was not what the doctor would have wished to have said. Sir Robert Francis commented: "[T]*he whole thing had become: we have a process and we have to follow this, rather than allowing it to be clinically led by a perfectly honest doctor trying to do their best to be candid and to support the patient about something that had happened.*"[25]

38.17 Sir Robert Francis told the Inquiry:

> "[S]*ometimes it is forgotten that the overarching obligation is about openness and transparency of which candour and notification are an important part, but not the only part.*
>
> *The most important part is looking after your patient and their family, where appropriate the family and their concerns* … [T]*he process of the duty of candour has been treated as a defensive mechanism rather than an involvement mechanism and a resolution mechanism. The whole point of the duty of candour is to satisfy people who have been harmed or might have been harmed, giving them*

an opportunity to understand what has happened, and to take part in the process of improvement, to receive redress by way of apology and if necessary some money, but all without having to bother lawyers or the courts or disciplinary processes but to actually do things quickly and resolve them quickly and allow people to feel that they have been [respected,] *all those things and it doesn't happen if … -- the instinct is well, I am doing by the duty of candour is producing a defensive position. You have got to start from the position that: I am being candid because it is the right thing to do for my patient.*"[26]

38.18 Professor Dixon-Woods told the Inquiry:

"[T]*he legal duty of candour has been a very important intervention, but has been variably well implemented by Trusts.*

…

The duty is not easy to implement because it requires a set of procedures and not all Trusts are operationally excellent at creating operational change. It also requires a lot of behavioural change on the behalf of the professionals and implementing the disclosures was not easy for professionals.

> …
>
> [I]*t's another example of where something that looked like a good idea could have done with a lot more co-design with the families and with the staff before it was implemented. It was one of those things that was left up to NHS Trust*[s] *to figure out how to do it.*"[27]

She added: "*The challenge of implementing something like the duty of candour was significant because it required so much organisational engineering, culture and behaviour change and so on, and again it goes back to what I was saying earlier, I think a lot of that could have been much better supported.*"[28]

38.19 Professor Dixon-Woods asserted: "*I think there is scope for greater enforcement action … It again signals the seriousness of the requirement.*"[29] She was asked whether penalties are the driver of change. She replied that they can be. However, she cautioned that the effects of regulatory fines on healthcare organisations had not been evaluated. She also pointed out that fines take more resources out of organisations that are already struggling financially. She considered: "[Y]*ou probably need a range of*

things if you're going to implement something like this [the duty of candour] *effectively.*"[30] She pointed to openness policies, data, collaborative improvement and feedback. In her view, there is a need to find ways that encourage "*authentic and genuine commitment to the interests of patients that isn't necessarily because it was a big stick going to be waved, but the big stick should be there if there's still non-compliance, absolutely*".[31]

38.20 Speaking generally about the duty of candour, Mr Vineall, on behalf of DHSC, said that, in November 2024, results from a consultation were released which "*showed that the duty of candour was working in places but was probably somewhat underwhelming in totality*".[32]

38.21 Mr Vineall stated that DHSC were aware of the concern that has arisen from some areas of this Inquiry about the challenge of applying the duty of candour to circumstances in which a person suspects deliberate harm. He asserted that, in these circumstances, the "*duty of candour does apply*".[33]

38.22 In oral evidence, Sir Rob Behrens said:

> "[T]*he duty of candour does not work and needs urgent reviewing and replacement with stronger powers.*
>
> …
>
> [I]*t doesn't work because it doesn't apply to individuals, it applies to persons and that is interpreted as a public body and, secondly, the fines for it are so puny that it doesn't have any impact on the behaviour of the leaders of the Trust.*
>
> *And so there is time and again, from cases that I have seen, a failure of staff to disclose what really happened in situations and the way that that happens in my view is wrong.*"[34]

38.23 Speaking on the organisational statutory duty of candour, Dr Alan Clamp, Chief Executive of the Professional Standards Authority for Health and Social Care, considered there was scope for CQC to improve how they hold organisations to account, with the sanctions they impose and the guidance they provide.[35]

38.24 Dr Clamp supported the regulation of senior managers. He considered "*it would be very useful to pursue the idea of the statutory duty of candour for individual managers*".[36] He pointed out that regulated professionals

must comply with the professional duty of candour and that, if they do not, there will be repercussions from the regulator.[37]

38.25 In a nutshell, the discharge of the duty of candour, organisational and professional, is patchy. There is no duty of candour for non-clinically qualified managers.

The government's consultation on the introduction of a professional duty of candour for NHS managers

38.26 I have already dealt comprehensively with the parts of the November 2024 government consultation that deal with the regulation of managers (see Chapter 37).[38] The consultation also invited views on introducing a professional duty of candour for NHS leaders, similar to that for regulated health and care professions, and views on introducing for managers a duty to record, consider and respond to any concern raised about the healthcare being provided, or the way it is being provided. At present, under Freedom to Speak Up, the person speaking up is protected, but there is no obligation on the organisation to act on the concern.

38.27 The response to the consultation revealed strong support for NHS managers to have a professional duty of candour as part of the standards that they are required to meet (96%), and for NHS managers to ensure that the statutory duty of candour is correctly followed in their organisation (95%).[39] Respondents explained this would encourage a culture of honesty, openness and transparency within NHS management, and a professional duty of candour should be extended to NHS managers, to standardise professions and to ensure consistency in the guidelines being followed.

38.28 The government's response ignores the question of introducing a professional duty of candour for NHS leaders or managers.[40] Instead, in the written statement on the consultation response, the government commits to "*consider what further sanctions may be required in relation to failing to uphold the principle of candour*".[41] There is no proposal for a duty of candour for non-clinically qualified managers.

38.29 This is disappointing and unwise. Since most management and leadership at senior levels, in particular, is done by non-clinically qualified managers, it is important that they,

too, are subject to a duty of candour. The arguments in favour of the duty for doctors, nurses, healthcare professionals, and the organisation itself, are just as powerful for the managers, who control all the resources and make decisions which affect all aspects of the running of the hospital and patient care. Managers and leaders should be responsible for discharging the organisation's duty of candour, but poor compliance with the organisational duty leads to fines for the organisation, and there is no personal accountability. An individual duty imposed on managers, mirroring the duty on nurses, doctors and other healthcare professionals, coupled with clear guidance from CQC, should achieve a better understanding of, and overall compliance with, the duty of candour.

38.30 As I have set out in Chapter 37, the NHS Leadership and Management Framework Code was published in July 2026. The code declares at the outset, "*for the first time, the principles and characteristics that all leaders and managers are expected to meet in the sector*".[42] It then refers to several other NHS documents, and to The Seven Principles of Public Life with which it says it aligns.[43]

38.31 Under the heading ‘Be accountable’, the NHS Leadership and Management Framework Code reads:

> “*As a leader or manager in health and social care, you must:*
>
> - *take responsibility for your actions and decisions*
> - *hold yourself and others to account for doing the job well, working together fairly and effectively and always looking for ways to improve.*
>
> *That means:*
>
> - *following the relevant professional codes of conduct, including duty of candour where appropriate.*”[44]

38.32 As I have said already, other than the code from which this is an extract, there is no professional code of conduct for non-clinicians. The structure of the ‘Be accountable’ text above suggests that the duty of candour applies only to those who are already subject to it as part of their professional codes of conduct. This immediately differentiates between clinical and non-clinical managers. It undermines the opening statement of the document, which says that the code sets out “*the principles and*

characteristics that all leaders and managers are expected to meet". The result is that nurses and doctors (and other healthcare professionals) have a duty of candour under their professional codes, but non-clinically qualified managers do not. If that is the intention (and the government response to the consultation suggests it is), it is unacceptable and unjustified. A simple amendment should be made, making it clear that the duty of candour applies to all.

38.33 I am in no doubt that there should be no exemption for non-clinical managers from this important duty, which should be clear on the face of the NHS Leadership and Management Framework's Code (of conduct), and should apply to all managers.

The government's consultation on the duty to respond to healthcare concerns

38.34 In the same consultation issued by the government in respect of regulating managers and the duty of candour, there was a further section on whether or not to introduce a duty to record, consider and respond to any concern raised about the healthcare being provided, or the way it is being provided. A high percentage of respondents (94%)

supported the principle of NHS managers having a duty to respond to safety incidents. A similarly high percentage (95%) supported the introduction of a duty on managers to ensure processes are in place for responding to concerns.

38.35 Respondents explained that this would mean that managers are held accountable for poor decision-making and that it would encourage transparency. They also expressed the importance of staff and patients being able to raise concerns without fear of managers dismissing them without consideration. Negative experiences of whistleblowers and those speaking up were pointed out by some respondents, suggesting a duty to respond would protect staff and patients, and hold managers accountable.

38.36 A duty to respond was explained by respondents as a basic ethical approach within healthcare, with some respondents saying that it is already being followed (or should be). However, some respondents recommended that processes should be in place to deal with concerns on a systemic level, rather than having managers directly respond. For example, they proposed a triage system to address concerns proportionately,

with serious forms of misconduct subject to this duty, and less serious concerns dealt with differently.

38.37 I heard evidence about this. Given the enormous effort that has gone into setting up Speak Out Safely and then Freedom to Speak Up Guardians, it is puzzling that there is no requirement for hospitals and other providers of healthcare, or for managers at any level, to do anything about the concerns raised with them, although many do. Ms Sybille Raphael, on behalf of Protect, recommended that there should be a legal duty to investigate concerns. She pointed out that this exists in the EU in respect of employers with more than 50 employees.[45]

38.38 Professor Bowers KC supports such a duty:

> "*I think the other thing is that it would be very useful to have a duty on the employer to consider the disclosures because at the moment, there's no obligation to do that. There's protection for the whistleblower in whistleblowing, but there's nothing of a duty on the employer to follow up on the* [disclosure] *and I think that is an important thing; that actually would give succour to or support to whistleblowers who often feel extremely beleaguered that they have gone out of their way, sometimes lost their careers, to make information available and then nothing is done with it.*"[46]

38.39 This should be considered as part of the Freedom to Speak Up process (see Chapter 40). The government's position, as set out in its consultation response, is short. It recommends no action on this issue, on the grounds that it would be "*complex to implement and enforce*",[47] so there are no specific or new actions taken from this feedback. It points to existing whistleblower protections. That is to miss the point; this is not about the whistleblower, but the concern that has been raised.

38.40 I don't doubt that there are concerns raised which require no or little action, and it is the case that many concerns are acted upon. I am also satisfied, on the evidence I have heard, that in many places managers do respond to concerns that are raised, and no properly run hospital would ignore such concerns. Consideration should be given to imposing a duty as set out in paragraph 38.38 above.

Endnotes

1 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/76/ para 7.2.1**; The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20 (**https://www.legislation.gov.uk/uksi/2014/2936/regulation/20**)

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7 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,

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13 **Witness statement of Ian Trenholm INQ0012634/31/para 156**

14 **Chris Dzikiti 14 January 2025 110/25 to 111/6**

15 **Chris Dzikiti 14 January 2025 110/1-6**

16 **Witness statement of Ian Trenholm INQ0012634/31/para 154**

17 **Witness statement of Ian Trenholm INQ0012634/30-31/paras 150-156**

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25 **Sir Robert Francis KC 30 September 2024 112/15 to 113/12**

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30 **Prof. Mary Dixon-Woods 26 September 2024 108/10-12**

31 **Prof. Mary Dixon-Woods 26 September 2024 108/13-17**

32 **William Vineall 15 January 2025 85/15-17**

33 **William Vineall 15 January 2025 86/13**

34 **Sir Rob Behrens CBE 10 December 2024 47/13 to 48/11**

35 **Dr Alan Clamp 7 January 2025 161/10-16**

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37 **Dr Alan Clamp 7 January 2025 160/24 to 161/6**

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45 **Sybille Raphael 5 December 2024 48/3 to 49/8**

46 **Prof. John Bowers KC 5 December 2024 67/5-15**

47 DHSC, ‘Leading the NHS: Proposals to regulate NHS managers: Consultation response’, 21 July 2025 (**https://www.gov.uk/government/consultations/leading-the-nhs-proposals-to-regulate-nhs-managers/outcome/leading-the-nhs-proposals-to-regulate-nhs-managers-consultation-response**)

Chapter 39. Culture of the NHS

39.1 Thousands of pages have been written in the last 25 years about the culture of the NHS. One approach is to consider 'culture' the umbrella term for the behaviours common to a particular group (ward/department/hospital). Another approach, adopted by the NHS for most of this century, is to identify a desirable culture in the hope and expectation that behaviours will align with that culture.

From the Mid Staffordshire inquiry to the present

39.2 As is clear from Part 1 of Sir Robert Francis's report prepared for this Inquiry, there have been many other inquiries that have called for an improvement in NHS culture, in particular for an improved safety culture or 'open' culture.[1] Sir Robert Francis's first recommendation in the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust was: "*The Trust must make*

its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard."[2] In his Part 1 report for this Inquiry, he said: "*While directed at the Trust in particular, the recommendation contained an implied requirement for the NHS as a whole. The NHS Constitution … contains a requirement to put patients at the heart of everything it does*."[3]

39.3 Despite these recommendations, and the focus that has been placed on the need for a safe culture, patients have still suffered avoidable harm through the actions of NHS staff and shortages of resources. Sir Rob Behrens referred to his report *Broken Trust*[4] and its related press release. The press release said: "*Every time an NHS scandal hits the front pages, leaders promise never again. But the NHS seems unable to learn from its mistakes and we see the same repeated failings time and time again*."[5] It referred to "*continued failures to accept mistakes and take accountability for turning learning into action*" and added: "*We need to see significant improvements in culture and leadership*."[6]

Finance

39.4 Sir Rob Behrens also referred to "*a healthcare system at breaking point*".[7] That was in 2023. Levels of financing remain a concern for all who are running hospitals. There is a constant risk that financial concerns drown out concerns for patient safety. Professor Dixon-Woods pointed out, in connection with the first report of Sir Robert Francis into Mid Staffordshire, that: "*The Inquiry identified that a key contributor to the disaster at Mid Staffordshire was that clarity of purpose in relation to patient safety and quality of care tended to be displaced by issues of finance and performance*."[8] Sir Robert Francis said in evidence:

> "[I]*n … a service in which resources are never going to be enough, we can never do everything all the time. They* [leaders] *need to be able to understand how to prioritise things – and to protect patient safety and the provision of the fundamental standards and they must have those standards and the interests of the patient in the case of a hospital always at the*

forefront of everything they do and they must make sure that everyone in the organisation does the same.

… you need to make sure that your finance department has at the front of its mind the interests of the patient, what is the best thing we can do for the patient and you will tend to find that the money then follows … you need to understand how to prioritise and you need to understand how to protect patient safety in your organisation."[9]

'No blame' culture

39.5 Since 2000, the culture to which the NHS has aspired has been described in academic and policy literature as 'no blame'. Developments in the approach to risk in aviation, rail and other industries demonstrated that it was possible to reduce the risk of accidents significantly by changing systems. Errors could be designed out. Where such systems are in place and an error does occur, it is said to be the result of an imperfection in the system rather than the fault of an individual. Professor Dixon-Woods'[10] impressive exposition of the history and development of the 'no blame' culture is set out in her report at paragraph 2.1.[11]

39.6 The central premise of a 'no blame' approach is appealing – that doctors and nurses are fundamentally well intentioned (or 'good apples', to use Professor Dixon-Woods' phrase). With that assumption in mind, NHS executives began to try to design out errors. This was the systematisation of risk management.[12] Within the NHS, HSSIB and the Healthcare Safety Investigation Branch before it have taken a systems-based approach to investigations. Disclosures to them are protected by law. HSSIB are rightly regarded as a successful organisation, despite a small budget and a small team. I deal with them in more detail in Chapter 43.

39.7 Accompanying the 'no blame' principle was an expressed desire to learn from mistakes. This was described as a 'learning culture' – that is, one in which errors are often described as 'opportunities for learning'. As I have said in respect of the submissions of the NMC, if an error is to lead to an opportunity for learning, there must be an honest acknowledgement of the error, an apology and explanation, and then a plan to prevent recurrence. I hope it is not unfair to observe that in some parts of the NHS – maternity units in particular – errors and learning opportunities have not led to improvement but to more of the same.

39.8 Throughout the time when the description ‘no blame’ was attached to NHS culture, there was, and still is, a lot of blame within the NHS. That is why it was necessary to introduce whistleblowing protections for those who spoke up about errors and failures within the NHS, and why in 2016 the concept of Speak Out Safely was introduced and, more recently, Freedom to Speak Up. These two steps demonstrate that (a) errors are not always reported or acted upon – because of a fear of blame; and (b) blame is placed on the reporter when they point out errors.

39.9 ‘Blame’ and ‘responsibility’ are often synonymous; in the following simple example both have negative connotations: “Who is responsible/to blame for this mess?” However, whilst blame is always negative, responsibility is not, as in the example “Who is responsible for this well-run department?” With responsibility for error comes responsibility for putting things right. It is likely that, had the culture of the NHS been described as a ‘no responsibility’ culture, the term would never have got off the ground.

Blame for clinical and other errors

39.10 In every workplace, people make mistakes. For most people, errors at work do not lead to injury or death. For doctors and nurses and other healthcare professionals, the reality is different, from the time they qualify. The effect of the law of tort is that, where an error leads to injury or death, the health professional may be liable in negligence. Healthcare professionals live with that reality. A question may arise as to whether the fault, blame or responsibility lies solely with the individual, or, as often happens, whether there was a broader systems error – faulty equipment, shortage of drugs, staff shortages, etc. If the latter, then the blame or responsibility, as well as financial accountability, lies with the organisation via the decisions of its managers.

39.11 Separately, managing allegations of misconduct against a backdrop of a 'no blame' culture can be difficult; HR and patient safety processes can be seen to run contrary to one another.[13]

39.12 Sir Robert Francis points to the innate tension between central commissioning and local delivery: the very structure of the NHS pitches them against each other, with senior managers looking to central government for

guidance while central government gives them increasing responsibility for care in their areas.[14] Fundamentally, there has been, for decades, a deliberate policy of distancing central government from the business of providing NHS services in the community and in hospitals, running in direct contradiction to any suggestion that the NHS operates a 'no blame' culture. This can lead to what Professor Dixon-Woods refers to as "*blame engineering*", where an organisation actually becomes preoccupied with avoiding blame, leading to an over-focus on process, and reputation management becomes a central organising principle of leadership.[15] This is what happened at the Countess.

The effect of a 'no blame' culture

39.13 Ironically, the push towards a culture that ascribes 'no blame' leaves the system, and the people who are part of it, unable to comprehend (or at least accept) that there may be healthcare professionals who are not well-meaning.[16] There was clear evidence of this at the Countess. This is an axiomatic failure; we know that not all healthcare professionals are well-meaning, and very few do cause harm deliberately, whilst others do

so negligently and, sometimes, recklessly. Instead of being safe, patients are at greater risk of harm in a 'no blame' culture.

39.14 Focusing on system faults rather than the failings of individuals, whether manager or clinician, coupled with a learning culture that omits the first step of acknowledging responsibility/blame, makes the 'no blame', culture innately forward-looking. Whilst superficially attractive, it avoids difficult conversations about conduct. This avoidance directly or indirectly undermines patient safety.

Moving on

39.15 The government's 10 Year Health Plan does not mention a 'no blame' culture.[17] The notion seems, quietly, to have been dropped. That is a positive development, reflecting the reality that, after 25 years, 'no blame' has run its course.

39.16 Recently, there has been a move towards a 'just' culture.[18] Accepting, as I do, that a 'just' culture is a better description of a desirable culture than a 'no blame' culture, I question the value of identifying a desirable culture and then adding a single adjective in front of the word 'culture' with the intention and hope of influencing people to behave in accordance

with that description. I cannot see why this will succeed. Notwithstanding the huge learning and interest in NHS culture and the repeated calls for changes in culture, I am not persuaded that 'culture' can be more than a description of behaviours.

39.17 Responses to the Inquiry questionnaire, administered and analysed by the Nuffield Trust, support this, with most senior managers suggesting – in responses to questions about culture – that they were not well placed to define the culture for the whole organisation.[19] Indeed, the list of factors that influence culture – positively or negatively – was exceptionally broad, encompassing relatively superficial initiatives, such as 'board breakfasts', as well as much more serious issues, such as bullying or harassment.[20] At the very least, the strength of the concept of 'culture' as a guide for managers looking to drive up standards is limited by the idea that there could be many different cultures, influenced by a huge range of factors.

39.18 It is behaviours that need to change. I am fortified in that view by Sir Robert Francis's evidence about patient safety conferences that involve well-meaning professionals meeting to agree that the culture in their

Trusts needs to be improved before they "*go back to wherever they come from* [and] *nothing much seems to happen to change it*".[21] What is currently being done is not working.

Back to basics

39.19 Earlier in my Report, I found it useful to identify the core purpose of a hospital: to treat and care for patients, and to do so with respect and kindness. The starting point for everyone must be patient safety. If, as I have said in respect of managers, patients are at the centre of all that is done in a hospital, appropriate positive behaviour should be expected and should follow.

39.20 Sir Stephen Powis said in his evidence that "*do no harm*" – the original and enduring first duty of a doctor – remained a guiding principle for all in the NHS, although the duty is now more usually described as 'keeping patients safe'. He was asked about the effect of finances on that principle. He said:

> "*Patient safety is … at the very top of NHS England's responsibilities and I would say that for every leader within the health system that is and should be top priority. 'First do no harm' is a phrase that you will*

recognise, it is a phrase that clinicians … live by and it's the same for organisations and senior leaders: our first duty is to 'first, do no harm'."[22]

He then added:

"[O]*bviously it is important to acknowledge that particularly in financially challenging circumstances, senior leaders have to make a decision about where they deploy their resources. But I go back to my previous answer. At the very top of everybody's list is patient safety … we are very clear currently that the priority is not to harm and therefore I would say deploying resources to support patient safety would be at or near the top of most people's priorities.*"[23]

I note the slight step back in the last remark. There should be no compromise on this. Patient safety must be the top priority for all managers – indeed, for all people working in the NHS. All behaviour must be directed to that priority.

The Countess

39.21 I have said much earlier in this Report that, in early 2015, the neonatal unit at the Countess was characterised by good relationships

between, and across, professional groups. It was a place where young doctors wanted to work; and it had a reputation for good training and high standards. It was also an active participant in the Operational Delivery Network.[24]

39.22 Once concerns rose about the number of deaths, staff on the neonatal unit became anxious. Later, when it was realised that the doctors had suspicions about a nurse, things changed. Ms Powell made her views plain, in strident terms. Ms Kelly and Mr Harvey ignored deteriorating relationships. The nurse managers accepted in evidence that, from that time, relationships could be described as 'nurses against doctors'. Whilst no one suggested that this adversely affected care on the neonatal unit, the unit became a very different place. Relationships were cooler.

39.23 At the heart of this deterioration in relationships was a well-known cultural phenomenon: sometimes referred to as tribalism, it is unthinking loyalty to one's team or profession. The senior nurses demonstrated unquestioning loyalty to Letby throughout the events with which I am concerned. It ran together with their certainty that there was nothing in the consultants'

concerns. Ms Powell said to Dr Green in her grievance interview at the end of 2016 that Drs Jayaram and Brearey were not usually malicious, but that view does not seem to have caused her to ask herself whether there might be something in their concerns even when asking herself, repeatedly, whether she was missing something. I accept that she, Ms Rees and Ms Kelly believed that Letby was not responsible for the deaths, but loyalty seems to have prevented them from considering the doctors' concerns with an open mind or thinking about safeguarding. The email sent by Ms Rees to Ms Kelly on 9 September 2016 contained the words:

> "[A] *Clinician is being listened to and supported, with potential devastating consequences for a nurse. How are the nurses on the NNU* [neonatal unit] *going to react? I have already witnessed that senior nurses on that unit do not even want to answer the telephone to that consultant, who is making these allegations and making clear his personal view.*"[25]

Mr Baker KC described this as frank tribalism.[26] It was clear evidence of unthinking loyalty.

39.24 The senior managers were concerned for the reputation of the hospital, which in general is not of itself a bad thing but here it contributed to the very long delay between those concerns being raised and contacting the police in May 2017. In evidence and in closing submissions the executives said that the reason for the delay in contacting the police (which they accepted occurred) was not because they intended not to call the police; it was so they could approach the police "*at the right time when the precise nature of the concern was clear and could be fully articulated*"[27] That submission is not borne out by the evidence that I have set out in detail.

39.25 It follows that I find that culture, as described, did play a part in the failures by managers at the Countess.

Endnotes

1 **Expert Report by Sir Robert Francis KC – Part 1 30 May 2024 INQ0101077**

2 **Expert Report by Sir Robert Francis KC – Part 1 30 May 2024 INQ0101077/36/para 7.1**

3 **Expert Report by Sir Robert Francis KC – Part 1 30 May 2024 INQ0101077/36/para 7.2**

4 Parliamentary and Health Service Ombudsman, *Broken Trust: Making Patient Safety More Than Just a Promise*, 2023 (**https://www.ombudsman.org.uk/publications/broken-trust-making-patient-safety-more-just-promise-0**); **INQ0014545**

5 **Witness statement of Sir Rob Behrens CBE INQ0014599/10/para 40**

6 **Witness statement of Sir Rob Behrens CBE INQ0014599/10/para 40**

7 **Witness statement of Sir Rob Behrens CBE INQ0014599/10/para 40**

8 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/39**

9 **Sir Robert Francis KC 30 September 2024 74/17 to 75/9**

10 **INQ0108025**

11 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/7-9**

12 **Prof. Mary Dixon-Woods 26 September 2024 4/21 to 5/10**

13 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/45-47**

14 **Expert Report by Sir Robert Francis KC – Part 2 30 May 2024 INQ0101079/10/paras 1.10-1.11**; **INQ0101079/39/paras 5.2.2-5.2.3**

15 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/15**

16 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/8-9**

17 UK Government and NHS, *Fit for the Future: 10 Year Health Plan for England*, 30 July 2025 (**https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf**)

18 **Report to the Thirlwall Inquiry: Addressing Part C of the Terms of Reference by Prof. Mary Dixon-Woods INQ0102624/63**

19 **INQ0018076/62**

20 **INQ0018076/66-69**

21 Sir Robert Francis KC 30 September 2024 30/24 to 31/1

22 Prof. Sir Stephen Powis 17 January 2025 189/16-23

23 Prof. Sir Stephen Powis 17 January 2025 190/3-12

24 Dr Nim Subhedar 20 November 2024 19/8-15

25 INQ0002860/1

26 Written Closing Submissions on Behalf of Family Group 2 and 3 7 March 2025 95/para 440

27 Written Closing Submissions on Behalf of the Senior Management Team 7 March 2025 3/ para 9

Chapter 40. Freedom to Speak Up Guardians

Background

40.1 Sir Robert Francis explained in evidence that the reason for the 2015 Freedom to Speak Up Review, which he chaired, was:

> "[T]*here were … cases of about 20 healthcare staff who one way or the other … raised concerns of a wide variety of things … most were about patient safety, but some were about fraud or other issues, and all of these people having raised the concern had found themselves the subject of an investigation or adverse action of some shape or form.*"[1]

He considered that "*the remedies available by way of employment law didn't seem to protect anybody*".[2] In response to his report, the appointment of Freedom to Speak Up Guardians (FTSU Guardians) became part of the standard NHS contract in 2017.[3]

Whilst whistleblowing legal protections had been in place for some time, there was not a developed system of speaking up.

40.2 The National Guardian's Office (NGO) came into being in 2016; it was a small organisation, with limited resources (16 staff) and limited powers. In a helpful written statement, Mr Charlie Cassell, Director of Operations and Strategy for the NGO, pointed out that it had neither the power nor resources to hold hospitals or other healthcare settings to account in respect of the raising of concerns/ FTSU. He explained the ways in which the NGO might be expanded to good effect.[4]

The FTSU Guardian role and its challenges

40.3 In her written statement, Dr Jayne Chidgey-Clark, National Guardian for the NHS (September 2021 to December 2021), summarised the FTSU Guardian role thus:

> "*Freedom to Speak Up guardians work alongside trust leadership teams to ensure all staff have the capability to speak up effectively and are supported appropriately. They work to ensure that speaking up processes are effective, continuously improved and that safety and quality are assured as a result. They also engage*

their Boards in all freedom to speak up matters and issues that are raised so that a culture of speaking up, listening up and following up, is instilled throughout the organisation and the NHS."

40.4 According to the most recent annual data report from the NGO – published in May 2026 and reporting on the period 1 April 2025 to 31 March 2026 – the number of FTSU Guardians serving in various organisations had risen to 1,519.[5]

40.5 Until very recently, all FTSU Guardians were appointed by hospital Trusts from within their existing staff. There was no central funding, and the role was in addition to their existing role (which could be anywhere in the hospital, clinical or otherwise). Trusts also appoint executive and non-executive leads for Speaking Up. The NGO's website (as of June 2026) said that some Trusts are now appointing full-time FTSU Guardians;[6] but no numbers are given, and I infer that this has happened in a small minority of large Trusts. Ms Helené Donnelly OBE, Ambassador for Cultural Change and Lead Freedom to Speak Up Guardian for the Midlands Partnership Foundation NHS Trust from 2013 to 2022, said that FTSU Guardians were busy

members of mid-level management. She thought the amount of time they had ring-fenced for their FTSU duties was unclear.[7] Mr Cassell's evidence mirrors that of Ms Donnelly, Ms Raphael (Director of Protect) and Mr Stuart Lythgoe (Director of Operations for the Hospital Consultants and Specialists Association): "*Unfortunately, there is variation in how the guardian role is implemented with evidence that many guardians do not have enough protected/ring fenced time to carry out their roles effectively.*"[8]

40.6 The NGO did not investigate individual cases, nor did it audit the work of individual Guardians. Rather, it provided well-regarded mandatory training;[9] offered support calls to guardians; collected anonymised data from guardians, every quarter, about the cases dealt with; and offered board/trustee development sessions for leaders. Ms Donnelly explained that there are three tiers of FTSU training – the first for all workers, the second for those with any leadership and management responsibility, and the third for senior leaders, including executives at board level and non-executives. Her experience was that most Trusts had mandated the first tier, some the second tier, but none all three.[10] She was aware that some

senior leaders asked their assistants to click through the FTSU e-learning materials.[11] I assume this is a small minority of senior leaders. Its effect is to undermine the importance of the FTSU system.

40.7 Professor Dixon-Woods said in evidence that there was significant variability in how well Trusts operated their FTSU Guardian system. She explained that in an organisation lacking the right culture at senior level, the introduction of a FTSU Guardian is treated as a box-ticking exercise, the thinking being: "*We need to ensure we've got one, we need to send in a report every year*."[12] In other hospitals with a "*highly open, learning committed culture, they would have put a lot of effort into finding the right person, briefing them and … providing them with the resources that they need and encouraging staff to come forward rather than treating it as literally yet another duty*".[13] Evidence from Ms Donnelly[14] and Mr Lythgoe confirmed the reality on the ground. Mr Lythgoe said that the Hospital Consultants and Specialists Association's advice to a doctor with a concern would depend on which hospital they worked for.[15] The move towards less national oversight, with the abolition of the NGO, is worrying in this context (see below).

40.8 Professor Bowers KC had a similar impression:

> "*I think there is a feeling that some Trusts have excellent Speak Up Guardians who are dedicated to the role and are sympathetic and have sufficient time to devote to it. But in some it's really just another role on top of busy, busy roles that they are conducting anyway and there's no, as I understand it, job description or standardisation of what they should do.*
>
> *So I think the answer is that in some Trusts it works well, with some dedicated people. In others, it works less well.*"[16]

40.9 Ms Donnelly's view, from her wide experience, was that many FTSU Guardians, and others, still do not feel able to speak up because there is often a culture of "*toxic negativity*" towards somebody who speaks up. She explained that with "*an absolutely overstretched National Health Service where everybody is firefighting, everybody is under pressure*", and therefore executives do not look kindly on members of staff bringing additional problems to them.[17] She pointed to the problem of a "*ripple effect*" – when a

concern is known not to have been dealt with, others, who would otherwise have raised a concern themselves, stay silent.[18]

40.10 The 2025 NHS Staff Survey showed a concerning decline in workers' confidence in speaking up, with the FTSU sub-score falling to a five-year low of 6.37 (down from 6.45 in 2024).[19] It was the view of Mr Lythgoe that the majority of hospital doctors did not feel it was possible to raise patient safety concerns without experiencing a detrimental effect on their careers. He pointed to the results of a survey carried out by the Hospital Consultants and Specialists Association in 2023, where 70% of the 526 respondents expressed that view.[20] The detriments reported included the threat of referral to a regulator and the threat of disciplinary proceedings.[21] This occurred at the Countess.

40.11 The experience of the Hospital Consultants and Specialists Association is that the GMC referrals lead to lengthy delays, and the GMC does not often investigate a complaint that a referral was made vexatiously. The disciplinary proceedings often take the form of action under the Maintaining High Professional Standards framework, but the process is slow, leading to "*inordinate delay*"

and loss of skills.[22] Investigations against doctors often themselves create problems of isolation or division within departments, and such divisions can then be a pretext for dismissal under the "*some other substantial reason*" provision in the Employment Rights Act 1996 (section 98(1)(b)).[23]

40.12 Ms Raphael's view was that whilst policies were all very good, there was a lack of accountability for dealing with whistleblowing at senior management level.[24] I addressed this question when dealing with the duty of candour (see Chapter 38). Ms Raphael also pointed to the absence of accountability at regulator level: "[A]*lthough there are a plethora of regulators in the health sector, there doesn't seem to be a single regulator that's actually focused on punishing those who silence whistleblowers*."[25] The number of regulators was commented on by a number of Inquiry witnesses, and I have dealt with this elsewhere. As to accountability for punishing whistleblowers, I return to this below.

40.13 Ms Donnelly's view was that a wish to protect the reputation of the organisation often led to concerns not being addressed. She was critical of the lack of transparency around the outcomes of investigations – for example, that

even where a finding of bullying was made, this was often not disclosed. Similarly, where an allegation of bullying was dismissed, this outcome was often not shared.[26]

40.14 Ms Raphael gave powerful evidence of active victimisation of whistleblowers by the malicious overuse of the Datix system.[27]

40.15 On 30 June 2025, as a result of Dr Dash's *Review of Patient Safety Across the Health and Care Landscape* (the Dash Review), for DHSC, it was announced that the NGO would be closed at the end of June 2026 and its functions transferred to NHS England – whose own abolition had been announced three months earlier.[28] A letter dated 13 August 2025 was published on the NGO's website and signed on behalf of NHS England, DHSC and the interim Director of Operations at the NGO. It sought to give reassurance that FTSU and the role of FTSU Guardians would be incorporated into the NHS Standard Contract for 2026/27; and expressed a commitment to the national support of, and guidance for, FTSU Guardians.[29]

40.16 In April 2026, NHS England updated their website to confirm that, from 1 July 2026, NHS England would take over delivering "*some activities previously undertaken*

by the National Guardian's Office" and "*trusts, primary care organisations, ICBs and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements*".[30] There is no comment on what will happen when NHS England is abolished.

40.17 FTSU Guardians should be properly supported and trained. The NGO provided confidential one-to-one support and access to a national employee assistance programme specifically for Guardians. From abolition, Trusts and other organisations are to ensure there is independent psychological support available locally to their Guardian. Guardians can contact the NHS England Contact Centre with general enquiries and request specialist one-to-one support. This contact centre is the same "*whistleblowing hotline*" that only one Trust mentioned in response to the questionnaire that the Inquiry conducted (see Appendix 2), suggesting limitations in its efficacy.[31]

40.18 A key change is training. Refresher training will no longer be mandatory, and the future of board-level training is unclear. The NGO previously monitored compliance with training;

this will now be done locally. In 2025/26, the NGO "*stepped down 304 guardians who informed us they are no longer in the guardian role or who were non-compliant with training requirements*".[32] Without an organisation to oversee national compliance, upholding standards may not happen. It could add to local variation, which I discuss below.[33]

40.19 Guardian networks and Guardian mentors have been a feature of the FTSU system. Ms Donnelly told the Inquiry: "[T]*he national and regional Freedom to Speak Up Guardian networks provide a safe space for Guardians to gain peer support and advice, to learn and share best practice*."[34] The NGO said these networks are "*a cornerstone of professional connection, offering trusted and confidential spaces for guardians to share experiences, seek advice, and navigate complex or sensitive cases. They play a critical role in upholding guardian well-being, reducing isolation, and promoting reassurance, reflective practice and mutual learning*."[35] The NGO helped to coordinate these networks and the mentoring scheme.

40.20 Mentors were introduced in the summer of 2022. They are "*experienced guardians who help newly appointed Freedom to Speak Up*

guardians reflect on their experience, helping them to identify any learning and support needs through discussion and guidance as they progress in their role".[36] Quarterly mentor meetings were facilitated by the NGO. NHS England's FTSU team and regional teams are now to take over network support. Any loss of national support needs is not acceptable. NHS England's position is that "[n]*ew guardians will be able to access mentors through the NHS England training platform*".[37] These new arrangements do not provide reassurance that Guardians will be adequately trained and supported.

40.21 With the abolition of the NGO, quarterly data collections are being handled through NHS England's national data process, and only cover NHS Trusts, Foundation Trusts and ICBs – not primary care and independent healthcare organisations.

40.22 As recommended in the Dash Review, under the new arrangements: "*The CQC will now verify guardian arrangements in NHS trusts through their Well-led inspections.*"[38] However, the plans for this are still to be confirmed, with NHS England stating it will "*continue to liaise with the CQC on how compliance will*

be assessed within the Well-led inspection regime".[39] That this is not already determined is concerning. See below.

Investigations

40.23 Ms Donnelly informed the Inquiry that HR departments, which should investigate concerns raised with, and then by, FTSU Guardians, frequently make poor decisions, such as appointing investigators who are "*known to be good friends with the person they are investigating or have worked very closely with them*".[40] What happened at the Countess was an example of an analogous situation, where neither investigator nor chair of the panel should have been appointed to deal with Letby's grievance. Ms Donnelly also pointed out the problem of busy managers being tasked with undertaking complex investigations when they lacked the training to do so. This leads to poor-quality investigations and detriment of the core role of the FTSU Guardian. Ms Donnelly suggested creating a central pool of investigators to deal with anything above low-level matters.[41] This echoed the evidence and views of Dr Benneyworth (see Chapter 43).

Scotland

40.24 Scotland has a different system for whistleblowing. There is a central body – the Independent National Whistleblowing Officer (INWO) – which has the power to investigate whistleblowing concerns in healthcare. Ms Rosemary Agnew is the current Scottish Public Services Ombudsman, which office, since 2021, includes the INWO. The INWO sets standards that NHS Scotland healthcare providers are expected to follow in handling whistleblowing concerns.[42]

40.25 Importantly, the INWO has the following power:

> "*As the final stage of the whistleblowing process, I can consider all action taken in the NHS organisation's investigation and their response to the concern. This includes* ***any decisions made about the substantive matter*** [emphasis added] *(not just the handling of the concern), and can consider any clinical judgement made or relied upon. The INWO is given explicit powers to comment on (speak up) culture and whether there has been any detriment to any individual.*"[43]

In other words, the role of the INWO is not just about process; it can also be about substance.

40.26 The INWO also runs "*monitored referrals*". As Ms Agnew explained:

> "*A monitored referral is where the INWO, with the whistleblower's consent, refers the concern* [raised] *to the NHS organisation on their behalf* …
>
> …
>
> *The benefits of this approach are that it gives whistleblowers the reassurance that the INWO is aware of the issue; and it puts the NHS organisation on notice that the INWO is aware of the issue. It also highlights for both parties that advice and support is available.*
>
> *I have made about 19 monitored referrals in total. With such small numbers, it is difficult to draw definitive conclusions, but one indicator of effectiveness is that, so* [far]*, only a small proportion of these have come back to the INWO for further investigation.*"[44]

40.27 The INWO has a statutory power to disclose information to appropriate bodies, including to the police and regulators, if there is a threat to the health or safety of a person or persons.[45]

Effectiveness of the INWO

40.28 Ms Donnelly said that she had spoken to individuals who had worked within the INWO system and escalated concerns to it, and that, while this system was not perfect, it had "*real bonuses to it*".[46] Mr Lythgoe's experience was that it had led to an improvement of the situation in Scotland.[47] Ms Raphael said that Protect was involved in drafting the INWO's standards, and her view was that the INWO was a good system because (a) it had the power to tell hospital boards to investigate concerns, and (b) its standards, in terms of expectations about how concerns should be addressed, were more specific than the standards that applied in England.[48]

40.29 Ms Agnew felt that "*significant and genuine progress has been made across Scotland*".[49] She noted that survey data showed that 79% of NHS Scotland staff said they were confident to speak up, and that 74% were confident that concerns would be followed up.[50] She reflected that placing whistleblowing

within the remit of the Scottish Ombudsman has had distinct benefits, and that: "*The underlying learning from this, is that there may be benefit to leveraging impact by strengthening what exists and building on experience already gained.*"[51]

Externally employed FTSU Guardians?

40.30 Mr Cassell's view echoed that of Sir Robert Francis: "*Guardians who work within the organisation they support are close to where care is delivered and the people who deliver it. They understand local culture and can build trust. However, managing confidentiality and real or perceived conflicts of interest can be challenging*."[52]

40.31 I accept the argument against making Guardians external to Trusts. When part of the hospital or other healthcare setting, Guardians are easier to contact, know the local conditions, and are able easily to contact those who need to be aware of the concerns. Hospitals and other settings ought to be encouraging of, and responsible for, the effectiveness of FTSU Guardians. Outsourcing effectiveness and responsibility for such an important function would be unwise.

An INWO for England?

40.32 Sir Rob Behrens, who was the Parliamentary and Health Service Ombudsman between April 2017 and March 2024, persuasively argued for the inclusion of an equivalent to the INWO within England's Ombudsman:

> "[O]*ne of the great ironies, lamentable ironies, is that the UK Ombudsman does not have the powers of the devolved Ombudsman that were created in the United Kingdom fairly recently.*
>
> *So the Northern Irish and the Welsh public service Ombudsman have the power of own initiative but we don't.*
>
> *And in Scotland, the law has been changed so that the Ombudsman is the body to which people who want to blow the whistle can go and get advice about what to do in these difficult circumstances. And … that's not perfect, but it means there is a public body that people can go to to raise their concerns and feel supported*."[53]

40.33 Sir Robert Francis agreed that there should be a central body to which people could turn, in addition to local Guardians:

> "*I would use it as something alongside your Freedom to Speak Up policy. We have talked about guardians and I am very keen on everywhere having guardians. But there is also a place for having an external agency to which people can go entirely confidentially.*
>
> *One would like to think that the regulator would be sufficient but it may not be … and if one is talking about sensitive issues whether they be crime as in harm to patients or sexual misconduct and harassment and bullying, all of that would benefit from having an external place that you can go to, either anonymously or not*[,] *to record your issue.*
>
> *I would like to think that it needs to be an outsourced place which has a clinical and professional understanding and expertise within it.*"[54]

40.34 As I have set out, Sir Rob Behrens gave evidence that the integration of the INWO within the Scottish Public Services Ombudsman seems to work very well, and he cautioned against a further flourishing of regulatory bodies in healthcare.[55]

40.35 Acknowledging that the NGO has been abolished I recommend that its functions to support FTSU Guardians should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include (a) investigating complaints that whistleblowing in the NHS has not been dealt with adequately, and (b) assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

40.36 This will increase the degree of independent oversight over the handling of whistleblowing in the NHS, whilst simplifying (or, at least, not further complicating), the regulatory matrix in the health service.

The Dash Review

40.37 As set out above, Dr Dash, in her review, in recommending the abolition of the NGO pointed out that its role is partly to build a network of FTSU Guardians and partly to provide a national voice and leadership. The first part had broadly been achieved (see above). It is not clear where the national voice and leadership is to come from. Dr Dash says that "*clear routes for staff to escalate concerns have been set out by government*" and so

it "*is not clear that there is a need for an independent oversight body*".[56] What seems to have been overlooked is that whatever issues are raised by the FTSU Guardian there is no requirement on hospitals to act upon concerns. Some do take action, and do so effectively. Many of them do not. I have dealt with this issue in Chapter 38.

40.38 Dr Dash considered that placing the responsibility for FTSU Guardians firmly within the responsibilities of commissioners and providers would raise the profile and importance of staff voices and allow for a more rapid response. This system is now in place. This seems to me rather optimistic, given that, even after ten years, Ms Donnelly was still pointing to failings within the system.[57]

40.39 Dr Dash acknowledges that there will still be a need to ensure a level of independence to support FTSU functions. In many organisations, this role is played by a senior non-executive director, and these arrangements should continue, according to Dr Dash. She recommends that ensuring that these functions are happening in all commissioners and providers should be a

core function of CQC as the independent regulator of health and care. This is also being acted upon.

40.40 Two things arise from this. First, I am confident that the level of competence of the CQC teams would need significant strengthening before CQC can be given another core function, particularly one of such sensitivity. Second, ensuring that the functions are happening amounts to no more than checking there is a process. It is likely that this will be another box-ticking exercise, as seen at the time of the inspection of the Countess in February 2016. It does not grapple with the substance of the concerns.

40.41 Dr Dash points to other industries' mechanisms that encourage and enable employees to raise concerns, which are of a wholly different order from those I have described in this Report so far. The Civil Aviation Authority and the maritime industry fund the Confidential Human Factors Incident Reporting Programme (CHIRP), where anyone working in these industries can raise safety concerns in confidence.[58] A similar organisation, CIRAS (Confidential Incident Reporting and Analysis Service), operates a 'Confidential Safety Hotline' that

serves the transport sector, including rail, buses, highways, ports and transport supply chains.[59] These examples support the view that an external body is necessary to allow the effective escalation of concerns and to enable action being taken. An important point is that these examples are properly funded by their respective industries and are acknowledged to be essential.

Conclusions

40.42 Like Sir Robert Francis and several other witnesses at the Inquiry (Ms Donnelly, Sir Rob Behrens, Mr Cassell), and notwithstanding the abolition of the NGO, I am quite sure that an external structure with national reach is still necessary. The Parliamentary and Health Service Ombudsman is ideally placed to carry out this work. It would require appropriate funding. Another, probably more expensive, approach would be to set up a structure along the lines of the successful Scottish INWO model.

40.43 I firmly recommend that FTSU Guardians remain in place; that their work – and the responses to it by the hospitals/other healthcare settings – is properly monitored and reported upon; and, importantly, that

there is an external body with powers to act, to whom FTSU Guardians and others may go when they have serious concerns that are not being dealt with by the hospital or healthcare organisation. It is to be expected that the number of such referrals will be small, as all hospitals develop a positive approach to raising concerns and acting upon them. But an external, independent body of the type I have described is essential.

Endnotes

1 **Sir Robert Francis KC 30 September 2024 176/16-24**

2 **Sir Robert Francis KC 30 September 2024 177/25 to 178/1**

3 **Helené Donnelly OBE 4 December 2024 151/1-2**

4 **Witness statement of Charlie Cassell INQ0108922**

5 NGO, *Annual Report April 2025–March 2026*, May 2026, page 23 (**https://nationalguardian.org.uk/wp-content/uploads/2026/05/J70605_NGO_Annual-Report_A4_36pp_v3_ACCESSIBLE_WEB.pdf#page=23**)

6 NGO, *Annual Report April 2024–March 2025*, November 2025, page 15 (**https://nationalguardian.org.uk/wp-content/uploads/2025/11/NGO_AR_2025_Digital-3.pdf#page=15**)

7 **Helené Donnelly OBE 4 December 2024 154/13-22**

8 **Witness statement of Charlie Cassell INQ0108922/3/para 14**

9 NGO, 'Training for Freedom to Speak Up Guardians' (**https://nationalguardian.org.uk/for-guardians/training-for-guardians/**)

10 **Helené Donnelly OBE 4 December 2024 168/13-25**

11 **Helené Donnelly OBE 4 December 2024 169/18-22**

12 **Prof. Mary Dixon-Woods 26 September 2024 106/3-4**

13 **Prof. Mary Dixon-Woods 26 September 2024 105/24 to 106/12**

14 **Helené Donnelly OBE 4 December 2024 153/1-9**

15 **Stuart Lythgoe 5 December 2024 21/16 to 22/1**

16 **Prof. John Bowers KC 5 December 2024 70/12-21**

17 **Helené Donnelly OBE 4 December 2024 157/9-21**

18 **Helené Donnelly OBE 4 December 2024 158/22**

19 NGO, *Annual Report April 2025–March 2026*, May 2026, page 12 (**https://nationalguardian.org.uk/wp-content/uploads/2026/05/J70605_NGO_Annual-Report_A4_36pp_v3_ACCESSIBLE_WEB.pdf#page=12**)

20 **Stuart Lythgoe 5 December 2024 4/10-16**

21 **Stuart Lythgoe 5 December 2024 4/21 to 5/5**

22 **Stuart Lythgoe 5 December 2024 8/11-12**

23 **Stuart Lythgoe 5 December 2024 11/1 to 12/19**; Employment Rights Act 1996, section 98 (1)(b) (**https://www.legislation.gov.uk/ukpga/1996/18/section/98**)

24 **Sybille Raphael 5 December 2024 40/2-4**

25 **Sybille Raphael 5 December 2024 40/5-8**

26 **Helené Donnelly OBE 4 December 2024 185/16-24 and 187/21 to 188/1**

27 **Sybille Raphael 5 December 2024 41/10-17**

28 NGO, 'Announcement about the future of the National Guardian's Office', 30 June 2025 (**https://nationalguardian.org.uk/2025/06/30/announcement-about-the-future-of-the-national-guardians-office/**); Dr Penny Dash, *Review of Patient Safety Across the Health and Care Landscape*, DHSC, 7 July 2025 (**https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape/review-of-patient-safety-across-the-health-and-care-landscape**)

29 NHS England, 'Update following the publication of the Patient Safety Landscape Review' (letter), 13 August 2025 (**https://nationalguardian.org.uk/wp-content/uploads/2025/08/Update-to-FTSU-Guardians-DHSC.NHSE_.pdf**)

30 NHS England, 'The future of Freedom to Speak Up', 16 April 2026, updated 9 June 2026 (**https://**

www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up/#summary)

31 **INQ0018076/105**

32 NGO, *Annual Report April 2025–March 2026*, May 2026, page 23 (**https://nationalguardian.org.uk/wp-content/uploads/2026/05/J70605_NGO_Annual-Report_A4_36pp_v3_ACCESSIBLE_WEB.pdf#page=23**)

33 NHS England, 'The future of Freedom to Speak Up', 16 April 2026, updated 9 June 2026 (**https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up**)

34 **Witness statement of Helené Donnelly OBE INQ0017906/5/para 14**

35 NGO, *Annual Report April 2025–March 2026*, May 2026, page 28 (**https://nationalguardian.org.uk/wp-content/uploads/2026/05/J70605_NGO_Annual-Report_A4_36pp_v3_ACCESSIBLE_WEB.pdf#page=28**)

36 NGO, *Making Speaking Up Business as Usual: Annual Report, April 2022–March 2023*, November 2023, page 28 (**https://nationalguardian.org.uk/wp-content/uploads/2023/11/NGO_AR_2023_Digital.pdf#page=28**)

37 NHS England, 'The future of Freedom to Speak Up', 16 April 2026, updated 9 June 2026 (**https://**

www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up)

38 NHS England, 'The future of Freedom to Speak Up', 16 April 2026, updated 9 June 2026 (https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up)

39 NHS England, 'The future of Freedom to Speak Up', 16 April 2026, updated 9 June 2026, Appendix 1: Timeline (https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up/#appendix-1-timeline)

40 Helené Donnelly OBE 4 December 2024 177/1-3

41 Helené Donnelly OBE 4 December 2024 172/16 to 173/19 and 174/13-20

42 Witness statement of Rosemary Agnew INQ0108777/2/para 5

43 Witness statement of Rosemary Agnew INQ0108777/3/para 9

44 Witness statement of Rosemary Agnew INQ0108777/4-5/paras 19-22

45 Witness statement of Rosemary Agnew INQ0108777/11/para 53a

46 Helené Donnelly OBE 4 December 2024 164/10

47 Stuart Lythgoe 5 December 2024 18/11-13

48 **Sybille Raphael 5 December 2024 46/20 to 47/14**

49 **Witness statement of Rosemary Agnew INQ0108777/9/para 43**

50 **Witness statement of Rosemary Agnew INQ0108777/8/para 38ci and cii**

51 **Witness statement of Rosemary Agnew INQ0108777/11/paras 50-51**

52 **Witness statement of Charlie Cassell INQ0108922/8/para 35**

53 **Sir Rob Behrens CBE 10 December 2024 25/14 to 26/1**

54 **Sir Robert Francis KC 30 September 2024 132/19 to 133/8**

55 **Sir Rob Behrens CBE 10 December 2024 27**

56 Dr Penny Dash, *Review of Patient Safety Across the Health and Care Landscape*, DHSC, 7 July 2025 (**https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape/review-of-patient-safety-across-the-health-and-care-landscape**)

57 **Helené Donnelly OBE 4 December 2024 149/22-25**

58 UK Civil Aviation Authority, 'What is CHIRP' (**https://www.caa.co.uk/safety-initiatives/working-with-industry/chirp/what-is-chirp**)

59 Confidential Incident Reporting and Analysis Service, ‘CIRAS: Confidential Safety Hotline’ (**https://www.ciras.org.uk**)

Chapter 41. Patient safety, safeguarding and employment law

41.1 When giving evidence to the Inquiry, Professor Bowers KC, an expert in employment law, explained the tensions that arise between the requirements of employment law and the interests of patient safety:

> "[T]*here's a tendency to consider employment issues separate to the issues of patient safety so that we look as employment lawyers, for example, at whether the employee might have a potential claim for constructive dismissal or have a valid grievance and perhaps put issues of patient safety into another box.*"[1]

He explained that "*there's usually not a right to suspend. So suspension would be a potential breach of contract, could lead to a constructive dismissal*."[2] All of these elements featured in the discussions between the HR department and the solicitors representing the Countess in 2016.

41.2 In my view, as a general principle, where safeguarding or other concerns about patient safety are raised in good faith, the balance to be struck by a responsible NHS employer between the risk of an employment claim and the risk to patient safety comes down firmly in favour of protecting the patient. In most cases within the NHS, deployment to another part of the organisation will be possible. Where suspension is the only option that will allow a fair investigation of concerns, while protecting other patients, that will be a defensible choice.

41.3 As I have explained at length in Chapter 12, when safeguarding concerns are raised, there is a duty on a hospital (and the senior managers within it) to take action. In schools, there is a clear understanding of what to do when concerns about, or suspicions of, deliberate harm are raised against teachers. The most usual and correct response is to move the person about whom the concern has been expressed to a post where they can do no harm, or to exclude them from the school while the matter is investigated, either internally or by the police depending on the nature of the allegation. This is always described as a neutral act, and often the complaint or concern comes to nothing. I acknowledge that it is deeply unpleasant

and distressing to be the subject of such a complaint, particularly when the complaint is unjustified, but that outcome is undoubtedly better than leaving in place a person about whom there are concerns or complaints who goes on to cause (further) harm. Teachers and head teachers understand that. Doctors, nurses, managers and all those who work in the NHS must understand it too.

41.4 Professor Mary Dixon-Woods spoke about the lack of clarity in employment policies for handling serious concerns:

> "*I think there is an absence of clarity about what you do in -- confronted with an unexpected series of highly transgressive events, particularly in those caring for children.*
>
> …
>
> *If somebody is suspected of fraud, there is a series of steps that the organisation knows what to take. I'm not sure that the same clarity is there in* [the] *event that somebody is suspected of murder, for example, or attempted murder, so what may happen is that patient safety incidents are handled through patient safety incident processes, they are … effectively are sequestered from issues to*

do with discipline and HR issues, so may enter a different process which remains confidential and those two systems don't necessarily handle very well issues of highly transgressive behaviour."[3]

41.5 That is what happened at the Countess. There was an example of the separation of HR and safety processes when Ms Millward dismissed Ms Lawrence's concerns about the repeated appearance of Letby's name in the appendix to the Thematic Review (see Chapter 6). Ms Millward considered this was an HR matter. The RCPCH's recommendation of an HR investigation into the concerns about Letby was, as I have explained elsewhere (see paragraph 20.103, Chapter 20), misguided – and was ignored by the Countess in any event.

41.6 There is no step-by-step guidance on what to do if suspicions of deliberate harm or even killing have been raised in a hospital. This suggests there is only one thing to do when that point has been reached – contact the police. I reject the assertion of the senior managers that they did not know what to do. They knew they should contact the police and, after many months of delay, that is what they did. Their repeated request in submissions

for guidance about what to do when there is no evidence is disingenuous. They were not in the position of having no evidence in support of the doctors' concerns: there was a marked increase in the number of deaths; the deaths were preceded by collapses which were unexpected and unexplained; most of them occurred between midnight and 04:00; the same nurse, Letby, was on duty for all the deaths and most of the collapses; the babies did not respond to resuscitation as they should. The type and quality of the evidence was a matter for the police to investigate. The fact that the managers did not believe what they were being told is nothing to the point. Once suspicion of harm is reported in good faith, managers and leaders must act.

41.7 There will be cases, as at the Countess in the early months, when there may not be sufficient information to lead to suspicion, but there is an emerging concern of harm by an individual. In that situation, the first step is to protect each child by moving the person who may be responsible. In the ordinary course of events, internal investigations, like those done by Dr Brearey, would reassure those with concerns that there is a clinical explanation, or they would have the opposite effect and lead to greater concern and suspicion. Since

life is rarely neat, it is more likely that the internal investigation would not help one way or the other. In that situation, the ideal way forward would be to take the emerging concern to a suitable expert, or experts, from another hospital, who would review the case or cases and give their views. There would have to be full and frank disclosure to them of all the relevant background and any emerging concerns. Depending on the outcome of that review, either the matter would stay where it was or be reported to the police.

Contractual duty to report safeguarding concerns

41.8 Professor Bowers KC was supportive of including in employment contracts a term requiring the employee to make safeguarding referrals whenever appropriate: "[Y]*ou could put it in the employment contract as a duty. That would be another mechanism because, as you say, not everybody even within the health service would be under professional duties.*"[4] There can be no reasonable objection to this.

41.9 All staff who may come into contact with vulnerable patients (nearly everyone) should receive safeguarding training which includes

the fact that it is a term of their employment contract that they make a safeguarding referral where they (or someone who has confided in them) have concerns that a member of staff has harmed a child. In that situation, the person complained about is moved from their role while the matter is investigated.

41.10 For safeguarding referrals involving babies and young children, the investigation could be done by the Maternity and Newborn Safety Investigations programme (assuming it is properly resourced). Alternatively, it would go to the police through the safeguarding route.

Changes to HR policies in Trusts

41.11 Most witnesses agreed that HR policies need to be rebalanced in favour of patient safety. For reference, the Countess's current policies are: the Disciplinary Policy, the Grievance Policy and the Freedom to Speak Up Policy.

41.12 All employment policies should include a clearly stated overriding objective, which is the safety of patients.

41.13 Grievance policies should be amended to make it clear that, where a grievance is raised after disciplinary procedures have been started, the grievance will be

considered either after the conclusion of the disciplinary process, or at the time of the disciplinary process.

Contractual duty upon managers

41.14 The suggestion of a contractual duty upon managers to take seriously, and to respond to honestly held concerns and act upon them, ought to be uncontroversial.

41.15 Professor Bowers KC supports such a duty:

> "[I]*t would be very useful to have a duty on the employer to consider the disclosures because at the moment, there's no obligation to do that. There's protection for the whistleblower in whistleblowing, but there's nothing of a duty on the employer to follow up on the disclosed and I think that is an important thing; that actually would give succour to or support to whistleblowers who often feel extremely beleaguered that they have gone out of their way, sometimes lost their careers, to make information available and then nothing is done with it.*"[5]

Suspicion of Deliberate Harm Protocol and guidance

41.16 Professor Bowers KC, Professor Dixon-Woods and Sir Robert Francis agreed about the need for a protocol that sets out the actions to take when "*transgressive behaviour*" is suspected.[6] I agree. Safeguarding requirements are instructive in this regard. Organisations must ensure that individuals know what to do when they suspect a member of staff (or anyone else) is harming children (or other patients).

41.17 Sir Robert Francis underlined that:

> "[I]*t must be a system which makes it clear that raising a concern of that serious nature obviously needs to be done in good faith but you -- it doesn't matter if you turn out to be wrong, you are raising something that requires investigation and you are entitled and indeed it is your duty to do that. But then people need to know what to do after that and naturally it is probably a protocol that needs to be agreed, not only within the health service, but also with other agencies. You know, something similar to the Child Death Review, you need a multi-agency response and you*

need to know whether you should be reporting to the police or whether if you do report it to the police you can be carrying on some other investigation of your own and so on. These are all difficult issues and often time is at a premium in doing the right thing quickly. So absolutely, you need clear guidance which needs a little bit of training but it also needs to be sufficiently clear that ***even if you are untrained, you can pick it off the internet or wherever and use it*** [emphasis added].

So, you know, a little like the sort -- of it was mentioned I think last week, the sort of checklist a pilot would have to deal with a crisis. Checklists do work in emergencies much as they do in less certain situations."[7]

41.18 Trusts should be required to embed the Suspicion of Deliberate Harm Protocol and guidance (see Recommendation 9) within their hospital. No member of staff, clinical or managerial, should be in any doubt about what to do when suspicions are raised that a member of staff (or any other person) has caused harm to a child. If the suspicions are obviously unfounded or malicious, the Trust should document precisely why it has considered the concern to be malicious or

unfounded, and why it is not going to take any further action. It should be completely understood that there is no evidential requirement before action is taken.

Endnotes

1 **Prof. John Bowers KC 5 December 2024 63/5-11**

2 **Prof. John Bowers KC 5 December 2024 65/4-6**

3 **Prof. Mary Dixon-Woods 26 September 2024 8/4-7 and 8/13-25**

4 **Prof. John Bowers KC 5 December 2024 94/21-25**

5 **Prof. John Bowers KC 5 December 2024 67/5-15**

6 **Prof. Mary Dixon-Woods 26 September 2024 96/10-25**

7 **Sir Robert Francis KC 30 September 2024 130/8 to 131/7**

Chapter 42. Care Quality Commission

Background

42.1 In Chapter 7, I dealt with the CQC inspection of the Countess and set out in brief outline its role in regulating healthcare. I repeat some of the background here for ease of reference.

42.2 CQC is the independent regulator of healthcare in England. It was established on 1 April 2009 by the Health and Social Care Act 2008. It is an executive non-departmental public body sponsored by DHSC and is accountable to Parliament through the Secretary of State for Health and Social Care.[1] It replaced, and brought together, the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. CQC was to streamline oversight of the health and social care sector.[2] CQC is responsible for the registration, monitoring, inspection and regulation of service providers with prescribed

regulated activities. This includes NHS Trusts.[3] Its purpose is to ensure that health and care services provided are safe, effective, compassionate and of a high quality.[4] The remit is enormous.

42.3 The funding for CQC in 2023/24 was £294.4 million, made up of fee income from registered providers, grants from DHSC, income from contracts and other sources, and a non-cash allocation from DHSC.[5]

Changes in CQC's approach to inspection

42.4 CQC has a duty to conduct inspections of health and social care service providers and publish a report of its findings. Initially, it took a generalist approach to inspection. In 2013, it changed its approach to inspecting and rating NHS hospitals. The change was triggered by several high-profile failures of care that raised questions about regulators' ability to identity and act on poor performance.[6]

42.5 An example of CQC's regulatory activities, for better or worse, is its involvement in the investigation of maternity care at the University Hospitals of Morecambe Bay NHS Foundation Trust. This preceded the 2013 changes to CQC and is an example of a high-profile failure of care in which CQC failed

initially to act. In 2009, following concerns about serious incidents in maternity services, including maternal and neonatal deaths, the North West CQC team referred Morecambe Bay to the central CQC team for a potential investigation of maternity services. The central CQC investigation team declined, on the grounds that the incidents were deemed unconnected, and it was thought that there were not systemic problems. Notably, CQC was not given a key review.[7]

42.6 In 2010, CQC allowed Morecambe Bay to register with it, and Monitor granted it Foundation Trust status. In 2011, external concern about the incidents heightened.[8] CQC, and others, went on to review Morecambe Bay maternity services. CQC uncovered poor clinical practices, inadequate staffing and weak leadership, leading to significant scrutiny of the hospital's management.[9] In 2015, Dr Bill Kirkup published *The Report of the Morecambe Bay Investigation*. He found there was "*significant organisational failure on the part of the CQC, which left it unable to respond effectively to evidence of problems*".[10]

42.7 Post-2013, CQC changed its approach so as to include larger and more specialist teams of inspectors and experts with experience of hospital care.[11] As set out in Chapter 7, the inspection teams now assessed against five quality domains and produced ratings in an inspection report. The five domains concerned whether the service provider was safe, effective, caring, responsive and well-led.[12]

42.8 The fact that CQC had not been provided with an important document when being asked to investigate Morecambe Bay, coupled with the swingeing findings of Dr Kirkup in his report, published in 2015, ought to have alerted CQC to the urgent need to ask more questions, to probe the answers given, or, to use the current favoured phrase, 'show more curiosity' during its inspections. Had it done so at the Countess in 2016, it may well be that it would have uncovered the rise in the mortality rate. As I said in Chapter 7, Children's and Young People's services were rated 'good' overall and 'good' in the categories 'effective', 'caring', 'responsive' and 'well led'. The rating for the 'safe' category was 'requires improvement' because of shortages of nursing staff.

Strategies

42.9 In 2016, CQC released its five-year *Shaping the Future* strategy.[13] CQC aimed to build a unique baseline of knowledge by inspecting all service providers. This would then enable CQC to target inspections where poor care, or change in quality, was more likely.[14]

42.10 In September 2018, Alliance Manchester Business School and the King's Fund published a report on the impact of CQC on the performance of the hospitals and other settings they inspected.[15] The report found that, overall, providers accepted and generally supported the need for quality regulation within the health and care system, and saw the approach introduced by CQC in 2013 as a significant improvement on the system it replaced.[16]

42.11 The following year, in 2019, Alliance Manchester Business School was commissioned to do a further report. This was published in 2020 and focused on CQC's impact on the quality of care. In short, performance was patchy.[17]

42.12 In 2021, CQC released *A New Strategy for the Changing World of Health and Social Care*.[18] Alongside the new strategy, CQC

introduced an organisational restructure, a single assessment framework across all the sectors that CQC regulated, and a new IT system, named the regulatory platform (with a provider portal).[19]

Dr Dash's review

42.13 Only three years after the publication of the new strategy, Dr Penny Dash published her report into the operational effectiveness of CQC, in October 2024.[20] Dr Dash found:

> "*significant failings in the internal workings of CQC, which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improve quality – and a direct impact on the capacity and capability of both the social care and the healthcare sectors to deliver much-needed improvements in care*".

Dr Dash came to ten conclusions and made seven key recommendations.[21] These repay re-reading.

CQC's IT system failures

42.14 To register with CQC, providers are required to meet the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 13 requires providers to safeguard service users from abuse and improper treatment.[22]

42.15 CQC's guidance for providers specifies: "[W]*here a provider becomes aware of any allegation or evidence of abuse, they must take appropriate action without delay, which must include investigation and may also include referral to an appropriate body.*"[23] It is not the role of CQC to investigate safeguarding concerns. If CQC is the first recipient of a safeguarding concern, it should make a referral to the local authority, which has a responsibility to investigate under the Care Act 2014.[24]

42.16 In 2016, in the context of neonatal services, CQC assessed safeguarding issues, as required by Regulation 13, by looking at data from NHS England on StEIS and the NRLS. This information was included in a data pack that was shared with the inspection team, for them to consider whether there were any issues with patient safety.[25] The inspectors

were expected to speak to, and observe, staff delivering care, and to speak to patients who had received care.[26] I have described the flaws in the process before and during the Countess inspection in February 2016 in Chapter 7.

42.17 Post-2021, CQC introduced a new regulatory platform and provider portal. The Dash Review of CQC found that the development of these IT systems caused practical issues and time loss for CQC staff and service providers. Uploading evidence to the portal caused delays in the inspection process and the production of reports. CQC's referrals to local authorities contained inadequate information and CQC had challenges in ensuring concerns raised were being managed in a timely manner. The Dash Review of CQC in 2024 demonstrated that IT system failures were hindering CQC's safeguarding role.[27] The first recommendation of the Dash Review of CQC involved CQC fixing the provider portal and regulatory platform.[28]

Professor Sir Mike Richards' review

42.18 Professor Sir Mike Richards was also commissioned by CQC to consider the impact of the changes that it had made following its

2021 strategy. His report was also published in October 2024. It found that the changes had "*major adverse consequences*" and failed to deliver the benefits that were intended.[29]

42.19 The review found that fewer inspections were carried out than in previous years. There were serious concerns about the inspection process and quality of reports. The single assessment framework was far too complex. One size did not fit all. It did not allow for the huge differences in the size and functional range of the services that CQC regulates. The regulatory platform was found to have a serious adverse impact on the working lives of CQC staff and provider organisations, who were expected to upload information onto the provider portal. Staff morale was found to be low. A finding was made that CQC was now unable to fulfil its purpose to ensure that providers' services were safe, effective, compassionate and high quality.[30]

Current position

42.20 In October 2024, CQC made a public statement in which it "*accepted the high-level recommendations of both reports* [by

Dr Dash and Sir Mike], *which identify serious organisational failings, and is taking rapid action in response*".[31]

42.21 The same month, CQC announced the appointment of a new Chief Executive, Sir Julian Hartley. Sir Julian has experience of leadership roles in numerous hospitals. He was the Chief Executive of Leeds Teaching Hospitals NHS Trust for a decade.[32] In October 2025, an inquiry into poor maternity care and avoidable deaths in maternity services at Leeds Teaching Hospitals NHS Trust was announced. The Inquiry's work will include examining the time period during Sir Julian's tenure as Chief Executive. Sir Julian resigned from CQC, explaining: "[M]*y current role as Chief Executive of CQC has become incompatible with the important conversations happening about care at Leeds Teaching Hospitals NHS Trust, including during the time I was Chief Executive there.*"[33] Dr Arun Chopra became the interim Chief Executive of CQC at the end of October 2025.[34]

42.22 Sir Mike became Chair of CQC in April 2025.[35] On 6 February 2026, he stepped down as Chair on the grounds that the turnaround of CQC needed a longer-term commitment than

he was able to make. He also considered that a new Chair should lead the search for a permanent Chief Executive.[36] He agreed to remain in post until the appointment of his successor, but due to personal circumstances, as of 1 June 2026 a new caretaker Chair has been appointed, Ms Kay Boycott, until a substantive appointment to the role can be made.

42.23 CQC has not often achieved its purpose since it was set up in 2009. There have been two strategies to which I have referred. The strategies have failed. I am confident that informed and very able people are now looking at the way ahead, and it is not for me to opine on how to improve it. I would suggest, however, that after 17 years and a number of failed strategies, it needs more than a reboot. It needs to focus on its core purpose and develop teams who work to achieve that purpose. It is essential that the new Chief Executive is an exceptional leader and manager, who is supported by an outstanding team. CQC must not fail again. For that reason, I would counsel extreme caution before adding to its responsibilities until it has achieved the transformation required.

42.24 I recognise and welcome that, as I write in June 2026, and in marked contrast to its predecessors, the most recent iterations of the CQC website, from November 2025 onwards, have a clear focus on patients and those in care homes and the importance of listening to what they have to say.[37] I hope this marks the beginning of real improvement at CQC.

Endnotes

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Chapter 43. The Health Services Safety Investigations Body

Background and context

43.1 The Health Services Safety Investigations Body (HSSIB), established under the Health and Care Act 2022,[1] investigate patient safety issues across health services in England.[2] Their investigations are national in scope and are distinct from regulatory, disciplinary and judicial processes. HSSIB are not concerned with the attribution of blame to individuals or organisations and do not investigate civil liability, criminal conduct or professional fitness to practise, which remain matters for civil courts, the police, prosecuting authorities and professional regulators.

43.2 The role of HSSIB is to carry out independent investigations that identify risks to patients and facilitate the improvement of systems and safety practices in the provision of healthcare services in England. HSSIB focus their investigations on patient safety issues that

occur in multiple places across the country, and on issues where HSSIB consider they can add value and address inequalities.

43.3 HSSIB prioritise learning lessons about safety over individual accountability. To achieve this, they have created a safe space where staff can speak openly without fear of disciplinary action, professional referral, civil litigation or criminal investigation. Information, including witness accounts, staff interviews and evidence gathered or held by HSSIB for the purpose of safety investigations, is considered under statute to be "*protected material*", and must not be disclosed to any person,[3] save in the case of limited exceptions, as set out in Schedule 14 of the Health and Care Act 2022, or if ordered by the High Court.[4] Statutory powers cannot compel the disclosure of protected material, nor can such material be voluntarily shared with regulators, employers, the police, families, courts or litigants.[5]

Dr Benneyworth

43.4 Dr Benneyworth, the interim Chief Executive of HSSIB, gave evidence to the Inquiry. She explained:

> "*The HSSIB investigations are protected, the material that comes in to the organisation as part of the course of those investigations* [is] *protected by law. What that means is we don't disclose any of that information into any kind of legal proceeding, we don't talk about names of individual organisations, individual Trusts and we don't name individuals that have contributed to our investigations.*"[6]

43.5 Dr Benneyworth went on to explain the importance of the legislation in enabling people to speak freely during investigations without fear of recrimination or being blamed.[7] She noted in her evidence:

> "*Investigations have shown [you] healthcare staff greatly value the opportunity to speak with an independent and professional investigation team. Speaking openly about what happened after a patient safety event is easier when staff know the purpose of the conversation is to identify the systemic risks that made delivering healthcare safely more difficult rather than to pinpoint individuals for blame.*"[8]

43.6 Significantly, however, disclosure **would be permitted** under Schedule 14 of the Health and Care Act 2022 where the chief

investigator "*reasonably believes that the disclosure of the material is necessary to address a serious and continuing risk to the safety of any patient or to the public*", and "*that the person* [to whom the material is disclosed] *is in a position to address the risk*".[9]

43.7 Dr Benneyworth explained that the exemptions in the legislation mean that, if a disclosure is made concerning negligence, criminal behaviour or any immediate risk to patients, HSSIB will flag these internally in the provider organisation.[10] Further, if HSSIB do not consider that the organisation is taking action, the concern can be raised with regulators and the police if necessary.*

43.8 Dr Benneyworth was asked about the situation where there were suspicions of deliberate harm. She stated that these issues

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* Any person who intentionally obstructs an HSSIB investigator and fails, without reasonable excuse, to comply with the notice to provide information, or provides false or misleading materials to HSSIB, may be liable, on summary conviction, to a fine. These powers have been in place since October 2023. However, they have not yet been used.

would be escalated and not ignored, noting also that all the HSSIB team were trained in safeguarding.[11] She said:

> "[I]*f my team when they are out investigating areas have concerns about negligence, have concerns about any criminality or do have concerns that there is a very significant risk that the provider is not addressing then we will escalate those and we have the exceptions within our legislation to be able to do that.*"[12]

43.9 HSSIB are modelled on accident investigation branches in transport, which gather evidence solely for safety investigations and have strong statutory prohibitions on disclosure in order to promote candour, learning and non-blame. Further, the team of HSSIB investigators bring experience from safety-critical industries and other professions, including healthcare, military, aviation and law.[13]

43.10 However, HSSIB's *Annual Report and Accounts 2024/25*, in its foreword by the Chair, Professor Baker, acknowledges that healthcare still lags behind other industries:

> "*Other safety critical industries have paved the way and provide principles and learning that should be adopted and adapted for healthcare* … [W]*e still are not close to other industries in relation to how they manage, plan, and mitigate safety risks. Crucially, they have built a culture around safety that provides a clear framework for accountability without attributing blame.*
>
> …
>
> *Through our work and analysis of safety management, we have found that effective safety investigation bodies in other industries issue a small number of high-impact recommendations, which are then implemented and embedded by national regulatory bodies. This is the standard we must achieve in healthcare.*"[14]

43.11 In health, the complexity of the NHS regulatory and governance landscape, the competing organisational priorities and the cumulative volume of safety recommendations issued across the system risk diluting the impact of HSSIB's reports and their training role.[15]

43.12 Dr Benneyworth spoke of the need to empower local systems to deliver good care, noting this might require the "*rationalisation of organisations*". However, she considered the immediate priority was to collaborate and consider "*how we coordinate things much more formally across the system*".[16]

43.13 In addition to their investigatory role, HSSIB also have an education team which deliver a training programme to help healthcare staff improve patient safety in their organisations. The aim is to support a professional approach to healthcare safety investigations and to ensure learning from patient safety incidents.[17]

43.14 Dr Benneyworth spoke about the need for education and training of those working within hospitals faced with conducting an investigation. She considered that managers need to listen to staff when they speak up, noting the need for a no-blame philosophy, where people feel encouraged to talk openly and are not bullied or subjected to poor behaviour as a result.[18] In her evidence, she said:

> "*So often we hear from patients and families involved in investigations that they are not involved well in investigations.*
>
> *We often hear that staff are often made to feel blamed when local investigations happen and often that the local investigations don't lead to the changes and the improvements that are needed on the ground. So we think it's very important that we upskill investigators that are undertaking these very complex investigations locally.*"

She went on to say: "*We really need to understand the system wide factors as to why things go wrong. Often it is not one individual -- one individual person or one individual problem that leads to things going wrong.*"[19]

43.15 HSSIB training courses, predominantly delivered online,[20] are primarily aimed at staff who are involved in safety investigations. They are delivered by an education team that are drawn from multiple disciplines, including academia, healthcare, nuclear, occupational psychology and the police.[21] Dr Benneyworth noted in her evidence that "*investigation is one of those skills that is often undervalued* … [I]*t needs very specialist* [skills;] *it doesn't need necessarily clinical skills, it needs the*

subject matter expertise, it needs specialist investigation skills and I think that's quite under-recognised really in the system in terms of the skills need."[22] This is an important point. It arises in employment situations, where untrained managers are expected to investigate complaints about a staff member from other members of staff. It arose at the Countess when Mr Harvey conducted his investigation in July 2016 with neither specialist investigation skills nor relevant clinical skills (see Chapter 15). Dr Green's inadequate conduct of the grievance investigation (see Chapter 22) was the result of inexperience and lack of training.

43.16 Dr Benneyworth also acknowledged the financial and operational pressures on middle and senior managers, and the fact that this can lead to those who raise concerns facing poor behaviours. She explained that, often, "*there isn't an easy fix* [to the safety concern] *and so for a very busy person working in a challenging … environment I suspect when someone raises concerns and they don't know how to fix it that can cause tensions*".[23] Along with financial and operational pressures, reputational issues loom large, as they

did at the Countess, and divert the senior managers from their primary task of keeping patients safe.

43.17 Dr Benneyworth noted that HSSIB have observed that, when people raise concerns and are not listened to, frustrations grow. This can lead to escalating tensions within relationships. Further, if middle managers do not have an escalation route, they can feel helpless and powerless in terms of what they can do. To combat this, Dr Benneyworth considered it important that the right culture is set at board level. This includes listening to people when they speak up and taking appropriate action.[24] The importance of listening is underestimated in many settings, including healthcare. Where a whistleblower raises a concern, it should be listened to and acted upon. As I have mentioned elsewhere in the Report, this is not always a given in hospital settings.

43.18 Dr Benneyworth outlined that HSSIB training includes training for senior managers and board members:

> "[W]*e actually run a programme that is becoming increasingly popular, which is called a strategic decision managers -- makers programme and that's a two*

hour programme that we run with boards, with senior leadership teams face to face and it really gives, gives the kind of people in those boards and those senior leadership teams the understanding as to how to support people doing these investigations, understanding about how you take a systems-wide approach so how do you move away from looking at what an individual has done to what actually the environments, the processes the systems that are going to help your teams deliver better care."[25]

43.19 Dr Benneyworth also spoke of the benefits of training people in healthcare organisations, so that patients and their families feel that the investigation is done properly and that they are at the centre of the investigation. Further, training can assist investigators in understanding how to untangle the complexity of the system, look at system-wide factors as to why things have gone wrong, and make changes on the ground to prevent the cycle of harm happening again.[26]

43.20 Dr Benneyworth described circumstances where, after an incident, healthcare professionals are secondary victims. She explained this is because healthcare

professionals, particularly those who raise concerns, are blamed and made to feel responsible for what has happened, which can exacerbate stress.[27]

43.21 Dr Benneyworth also emphasised that there is a financial benefit to improving safety, and that it is imperative that safety is not an afterthought. She explained that dismissing safety concerns is counterproductive, because "*between 12 and 15% of an organisation's spend*" is "*on safety failure*".[28] If safety concerns are addressed, this in turn helps alleviate some of the financial and operational pressures faced by senior leaders and boards.[29]

43.22 Dr Benneyworth was an impressive witness. It is clear that HSSIB have contributed to the identification of cross-cutting patient safety risks that are deemed unlikely to be fully addressed through local provider-led investigations alone. Their reports have resulted in national recommendations directed at regulators, commissioners and policy-makers.[30]

43.23 However, HSSIB have no enforcement powers and rely on other organisations to respond to, and implement, their recommendations. This creates the risk of an

'implementation gap' between learning and tangible improvement.[31] Further, HSSIB are a small organisation with a limited budget. Dr Benneyworth was candid in her evidence that HSSIB are "*an incredibly small team so our resources are limited*".[32] At the time of her evidence to the Inquiry (January 2025), there were 44 members of staff working remotely around the country.[33]

Continuation and development of HSSIB

43.24 The strongest argument for the maintenance of a training and investigatory body such as HSSIB is that it encourages candour and honesty. Clinicians are more willing to speak openly, and instances of withholding information or providing sanitised or legally defensive narratives are reduced. Investigations focus on human factors, organisational culture and system design, rather than individual blame. The aim is that this approach leads to better safety recommendations and identification of latent risks. The hope is also that a no-blame approach to investigations leads to less defensive behaviour and improves systemic learning, because witnesses feel protected. In the long term, the cultural benefit would

be clinicians who are less likely to practise defensively, with fewer distortions of care motivated by fear of litigation.

43.25 The experiences at the Countess demonstrated that, despite Freedom to Speak Up initiatives, staff did not feel able to raise concerns. Dr Brearey expressed regret that he did not spell out his concerns clearly in the Thematic Review. Dr Jayaram referred to the need for courage to speak out, and Dr Isaac feared repercussions and so she did not send a letter raising her concerns. Ms Lawrence felt (and was) reprimanded for voicing her worries about the deaths on the neonatal unit and a possible association with Letby.

43.26 The Inquiry also heard evidence that doctors feared disciplinary action or professional referral. The fear was not illusory. Dr Brearey and Dr Jayaram both received letters that made reference to referral to the GMC and both were criticised following the grievance procedure, to the extent they were required to apologise to Letby.

43.27 The experiences at the Countess suggest that there is a place for HSSIB. It is true that the issue at the Countess was one of concern about a particular nurse on a particular unit. This is not the sort of systemic issue that

HSSIB would investigate. However, the Inquiry into the events at the Countess has revealed issues that were almost certainly more widespread:

a. the misunderstanding of SUDIC guidance, with regard to a baby that dies suddenly and unexpectedly in hospital

b. the failure to train staff that concerns about a member of staff harming a child raises safeguarding issues

c. the failure to follow safeguarding procedures

d. the continued barriers – despite Freedom to Speak Up initiatives – to healthcare staff speaking up

e. the failure of senior managers to listen to genuine concerns

f. the apparent inability of the senior executives to handle a serious complaint that raised the possibility of deliberate harm, and to know when referral to the police was appropriate.

43.28 HSSIB have the advantage of conducting national investigations and can thus address issues that are widespread. An investigation which hears evidence from clinicians, given

without fear of reprisal, could lead to "*a small number of high-impact recommendations, which are then implemented and embedded by national regulatory bodies*". This is what HSSIB say, in their annual report, is the hallmark of "*effective safety investigation bodies in other industries*".[34]

43.29 The experiences at the Countess exposed the need to train those who investigate complaints or concerns within hospitals. At almost every stage of the investigation, from the first concerns being raised about Letby to the belated referral to the police, and at all levels, from the ward sister and the Risk and Patient Safety Lead to the executives, there were errors in the approach to investigation. There was a failure to recognise, still less consider at an early stage, the fact that staff rotas may be a potential factor in the increased mortality. There was a failure to prioritise the safety of babies and to remove Letby pending investigation, in accordance with fundamental safeguarding principles. Even once Letby was belatedly moved off the neonatal unit, the executives became distracted by the grievance process and failed to recognise that the concerns about Letby were matters that required police investigation.

43.30 Had staff at the Countess undergone training by HSSIB, some of these errors may have been avoided. Looking to the future, training must ensure that such failings are not repeated.

43.31 It is true that HSSIB exist in an already overcrowded and complex regulatory landscape, and that the concept of 'protected disclosure' means material obtained in the course of an investigation will generally be legally inaccessible to families, regulators and courts. Some patients and bereaved families may well object to the absence of individual accountability within the process and there is the possibility of parallel investigations and duplication of evidence-gathering. Healthcare, unlike transport incidents which employ 'no-blame' investigations, concerns the ongoing care of a patient in an environment where there is a strong expectation of individual accountability.

43.32 However, the events at the Countess demonstrate that failings in handling concerns raised by staff are likely to exist beyond an individual institution. This calls for an investigatory organisation that can consider national and systemic problems. The learning from other industries, that a no-

blame approach changes the culture and improves safety, is compelling but, as I have said earlier, it has not been successful in changing the culture in the NHS. Above all, the evidence from the events at the Countess suggests that internal investigations are failing and the need for training of investigators is necessary.

43.33 It is undoubtedly the case that coordination and a rationalisation of regulatory organisations is necessary. HSSIB's greatest test of success would be to get to a point where they were no longer needed. However, at present, HSSIB are fulfilling a needed function and require the resources and staff to carry on doing this effectively.

Endnotes

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14 HSSIB, *Annual Report and Accounts 2024/25*, 17 July 2025, page 5 (**https://hssib-ovd42x6f-media.s3.amazonaws.com/production-assets/documents/HSSIB_Annual_Report_and_Accounts_202425.pdf#page=8**)

15 **Dr Rosie Benneyworth 8 January 2025 39/1-5**

16 **Dr Rosie Benneyworth 8 January 2025 53/11-15**

17 **Dr Rosie Benneyworth 8 January 2025 8/23 to 11/5**

18 **Dr Rosie Benneyworth 8 January 2025 22/12 to 23/9**

19 **Dr Rosie Benneyworth 8 January 2025 9/5-20**

20 **Dr Rosie Benneyworth 8 January 2025 12/18-21**

21 HSSIB, 'Our team' (**https://www.hssib.org.uk/about-us/our-team/**)

22 **Dr Rosie Benneyworth 8 January 2025 13/12-18**

23 **Dr Rosie Benneyworth 8 January 2025 23/15-19**

24 **Dr Rosie Benneyworth 8 January 2025 27/2-7**

25 **Dr Rosie Benneyworth 8 January 2025 12/1-13**

26 **Dr Rosie Benneyworth 8 January 2025 69/8 to 70/2**

27 **Dr Rosie Benneyworth 8 January 2025 21/22-25**

28 **Dr Rosie Benneyworth 8 January 2025 28/11-12**

29 **Dr Rosie Benneyworth 8 January 2025 28/12-15**

30 HSSIB, 'Patient safety investigations' (**https://www.hssib.org.uk/patient-safety-investigations/?page=1**)

31 Patient Safety Learning, 'Mind the implementation gap: The persistence of avoidable harm in the NHS', 7 April 2022 (**https://www.patientsafetylearning.org/blog/mind-the-implementation-gap-the-persistence-of-avoidable-harm-in-the-nhs**)

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33 **Dr Rosie Benneyworth 8 January 2025 8/8**

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Chapter 44. Memorandum of Understanding

Background

44.1 A Memorandum of Understanding (MoU) was published in February 2006 with the title 'Investigating patient safety incidents involving unexpected death or serious untoward harm: a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive'.[1] It seems to have fallen out of use at about the time the Association of Chief Police Officers was dissolved in 2015 and replaced by the National Police Chiefs' Council. It was nine years before a new MoU was published, arising out of the work of Professor Sir Norman Williams in 2018.

The Williams Report

44.2 The Williams Report, published in June 2018, was a rapid policy review of gross negligence manslaughter in healthcare. It was

motivated by a concern amongst healthcare professionals that simple errors and accidents could result in prosecution for gross negligence manslaughter.[2] Sir Norman found that the objective risk of being prosecuted for gross negligence manslaughter was small, and the chance of prosecution was even smaller still.[3] However, the concern was primarily that investigations can "*cast a long shadow*",[4] and the fear of those investigations was higher given the poor understanding of the law on gross negligence manslaughter.[5]

44.3 Sir Norman recommended the development of a new MoU between all relevant agencies.[6] This document would:

> "*set out the respective roles of the police, CPS* [Crown Prosecution Service]*, HSE* [Health and Safety Executive] *and health service bodies (such as the Care Quality Commission, the Healthcare Safety Investigation Branch and healthcare professional regulators) in investigating unexpected deaths in healthcare settings in order to ensure that patient safety lessons can be understood and acted upon*".[7]

44.4 Sir Norman recommended that, as a minimum, the roles and responsibilities of the organisations should be defined, and that there should be effective liaison and communication between them. Expectations of expert witnesses should be clear. The MoU must be disseminated "*in order to promote a greater understanding of legal issues among healthcare professionals and of healthcare issues (including systemic and human factors) among prosecuting authorities, the police and coroner services*". It is expressly hoped that "*this would help support the development of a 'just culture' in healthcare*".[8]

The current MoU

44.5 The current document, 'Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm', was published in December 2024, during the Inquiry hearings.[9]

44.6 Under the subtitle 'A memorandum of understanding (MoU) between regulatory, investigatory and prosecutorial bodies', there was a list of signatories as follows:

- Care Quality Commission (CQC)
- Crown Prosecution Service (CPS)

- Health and Safety Executive (HSE)
- National Police Chiefs' Council (NPCC)
- NHS England
- General Medical Council (GMC)
- Nursing and Midwifery Council (NMC)
- General Dental Council (GDC)
- Health and Care Professions Council (HCPC)
- General Pharmaceutical Council (GPhC)
- General Optical Council (GOC)
- General Chiropractic Council (GCC)
- General Osteopathic Council (GOsC).[10]

44.7 The guidance applies, in England only,[11] when more than one of the signatories needs to investigate any incident where there is reasonable suspicion that a criminal offence has or may have been committed by any individual who is providing healthcare services in health or care settings, which leads to or significantly contributes to the death or serious life-changing harm of a patient or service user.[12]

44.8 The MoU gives the following guidance on the types of incident that may prompt an NHS organisation to involve the police. It is incidents that display one or more of the following characteristics:

a. where there is reasonable suspicion that the actions leading to harm were intended to cause harm

b. where there is reasonable suspicion of 'gross negligence' and/or 'recklessness'.[13]

44.9 The guidance makes no reference to safeguarding, and in particular the safeguarding of children. In such a situation the police would become involved at the point of any concerns being raised.

44.10 I pause to note that the threshold of 'reasonable suspicion' is higher than that applied by the police (see paragraph 26.59(b), Chapter 26). In my view, this risks setting the bar for referral too high. Instead, in my view, the threshold should be one of 'good faith suspicion'. In reaching this view, I have borne in mind Mr Vineall's answers, in which he spoke in support of the current formulation, when giving evidence about the language of reasonable suspicion in the MoU.[14] Nevertheless, in my view, the current

formulation gives rise to a risk that concerns which should be referred to the police are not and change is required.

44.11 There are then a number of explicit considerations about the way in which the incident coordination group should exercise its function, including who should convene the first meeting, who should attend subsequent meetings and who should be on notice to those meetings. This includes the need for the ICB and CQC (or other relevant regulator) to be informed,[15] for a professional regulator to be informed if the incident raises questions of fitness to practise,[16] and for the coroner to be informed and invited to send a representative in circumstances where the death is suspicious.[17]

44.12 Of particular relevance to this Inquiry is the requirement for the Maternity and Newborn Safety Investigations programme to be informed in cases that involve early neonatal deaths, intrapartum stillbirths, and severe brain injury in babies born at term following labour or maternal deaths. This is to allow that programme to discharge its functions.[18]

44.13 The MoU then goes on to consider the role of the police, who must appoint a senior investigating officer, who will be

responsible for seeking advice from the Crown Prosecution Service and obtaining the view of an expert witness.[19] The expert witness is accountable to the police, and not the incident coordination group.[20]

44.14 The police have an obligation to inform CQC (or other relevant regulator) within seven days of referring a case to the Crown Prosecution Service, so that the regulator can determine whether they have a responsibility to take further action to prevent further harm.[21]

44.15 Representatives of the organisations who attend the incident coordination group must have sufficient authority to make decisions on behalf of their organisation.[22]

44.16 The MoU goes on to give guidance on the roles of the incident coordination group and the decision-making process to be followed, including guidance on minuting meetings and providing legal representation for those who are under suspicion.[23]

44.17 The organisations represented on the incident coordination group are explicitly responsible for their own "*patient safety learning responses*"[24] and the incident coordination group has "*no role in directing the patient*

safety learning responses and investigations of the NHS, CQC, police, regulators and/or HSE".[25]

44.18 The MoU provides comprehensive guidance but for a limited purpose. It is not directed at, and does not provide useful information to, healthcare professionals who may have suspicions of their colleagues. It is aimed at executives or senior managers who have been made aware of suspicions, assessed them as worth investigating and then considered that there is a need for an investigation by more than one of the signatories.

44.19 If an incident falls within the scope of the MoU, the guidance given is thorough, and gives a clear indication of the expectations of the incident coordination group in managing and coordinating a response from multiple organisations to an incident in which there was a suspicion of gross negligence or of deliberate harm.

44.20 A further limitation of the document is that it requires internal reporting processes to allow for – for example – the accurate identification of those incidents that are serious enough to trigger the response codified by the guidance. In the case of the Countess, concerns were

raised but the executives did not consider they were justified. It took over a year to bring in the police. The MoU is unlikely to have made any difference to the actions of those executives. For the MoU to be effective requires hospital executives to be respectful of clinicians' views. It is always reasonable to challenge the views of others, but when the concerns were so serious and genuinely held, they were bound to be acted upon. Were that approach to prevail, the MoU would be effective.

44.21 Read as a whole and alongside the Williams Report, the reason for and the purpose of this MoU appears to be to reassure healthcare professionals that incidents at work (not occurring as a result of intentional harm) are unlikely to result in any criminal or other sanction. In particular, the importance of the wider context and systematic failure is highlighted. The MoU:

> "*has been drafted with a view to supporting the development of a 'just culture' in healthcare, which recognises the need to consider the wider context and circumstances in which any incident involving a breach of a duty of care occurs. This includes considering the wider*

systems in place at the time of the incident, to support a fair and consistent evaluation of the actions of individuals."[26]

44.22 The guidelines accompanying the original 2006 MoU emphasised that "*it is best practice to make early contact with the police and/or HSE to discuss concerns and to take their advice on further action*".[27] This good advice is absent from the current MoU. Mr Vineall, on behalf of DHSC, was asked why that advice had been omitted. It was his view that guidance is not needed to make the point that, "[I]*f people are in doubt at a local level and they see something serious that they think may be the result of malevolent behaviour that they are able to call the police. I mean, that is a I think it's fair to say a common sense expectation that we would all have of most institutions*."[28] Experience at the Countess does not bear out that expectation.

44.23 Whilst a comprehensive document is informative and provides context as well as direction, a shorter document would be more useful to someone faced with one of the situations identified in the document. I acknowledge Mr Vineall's reasonable resistance when I asked him about the desirability of producing a shorter document.

He made the point that the document had only recently been published and it was intended to see how it was going after a year (i.e. by December 2025).[29] By the time this Report is published, the document will have been in place for 21 months. That will be time for a shorter guide to be considered and, if appropriate, drafted.

Absence of safeguarding input

44.24 The fact that the MoU reflects no input in respect of safeguarding[30] rather underlines my view of its purpose. Whatever the reason for the omission – oversight or deliberate – Mr Vineall and Sir Stephen Powis[31] agreed to provide further information. Some information was provided in a follow-up statement in February 2025. Mr Vineall stated that there was not "*any decision to exclude the subject from the 2024 MOU*" and "*the 2024 MOU was not intended to replace or duplicate guidance on wider issues*" such as *Working Together to Safeguard Children 2023*.[32] I have followed up on this, and the latest information provided by DHSC and NHS England on 20 May 2026 is that a review of the MoU was initiated in December 2024 and is ongoing. DHSC said they have been "*cognisant*" of my observations to Mr Vineall during his oral

evidence and stated: "*Safeguarding teams and others in the Department and NHS England have been engaged in the review process, and some proposed amendments have been drafted to enhance the prominence of safeguarding in the MOU and shared for views with the signatories*." I am encouraged by this and hope that the next MoU features safeguarding more prominently, as it should.

Endnotes

1 **Witness statement of Wiliam Vineall INQ0108007/2/para 5**

2 Prof. Sir Norman Williams, *Gross Negligence Manslaughter in Healthcare: The report of a rapid policy review*, June 2018, page 7, para 2.1 (**https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf#page=7**)

3 Prof. Sir Norman Williams, *Gross Negligence Manslaughter in Healthcare: The report of a rapid policy review*, June 2018, page 12, para 4.6 (**https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf#page=12**)

4 Prof. Sir Norman Williams, *Gross Negligence Manslaughter in Healthcare: The report of a rapid policy review*, June 2018, page 16, para 6.3 (**https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf#page=16**)

5 Prof. Sir Norman Williams, *Gross Negligence Manslaughter in Healthcare: The report of a rapid policy review*, June 2018, page 18, paras 7.1-7.4 (**https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf#page=18**)

6 Prof. Sir Norman Williams, *Gross Negligence Manslaughter in Healthcare: The report of a rapid policy review*, June 2018, page 26 (**https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf#page=26**)

7 Prof. Sir Norman Williams, *Gross Negligence Manslaughter in Healthcare: The report of a rapid policy review*, June 2018, page 25, para 9.13 (**https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf#page=25**)

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9 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 (**https://assets.publishing.service.gov.uk/media/67604bbd239b9237f0915471/investigating-suspected-criminal-activity-in-healthcare-mou.pdf**)

10 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, para 1.1 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#signatories**)

11 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, para 4.3 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#when-the-mou-applies**)

12 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, para 4.1 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#when-the-mou-applies**)

13 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, para 4.5 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#when-the-mou-applies**)

14 William Vineall 15 January 2025 119/23-131/19 (**https://thirlwall.public-inquiry.uk/wp-content/uploads/2025/01/Thirlwall-Inquiry-15-January-2025.pdf#page=30**)

15 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, paras 5.5-5.6 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

16 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, para 5.9 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

17 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, para 5.11 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

18 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, para 5.10 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

19 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, para 5.16 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-**

in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group)

20 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, para 5.18 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

21 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, paras 5.19-5.23 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-**

life-changing-harm-accessible-version#mou---incident-co-ordination-group)

22 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, para 5.14 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

23 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, paras 5.24-5.26 and 5.28 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

24 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, para 5.27 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

25 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, para 5.30 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#mou---incident-co-ordination-group**)

26 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, para 2.4 (**https://www.gov.uk/government/publications/investigating-suspected-criminal-activity-in-healthcare-mou/investigating-healthcare-incidents-where-suspected-criminal-activity-may-have-contributed-to-death-or-serious-life-changing-harm-accessible-version#introduction-and-background**)

27 **Witness statement of William Vineall INQ0107019/3/para 17**

28 **William Vineall 15 January 2025 131/11-19**

29 **William Vineall 15 January 2025 131/22 to 132/15**

30 **William Vineall 15 January 2025 211/25 to 212/20**

31 **Prof. Sir Stephen Powis 17 January 2025 87/22 to 91/4**

32 **Witness statement of William Vineall INQ0108867/2/paras 6-9**

Part Three

Chapter 45. Recommendations

My recommendations are set out below. The reasons for each are explained in the relevant chapters of this report.

The long-standing underfunding of hospital services for babies and children is well recognised and requires action. The drive to increase the provision of health services in the community should not obscure or undermine the urgent need for adequate and enduring funding for hospital services for babies and children. I trust that the government will give this issue the urgent attention it requires.

CCTV and monitoring

Recommendation 1

All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.

Chapter 33

Insulin

Recommendation 2

i. Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, *GIRFT Neonatology: Guide to safe insulin use*.

ii. Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.

iii. The GIRFT *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia* guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.

Chapter 34

Bereavement care

Recommendation 3

The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.

Chapter 29

Safeguarding and contracts of employment

Recommendation 4

i. All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff.

ii. By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.

Chapter 41

Operating systems (interoperability)

Recommendation 5

NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.[1]

Chapter 35

Monitoring deaths in hospitals

Recommendation 6

i. By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies.

ii. By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.

Chapter 35

Data reporting

Recommendation 7

i. All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.

ii. Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise:

   a. whether any alerts or a need for investigation have arisen

   b. the investigation or action plan in place.

Chapter 35

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Recommendation 8

i. NHS England must:

   a. Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital.

   b. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.

ii. DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.

iii. SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.

Chapters 12 and 28

Suspicion of Deliberate Harm Protocol and guidance

Recommendation 9

Protocol

i. By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. The Suspicion of Deliberate Harm Protocol must make explicit that:

   a. It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure.

   b. Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately.

   c. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified.

d. Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step.

e. The moving of a person suspected of causing harm and the investigation into suspicions and concerns about a member of staff is a neutral act.

f. Safeguarding steps must be followed, as a result of which the police will become involved.

Guidance

ii. Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.

Implementation

iii. Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.

Chapter 41

Panel of experts

Recommendation 10

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

The precise make-up of the panel should be determined by DHSC but could include, for example:

a. two doctors and two nurses from each clinical specialty

b. four senior managers

c. four pathologists including paediatric and perinatal pathologists

d. other experts as decided by DHSC.

Where necessary, a small team (always including clinicians from the relevant specialty/specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting the police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.[2]

Chapter 41

Medical examiners

Recommendation 11

i. The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.

ii. The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.

iii. Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.

iv. There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.

v. The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.

Chapter 32

Paediatric and perinatal pathologists

Recommendation 12

DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 *Paediatric and Perinatal Pathology Workforce Report*. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.

Chapter 28

Accountability and regulation of managers

Recommendation 13

i. DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032.

ii. NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that:

a. The move is not proposed because of the manager's lack of capability or misconduct.

b. The manager meets the fit and proper person test.

NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.

iii. In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.

iv. The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first.

v. In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "*I put patients first and report safety concerns and incidents.*"

Chapter 37

Care Quality Commission (CQC)

Recommendation 14

i. CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).

ii. Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes.[3]

iii. Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Chapter 42

Assessment of the performance of CQC

Recommendation 15

There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.

Chapter 42

Parliamentary and Health Service Ombudsman

Recommendation 16

The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include:

a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately

b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Chapter 31

Implementation of recommendations

Recommendation 17

A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

Chapter 31

Endnotes

1 Baroness Amos's final report from the National Maternity and Neonatal Investigation recommends DHSC/NHSE must deliver estates and digital systems that are fit for modern maternity and neonatal care with 12-month, 5-year and 10-year investment commitments and implementation deadlines. The importance of interoperable digital systems is a common theme in both our reports and should be treated as a priority. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf**)

2 Baroness Amos's final report recommends that NHS England, DHSC and CQC "*put in place a specialist regulatory unit, with a sufficiently sensitive methodology, to provide regulatory assessment for maternity and neonatal services*" within nine months. This must include clinicians so that "*the most recent clinical perspectives are fully integrated into the regulatory function*". This recommendation aligns with my recommendation and should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG

CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 20 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf #page=20**)

3 Baroness Amos's final report recommends that DHSC, NHS England and CQC must drive improvement within 12 months in the quality, transparency, oversight and accountability of their investigations, and ensure that learning is captured and acted upon when things go wrong. Our recommendations regarding CQC should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 16 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf#page=16**)

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Appendix 1. Terms of Reference

Introduction

On 21 August 2023, after a trial at Manchester Crown Court, Lucy Letby was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

Terms of Reference

The inquiry will investigate 3 broad areas:

A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.

B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:

(i) whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her

(ii) the responses to concerns raised about Lucy Letby from those with management responsibilities within the trust

(iii) whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby

C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

A non-exhaustive list of questions arising out of the terms of reference is set out in the annex.

Procedure

The inquiry will operate within the legal framework of the **Inquiries Act 2005**. The procedure and conduct of the inquiry will be directed by the inquiry chair. The terms of reference are decided by the Secretary of State after consultation with the chair.

The order in which the issues are to be considered has not yet been decided. The priority is to conduct a thorough inquiry as swiftly as possible. The length and timing of the hearings and where they take place will depend on the extent and nature of the live evidence that is required and upon the actions of the police and Crown Prosecution Service.

Report and recommendations

The inquiry chair will provide a final report (and if appropriate, interim reports) to the Secretary of State as soon as is practically possible. She will make recommendations as she considers appropriate.

Annex: questions

This is a non-exhaustive list of questions which the inquiry intends to seek answers to. This annex does not form part of the terms of reference.

A. The experiences of all the parents whose babies were named on the indictment at the criminal trial

1. During their involvement with the Countess of Chester Hospital and elsewhere what were the parents of each child told when and by whom about the condition of their baby, what was being done to treat them and what the prognosis was?
2. How and when were deteriorations (sudden or otherwise) in their babies' conditions explained to them?
3. Where parents raised concerns about the condition and/or care of their babies, what was done and what were the parents told?
4. When were they given access to their babies' medical records?
5. What information were the parents given by the hospital regarding concerns about Letby's conduct and when? What were they told was being done about the concerns?
6. What were the parents of each child told about the likely cause of death or injuries? When and by whom?

7. When were the parents of each child told that Letby was suspected of causing the death or injury to their child? Was the trust sufficiently candid with the parents throughout?

8. What are the views of the parents of each child as to the adequacy of the information they were given at each stage?

9. What was the parents' experience of the Patient Advice and Liaison Service (PALS)?

10. What are their suggestions for keeping babies safe on the neonatal unit?

B. The conduct of those working at the Countess of Chester Hospital including the board, managers, doctors, nurses and midwives during the period from the arrival of Lucy Letby at the hospital on 4 January 2012 to date

11. What was known and what should have been known about Letby's previous work as a nurse when she began employment at the Countess of Chester Hospital?

12. What concerns were raised and when about the conduct of Letby? By whom were they raised? What was done?

13. Should concerns, including about hospital or clinical data, have been raised earlier than they were? When? What should have been done then?

14. Were existing processes and procedures for raising concerns used, including whistleblowing and freedom to speak up guardians? Were they adequate?

15. What was the culture within the hospital? To what extent did it influence the effectiveness of the processes and procedures at question 14?

16. Whether systems, including security systems relating to the monitoring of access to drugs and babies in neonatal units, would have prevented deliberate harm being caused?

17. Were existing processes used for reporting concerns to external scrutiny bodies where appropriate? If so, when and what happened? Such bodies may include NHS England (and its regional bodies), local commissioners, Monitor, NHS Improvement, child death overview panels, the Care Quality Commission, the police and the successor of any of these organisations.

18. When was consideration given to reporting Letby to the police? When was she in fact reported to the police and by whom?

19. What information about each of the deaths was provided to the coroner? Was the trust's provision of information to the coroner appropriate?
20. Did the relationship between clinicians and managers, nurses, midwives and managers and between medical professionals (doctors, nurses, midwives and others) at the Countess of Chester Hospital contribute to any failure to protect babies on the neonatal unit from the actions of Letby? How did professional relationships affect the management and governance of the hospital?
21. Did the structures and processes for the management and governance of the hospital contribute to a failure to protect the babies on the neonatal unit from the actions of Letby? Is the management structure and governance typical of neonatal settings in other hospitals?
22. What was the board's involvement in the way concerns about Letby were dealt with by the hospital?
23. What was the board's oversight of clinical and corporate governance?
24. How was Letby managed once concerns were raised about her?

25. Was Letby reported to the Nursing and Midwifery Council (NMC)? When? What information, if any, was provided to the NMC, royal colleges and any other external scrutiny bodies? What was done by the bodies to whom the actions were referred? What happened as a result?

26. What information, if any, was provided to the General Medical Council (GMC) and what information was requested by the GMC? What was the result of any referral or discussions with the GMC?

27. What happened to those who raised concerns about Letby?

C. Wider NHS

28. Whether recommendations to address culture and governance issues made by previous inquiries into the NHS have been implemented into wider NHS practice? To what effect?

29. What concerns are there about the effectiveness of the current culture, governance management structures and processes, regulation and other external scrutiny in keeping babies in hospital safe and ensuring the quality of their care? What further changes, if any, should be made to the current structures, culture or professional

regulation to improve the quality of care and safety of babies? How should accountability of senior managers be strengthened?

30. Would any concerns with the conduct of the board, managers, doctors, nurses and midwives at the Countess of Chester Hospital have been addressed through changes in NHS culture, management and governance structures and professional regulation?

Appendix 2. Summary of Nuffield report on Inquiry questionnaire

Introduction

A2.1 The Inquiry commissioned the Nuffield Trust (Nuffield) to administer and analyse the results of a questionnaire for NHS Trusts in England providing neonatal care.[1]

A2.2 The questionnaire, drafted by the Inquiry, was sent to 121 Trusts with neonatal units and completed by 120 Trusts.* Trusts were asked to arrange for the questionnaire to be completed by the Medical Director and a non-clinical director with responsibility for neonatal care. These instructions were followed by 91 of the Trusts. Disappointingly, the remaining 29 Trusts either provided a single response or a joint response signed by more than one person. These responses were accepted by Nuffield.

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* This did not include the Countess.

A2.3 The report summarised the responses received under a number of headings, as summarised below.

Governance and accountability

A2.4 Trusts were asked for a general description of the way in which they were governed and to whom they were accountable. Many responses identified the board as responsible for the Trust's strategy, implementation of objectives for setting the culture of the organisation, and ensuring that the Trust is providing safe, high-quality care.[2] Some added that the board's role included other aspects of governance.

A2.5 There was very little uniformity, even between similar Trusts, in the manner in which Trusts organised their governance.

A2.6 Committees were described as playing a central part in governance structures. Some committees are required by statute, such as audit, appointment and remuneration committees. Other committees have specific remits to lead other areas of the Trust's work. These include quality and safety; people; research; safeguarding; equality, diversity and inclusion; and patient experience.[3]

A2.7 There was also little uniformity in how Trusts organised and managed their clinical functions. These were variously organised into 'divisions', 'care groups' or 'clinical service units' and could have different titles and configurations. For example, neonatal care was reported to sit within 'Family Care', 'Women's and Children's', 'Paediatrics and Neonates' or 'Family Health'.[4]

A2.8 When asked about their accountability, some Trusts gave details of the organisations that hold them to account and to which they need to provide reports. Where Trusts gave details of accountability, they pointed to the fact that they are accountable to NHS England, their own governance structures, ICBs, CQC and government. Others referred to regulators, either in general or by way of a list of the specific regulators they report to.[5] Others were more general and so rather uninformative, referring to, for example, "[t]*he population we serve … NHSE and our regulators (CQC and others)*".[6]

A2.9 The questionnaire revealed the complexity in both the accountability relationships in the NHS, and the wide range of ways in

which Trusts organise their own governance within the boundaries of their statutory responsibilities.

Trust policies

A2.10 Trusts were asked to submit copies of policies which dealt with the following:

a. safeguarding babies

b. investigating a neonatal death

c. Freedom to Speak Up Guardians

d. any other policies about escalating and raising concerns

e. whistleblowing

f. complaints.

A2.11 Many of the policies were lengthy, with multiple sub-sections. From my own observation, this is typical of policies within the NHS. They were usually catch-all policies, which covered all ground relevant to the policy's purpose. For instance, safeguarding policies covered adult, young person, child and neonatal safeguarding. The policies were described as "*generic but comprehensive*".[7]

A2.12 For many (but not all) Trusts, Freedom to Speak Up and whistleblowing policies were one and the same thing.[8]

A2.13 There was very little useful information provided by Trusts about how often the policies relevant to reporting of incidents were used, with many reporting that either data was not available, or that the policies were always used when appropriate. This suggests that this information is not routinely collected, and Trusts may not have a clear picture from staff on how useful individual policies are in directing responses to incidents. As I have observed elsewhere in this Report, lengthy policies are unlikely to be read because there is no time. As a result they are not of any real use in directing responses to incidents. The nature of the questionnaire responses supports that view.

A2.14 Approximately one-third of those surveyed (39 Trusts) had reviewed their policies as a direct result of Letby's conviction. A further 22 had reviewed their policies for some other reason since Letby's conviction, either as part of a regular review process or triggered by a change in national policy. 55 Trusts had not recently reviewed their policies. Of those who had not reviewed their policies, there was a

suggestion that the review, when it happened, would have regard to the Letby case and the findings of this Inquiry, when published.[9]

A2.15 19 of the Trusts that did review their policies made no changes. This appears to have been a deliberate and informed decision that had regard to the circumstances of the Letby conviction. There was often an explicit acknowledgement that there would be further review as this Inquiry published findings or national policies were changed.[10]

A2.16 In total, 25 Trusts gave details of the changes made to their policies as a result of Letby's conviction. Details of those changes can be found in the Nuffield report.[11] There was no general or common response from Trusts, which have responded to the findings in different ways.

A2.17 Some Trusts pointed out further changes they had implemented that went beyond policy review. These included psychological support for staff, family support and information sharing, board briefing, training, and improvements to relevant processes (i.e. monitoring and governance). While there are no clear trends in this information, it does

make clear that some Trusts have clearly tried to be proactive in supporting staff and parents at a difficult time for neonatal care.[12]

Staffing

A2.18 Trusts measure their staffing levels against guidelines produced by BAPM. These guidelines include the levels of experience required for medical staff and nurses. Trusts appeared to have more access to data about nursing vacancies than medical vacancies, with many Trusts being ambiguous about the number of medical vacancies they had. However, even with this in mind, 68 of the Trusts surveyed (i.e. significantly over half) were not compliant with nursing levels under the guidelines, while 56 reported not being compliant with medical staffing requirements.[13]

A2.19 Nursing levels were universally difficult to maintain, whereas medical staffing was more of an issue for units that treated sicker neonates (Level 3). This is a result of a greater level of specialism being required to fill those roles.

A2.20 There was also evidence that staffing levels would vary depending on the shifts required to be filled. This was borne out in the data

provided about staff cover, where evenings and weekends were, unsurprisingly, harder to cover than day shifts.[14]

A2.21 There was also a reported problem in half of surveyed Trusts in recruiting or training nurses with a QIS in neonatal care.[15]

A2.22 Many Trusts made the very good point that having a full rota and complement of staff did not mean that the guidelines were met. Sickness, parental leave and other absences all contributed to the continued need for temporary staff.[16]

A2.23 Trusts had a number of different methods for analysing staffing needs. In general, they looked at occupancy rates and at acuity to consider the staffing needs of a unit. Where more staff are needed, employment of bank and temporary staff, cancellation of non-clinical activity, shift swaps and redeployment of staff from other units are all ways managers try to ensure that staffing levels are compliant.[17] If necessary, cots can also be closed to ensure that the units remain safe. Given that staff shortages exist even where there is a full complement of staff on the books, thought should be given to assessing staff requirements in a way that takes account of predicted sickness levels, maternity

leave and so on. This must be something that software can calculate, given the huge amount of staff data across the NHS.

A2.24 It is clear from the evidence provided in the questionnaires that staffing remains a considerable area of difficulty for many Trusts. This means that staff are overworked. They do not have time to read, still less absorb, the mass of digital paperwork that comes in their direction.

Culture

A2.25 Trusts' responses to questions on culture varied significantly. This neatly makes the point that culture means different things to different people. It also supports my own view that there is no single NHS culture, no matter which adjective or descriptor is placed before the word 'culture'. This is consistent with the responses of those who felt they should not pass comment as they were not well placed to describe the culture of a large organisation.[18] They suggested that a Trust would have many different cultures within it. This is unsurprising and important, given the reliance placed on culture as an effective tool to improve patient safety.

A2.26 Trusts often reported that their culture was good, but referred to a range of different facets in their answers. These reflect the diversity of ways in which culture has been referred to in other evidence before the Inquiry, and include ‘safety’, ‘justice’, ‘openness’, ‘transparency’, ‘dedication’ and ‘cooperation’.[19]

A2.27 Broadly, where specifics were given about the nature of culture on neonatal units, they aligned with the wider Trust’s. There was also a view that neonatal units suffered from a greater level of scrutiny than other units. This can be an added tension to the culture on those units, on top of other pressures that included staffing levels, industrial action, Covid-19, waiting lists and burnout.[20]

A2.28 The increased scrutiny of outcomes can leave staff feeling that they are constantly under assessment.[21] This is likely to be the result of events at the Countess. It is also likely that maternity units feel under intense scrutiny now given the widespread and long-standing criticisms and concerns about maternity

units with the consequent inquiries, local and national. This year, two inquiries have reported and there is a further one ongoing.†

A2.29 That there are so many different factors listed by Trusts as evidence of both positive and negative aspects of culture shows how broad a concept culture has become. A positive culture encompassed initiatives such as 'board breakfasts' and celebrating International Nurses' Day, while a negative culture was evidenced by bullying, harassment and discrimination, and failures to comply with Trust policies.[22]

A2.30 There was a near universal acknowledgement from Trusts that, even where culture was reported to be positive, there was still work to do and improvements could still be made.[23]

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† These are: the National Maternity and Neonatal Investigation led by Baroness Amos, which covers 12 local investigations; the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust; and the Independent Review into Maternity and Neonatal Services at Leeds Teaching Hospitals. There are also calls for individual inquiries into Oxford and Sussex Trusts.

Working relationships

A2.31 In general, the respondents reported that working relationships were good. Some general challenges were noted, which involved the context of the Trusts in question. In particular, mergers and investigations were seen as acute stressors to working relationships between the different professions.[24]

A2.32 Working relationships between doctors and managers were reported as largely positive. This was especially true in Trusts that had a medical-led or multidisciplinary model, where clinicians were responsible for decisions.[25]

A2.33 Relationships between nurses, midwives and managers were not seen as positively. There was greater emphasis placed on the need for these relationships to be nurtured with regular, effective communication.[26] This echoes the findings of the Picker survey (see Appendix 3).

A2.34 The relationships between different groups of clinical professionals were also broadly positive. However, it is worth noting that this was the view of senior managers, a group that the Picker survey suggested routinely overestimated the quality of their relationships with other occupations. Further, despite

broadly positive views, disagreements could occur that required specific management and redress. Specific examples were given by different Trusts, but the suggestion is that different professionals may be more likely to disagree about care decisions, and there can be an element of tribalism involved that requires specific management.[27]

Reporting and managing concerns and complaints

A2.35 Nuffield recorded the very many ways in which patients and staff can raise concerns and complaints about NHS services. Patients wishing to raise a concern are often directed to their local PALS, while staff reporting routes will likely vary depending on internal relationships.[28] The most common starting points for staff were the Freedom to Speak Up Guardian and the staff member's direct line manager.[29]

A2.36 Nine Trusts described specialised anonymous reporting routes for staff, while others made clear that the Freedom to Speak Up Guardians could be reached anonymously over staff intranet or other internal incident-reporting software. A 'National Whistleblowing hotline' (presumably NHS England's

Speaking up to NHS England initiative) was mentioned by only one Trust as a potential mechanism for reporting.[30] This speaks for itself. The hotline is either not known about or considered irrelevant. DHSC will have the figures for use of the hotline, but the responses to the survey suggest this hotline is not being used.

A2.37 When a concern was raised, the most common response was for the incident to be logged on the Datix risk management system or some other similar system. This would then trigger a number of actions, including an investigation.[31]

A2.38 Informal concerns or complaints would often be treated informally, with conversations between staff and signposting to formal complaint procedures if this was insufficient. These investigations or reviews were often not recorded, as they were dealt with at a ward level.[32]

A2.39 More serious concerns would involve investigation by staff at different levels of the Trust. This group was variously referred to as the 'patient safety team', 'executive review group' or 'decision-making group'. The membership of such a group varied between Trusts but would often be multi-professional.

The group would then often provide an incident report to the board for consideration, though this may not be the process for less serious incidents, which would be reviewed by an intermediate body. Sign-off of the final written responses to the complaint or concern would often be the responsibility of a board member, usually the Chair or Chief Executive.[33]

A2.40 108 Trusts reported at least one complaint or concern raised about neonatal care in the year from 19 October 2022 to 19 October 2023. Of those, 97 Trusts had carried out at least one investigation in the same timeline. Respondents did not give much consistent information about the nature of the concern or complaint, the severity or complexity of the issues raised, or the details of the investigation carried out.[34]

A2.41 Trusts were clear that there were several external bodies that they were required to share information with, in specific circumstances. These include MBRRACE-UK, StEIS, Maternity and Newborn Safety Investigations, the Disclosure and Barring Service and CDOPs. Some Trusts

considered it appropriate to refer issues to professional regulators for further investigation and action.[35]

A2.42 In cases where disciplinary processes also needed to be followed, the Trust's HR department would be involved, alongside local employer liaison advisers from the GMC or the NMC. This process is guided by a framework called Maintaining High Professional Standards.[36]

A2.43 Trusts referred to regulators, the Disclosure and Barring Service and requesting a Healthcare Professional Alert Notice from NHS Resolution as mechanisms that could be used to manage a situation where there were concerns regarding the fitness to practise of an employee who had left the Trust.[37]

A2.44 Serious Incidents were dealt with according to the national Serious Incident Framework. They were discussed at regular meetings with ICBs. The reporting of incidents to the Learn from patient safety events service has replaced the NRLS. This data is reviewed by CQC and NHS England.[38]

A2.45 If the incident involved an early neonatal death, a report would be made to the coroner and reviewed using the national Perinatal

Mortality Review Tool. A referral would also be made to Maternity and Newborn Safety Investigations, which investigates early neonatal deaths.‡ Where the incident was categorised as a safeguarding issue, the LADO policy would be followed for escalation.[39]

A2.46 50 Trusts escalated a concern to their own board in the year from 19 October 2022 to 19 October 2023.[40] 56 Trusts reported that they had referred to external agencies in the same timeframe. The most common external referral pathways were MNSI and StEIS.[41]

A2.47 24 Trusts had made a report to a professional regulator or CQC, with the NMC being the most common regulator referred to.[42]

A2.48 Trusts were asked to give indications of factors that either inhibited or encouraged staff to raise concerns. The factors listed included:[43]

a. **A culture of not reporting:** They mentioned in particular competitive cultures between professions, and a fear of

‡ These are deaths of babies who are born alive and die in the first week (zero to six days) of life.

raising incidents being seen as punitive or risking punishment.

b. **A culture of reporting:** Positive reporting and learning cultures were seen as encouraging reporting, as were initiatives such as active bystander programmes.

c. **Staff voices:** Some voices would be prioritised, and some did not speak out in circumstances where they thought that their voice would not be listened to.

d. **Complex reporting structures:** These were often seen as inhibiting, but some Trusts saw the many routes through which concerns could be raised as a positive, as there were many opportunities for staff to raise issues.

e. **Public scrutiny:** There was a suggestion by some Trusts that the level of public scrutiny over maternity and neonatal services inhibited reporting of concerns.

A2.49 The most common factors inhibiting managers from acting on concerns were financial strain and understaffing. Another concern that was repeatedly referred to was the capacity and capability of managers who handled complaints. This included the fact

that neonatal care is so specialist that it can be hard for managers to deal effectively with complaints in this area.[44]

Reviewing evidence after a death

A2.50 Trusts provided information in different ways about the number of requests for perinatal pathology they had submitted. Some gave a full account of every request, while others reported having no information available. Further, the information provided about the length of time requests took to be processed varied significantly across Trusts. There were clear regional disparities in waiting times, from six to eight weeks to over nine months.[45]

A2.51 There was no consistency in the way in which unexplained or unexpected deaths were recorded by Trusts.[46] This is striking and echoes the findings I have made about the position ten years ago. This important matter needs to be addressed by DHSC/NHS England and as a serious training issue. I acknowledge and hope that the introduction of the medical examiner system in September 2024 has begun to improve consistency in this regard, given the responses to the questions about medical examiners in Chapter 32.

A2.52 Nuffield conducted a thematic analysis of the reasons given for the review process after a death. 119 Trusts referred to 'learning' as the key reason for any such review process. 31 Trusts spoke of the need for a robust and thorough investigation. Most Trusts reported learning, explanations and transparency/ accountability as the purpose of a post-death review, rather than a robust and thorough investigation.[47] It seems obvious that after a death the circumstances should be investigated thoroughly, the outcome should be shared and responsibility identified. A review after a death should be transparent and should look at all four of those aspects.

A2.53 An important finding is that every Trust that responded had access to a medical examiner. 82 Trusts had used a medical examiner to review a neonatal death. Most importantly, 112 Trusts had processes in place for medical examiners to identify trends or patterns in deaths across the Trust.[48] This is encouraging, not least because the questionnaire predates the full statutory system now in place in England and Wales.

A2.54 Trusts reported attending between zero and ten CDOPs in the year from October 2022 to October 2023. CDOPs were convened at

various intervals, depending on the way in which they were organised in the local area, with some Trusts attending every panel and some sharing attendance with other local Trusts. As CDOPs review deaths based on the area in which the patient was resident and not by Trust, this could mean that some deaths would not be reviewed by the relevant Trust at CDOPs. While some Trusts were able to contribute to panels convened out of their area, others found they were unable to.[49] I have dealt with this issue in Chapter 12.

A2.55 Nuffield completed a thematic review of the Trusts' responses to a question about the effectiveness of CDOPs. The primary benefit of CDOPs was seen by Trusts as their contribution to local learning, with 64 Trusts referring to this benefit. The independence of the scrutiny and the panels' expertise across multiple disciplines were also consistently seen as a benefit (57 Trusts). The most common limitation of CDOPs' effectiveness was the time delay between deaths and the panel being convened, reported by 14 Trusts.[50] This requires the attention of DHSC. I acknowledge that the CDOP process comes after all other investigations are completed, but since that is identified as hampering its effectiveness, a review is needed to establish

whether the order of events could be changed or, more radically, to consider the purpose of CDOPs when an inbuilt lengthy delay is apparently unavoidable.

What safety nets exist?

A2.56 Trusts reported that parental engagement in neonatal care is prioritised because of the benefits of parents being involved in both decisions relating to care and the care process itself. 118 Trusts reported that parents were involved in ward rounds, with many Trusts clearly adapting their practice to ensure that parents could attend. This included changing the timing of ward rounds, offering virtual attendance, or alternatives such as telephone consultations. It was also clear from responses that parental attendance at ward rounds was monitored by a number of Trusts, emphasising the point that this was taken seriously.[51] These were encouraging responses.

A2.57 116 of the 120 Trusts surveyed routinely gave discharge summaries to parents, with some providing these before discharge to allow parents to review and discuss the summary with clinicians as appropriate.[52]

A2.58 It was not routine for parents to have access to medical records. While some Trusts did provide access to some medical records through online portals, it was more common for these to be available on request, either through PALS or subject access requests.[53]

CCTV

A2.59 CCTV was reported at either the entrances and exits or in communal areas of the neonatal unit by 99 Trusts. No Trust reported that CCTV was present in clinical areas. 57 Trusts reported that they provided some form of access to webcam footage or video calling for parents. This was either live, ad hoc or pre-recorded.[54]

Medicine management

A2.60 Policies for the management of medicines varied across Trusts but broadly followed the same principles. No Trust reported a specific neonatal or maternity drug storage and administration policy. Medicines were kept locked away and required either a key or a swipe card to access them. Often, this key would be kept by a senior member of staff on duty. That member of staff had ultimate responsibility for the medication used on the ward. 19 Trusts had a system whereby the

swipe card used to access medication was logged, allowing for a register to be created showing who had accessed medicine at what time. For those Trusts without electronic registers, physical logbooks were used. Where information was included, insulin was reported to be kept in locked fridges or, in one case, was now treated in the same way as a controlled drug as a result of the Letby case.[55]

A2.61 Where drugs were being administered to neonates, most Trusts reported that their preparation and administration had to be checked by two authorised members of staff. Both members of staff then signed the relevant record, either on paper or electronically.[56]

Support for bereavement

A2.62 The primary mechanism through which families are supported when they suffer a bereavement after their child's treatment on a neonatal unit is PALS. The service was either signposted when neonates were admitted to the unit, or after death. Bereavement midwives were also trained and present in some Trusts, and would refer families to PALS as appropriate.[57]

A2.63 A further layer of support referred to by Trusts is the continued contact between the neonatal service and bereaved families that happens as part of review processes. This can either be as part of the duty of candour, where meetings are arranged and information sent out, or part of the work of medical examiners or clinicians completing the Perinatal Mortality Review Tool. Where appropriate, Trusts can also refer family members on to therapy services (such as those offered by the charity Petals) and other specialist support.[58]

A2.64 Trusts were less clear about the process through which support would be offered to parents who had previously suffered a neonatal bereavement when there is a new pregnancy. Where available, Trusts mentioned that they would refer to a specialist clinic (a so-called rainbow clinic). However, in areas where this was not available, Trusts seemed to rely on good communication between neonatal and maternity units to ensure that families got the care they needed.[59]

A2.65 There was no consistent process for recording on medical records that families had been bereaved. 37 Trusts used a sticker system (either in physical form or on electronic notes) to denote bereavement. To work effectively,

these required the community midwife or other clinician to look at medical notes before the appointment. Another common process was for discharge letters sent to local health networks and to GP practices to highlight the need for future support.[60]

Learning and making improvements

A2.66 Trusts were asked to suggest structural improvements that could be made to the management and governance of neonatal services. The clearest and most frequently made suggestion was that there needed to be simpler and more standardised processes, especially for external reporting and regulation. It was felt there was duplication of work in this area, and that the level of scrutiny placed too high a burden on Trusts.[61] I agree.

A2.67 Some suggestions were more local and Trust specific, while others were broader. For instance, some Trusts suggested that what was needed was better leadership, or an improved culture.[62]

A2.68 There was disagreement between Trusts about the appropriate way of organising neonatal units within wider maternity or obstetric services. Some preferred a ‘perinatal service’ to ensure continuity of care. Others

thought this may risk a lack of focus on neonatology, and could reduce visibility for neonatal services at board level as they are taken together with other services.[63] This disagreement is reflected in the manner in which Trusts do, in fact, organise their services. Neonatology often sits in different places, which suggests that there is no one agreed answer to the question of how to structure the provision of neonatal care.

A2.69 When asked what specific lessons Trusts had learnt in the period since October 2022, many Trusts took the opportunity to reassure the Inquiry that they are learning organisations that are continually looking to develop and improve.[64] When looking at specific answers to the question, the most common theme of Trusts' answers was that there needed to be an improved culture and a greater focus on reporting concerns.

Regulation of managers

A2.70 Respondents gave a variety of answers to the question of whether managers in the NHS should be regulated. Four themes were identified by Nuffield that were relevant to the question:

a. the purpose of regulation

b. other existing processes

c. whether regulation is an appropriate response

d. how regulation would work in practice.[65]

A2.71 Managers said that regulation could be beneficial for providing accountability and credibility to senior managers. There was some concern that regulation would be used as a method to identify scapegoats. To help prevent this, regulation was also identified as a way in which professionalism, training and development of senior managers could be properly supported. Respondents felt that better training could help to develop a career pathway for middle managers to take on higher-level roles. This would help with recruitment and retention, and could help senior managers to feel properly valued.[66]

A2.72 Some respondents pointed out that there are already a number of formal accountability processes in place for senior managers, either with their own professional regulators or via other routes such as CQC, employment contracts, the fit and proper person test and codes of conduct (including the Nolan principles).[67]

A2.73 There was concern (even amongst those respondents who felt that regulation was, in principle, a good thing) that it was not the proper response to the issues that the case of Letby highlights. There is a clear fear that regulation is a byword for blame, and that a move towards regulation in response to Letby is actually a thinly veiled attempt to scapegoat senior managers. Some respondents feel strongly that regulation (or what they describe as over-regulation) would not improve patient safety, and would in fact create more bureaucracy that would not be beneficial (see Chapter 37).[68]

Alternative to regulation

A2.74 Instead of regulation, it was suggested that strengthening existing processes would better support patient safety and prevent a repeat of the events seen at the Countess. Three Trusts mentioned improving oversight and governance, and six Trusts mentioned improving the process for reviewing neonatal deaths.[69]

Summary

A2.75 It is plain that there is wide variation amongst Trusts in the way they manage the provision of neonatal services. What is striking is the

clear evidence that managers see culture as a catch-all solution to improve patient safety and care outcomes and also a reason, if not **the** reason, that structural improvements are needed in the first place. Culture was mentioned as a cause and a solution. When asked what was learnt in the aftermath of Letby's conviction, culture was mentioned as central. When asked to evaluate factors that improve or inhibit the reporting of concerns, culture was mentioned as both a help and a hindrance. Predictably, given this context, the responses to questions specifically about culture make clear that it is not a term that is well understood or consistently applied across the NHS. I deal further with the question of culture in Chapter 39.

Endnotes

1 INQ0018076

2 INQ0018076/24

3 INQ0018076/23-25

4 INQ0018076/25

5 INQ0018076/27

6 INQ0018076/26-27

7 INQ0018076/31

8 INQ0018076/31

9 INQ0018076/40-41

10 INQ0018076/41-42

11 INQ0018076/42-43

12 INQ0018076/44-45

13 INQ0018076/51

14 INQ0018076/52

15 INQ0018076/54

16 INQ0018076/55-56

17 INQ0018076/57

18 INQ0018076/62

19 INQ0018076/62-64

20 INQ0018076/63

21 INQ0018076/64

22 INQ0018076/66-69

23 **INQ0018076/70**

24 **INQ0018076/82**

25 **INQ0018076/83**

26 **INQ0018076/84**

27 **INQ0018076/85-86**

28 **INQ0018076/102**

29 **INQ0018076/104**

30 **INQ0018076/105**; NHS England, 'Speaking up to NHS England', updated 26 March 2026 (**https://www.england.nhs.uk/ourwork/freedom-to-speak-up/how-to-speak-up-to-us-about-other-nhs-organisations**)

31 **INQ0018076/106**

32 **INQ0018076/112**

33 **INQ0018076/107-108**

34 **INQ0018076/109-110**

35 **INQ0018076/116-118**

36 **INQ0018076/118-119**

37 **INQ0018076/119**

38 **INQ0018076/120**

39 **INQ0018076/120-121**

40 **INQ0018076/133-134**

41 **INQ0018076/122**

42 **INQ0018076/123**

43 INQ0018076/124-131
44 INQ0018076/131-133
45 INQ0018076/140-141
46 INQ0018076/143
47 INQ0018076/147-149
48 INQ0018076/152-154
49 INQ0018076/159
50 INQ0018076/160-163
51 INQ0018076/170-176
52 INQ0018076/171
53 INQ0018076/172
54 INQ0018076/181-184
55 INQ0018076/184-187
56 INQ0018076/187
57 INQ0018076/191-194
58 INQ0018076/192-193
59 INQ0018076/194
60 INQ0018076/194-195
61 INQ0018076/198-199
62 INQ0018076/197-198
63 INQ0018076/200-202
64 INQ0018076/203-204
65 INQ0018076/222
66 INQ0018076/218-229

67 **INQ0018076/225**

68 **INQ0018076/226**

69 **INQ0018076/209**

Appendix 3. The Picker report

A3.1 In order to collect views on the culture of neonatal units across England, the Inquiry drafted a survey. The survey was then administered by Picker, an international health and social care charity, and sent to 32,121 staff from 118 Trusts* with neonatal units.[1]

A3.2 The survey was sent by email to nurses, midwives, doctors, consultants, managers or senior managers working in, or connected to, neonatal units on 1 February 2024. The survey was open to responses from 4 March 2024 to 8 April 2024.[2]

A3.3 Staff were asked about the overall culture of the neonatal units in which they work, and about their working relationships both with those in the same occupation and with others. They were asked to rate their

* 121 Trusts with neonatal units were approached to participate in the survey; 118 responded. The 121 trusts do not include the Countess.

level of agreement on a five-point scale (strongly disagree; disagree; neither agree nor disagree; agree; strongly agree) with a number of propositions. Responses that agreed or strongly agreed were rated as positive; any other response was rated as negative.[3]

A3.4 The final number of eligible responses was 7,497, representing a response rate of 24.2% – sufficient to yield statistically meaningful results. The response levels largely reflected the proportions of the entire population in each eligible occupation, and there was a regional spread of responses across England's commissioning regions.[4]

A3.5 The respondents were predominantly more experienced staff members: 42.6% had worked at their Trust for less than 5 years, compared with 57.4% who had worked there for longer than 5 years; 25.9% of respondents had been employed by their Trust for more than 15 years.[5]

A3.6 The majority of respondents (67.8%) had worked more than ten shifts on the neonatal unit in the preceding six months. Approximately a quarter of respondents (24%) had not worked on the neonatal unit in that time.[6]

A3.7 The survey found that 77.6% of respondents believed that the culture of their neonatal unit was good (i.e. they agreed or strongly agreed with the statement). Interestingly, only 20.6% of people stated that improvement in their unit's culture was unnecessary, which suggests there is no complacency and an openness to improvement.[7]

A3.8 Doctors and consultants were more likely than the other clinical occupations to report both that the unit's culture was good and that there was an open and frank culture on the unit. Nurses were the most likely to say that there was a need for improvement in the culture. Managers' and senior managers' views did not diverge from clinical staff members to any notable extent.[8]

A3.9 Each group was generally positive about working relationships within their occupation. Doctors were the most likely to be positive about their internal relationships (95%), along with consultants and senior managers (also over 90%). Midwives were the least likely to give a positive response (78.4%).[9]

A3.10 The evidence about cross-occupation working relationships shows a number of interesting results. Whilst it may be said that relationships between different groups of professionals

were broadly positive, it was apparent that senior managers routinely overestimate the quality of their relationships with other occupations and with more junior managers:

a. 61.2% of midwives reported a good relationship with senior managers, compared with 83.5% of senior managers reporting a good relationship with midwives.

b. Even fewer nurses reported a good relationship with senior managers (49.7%), compared with 87.5% of senior managers reporting a good relationship with nurses.

c. 56.7% of doctors reported good relationships with senior managers, whereas 82.0% of senior managers said they had good relationships with doctors.

d. For consultants, the relevant figures were 66.3%, compared with 82.1% of senior managers reporting good relationships with consultants.

e. 76.2% of managers reported good relationships with senior managers, compared with 91.9% of senior managers saying they had good relationships with managers.[10]

A3.11 Of the groups who treat and look after patients, midwives were the least likely to report having a good working relationship with other clinical staff.[11] This echoes the observations of nurses at the Countess in 2015 and 2016, but it may also be a reflection of the fact that the midwives answering the survey were far more likely not to have worked on the neonatal unit in the six months preceding the survey. This may also suggest that infrequent contact is more likely to lead to poorer-quality relationships.

A3.12 The fact that senior managers' views of their relationships differ so markedly from those on the other side of the relationship may be explained by a number of factors, including bias against senior managers, and the survey did not test for that. Another possibility – at least as likely – may be a lack of insight on the part of senior managers about how they are seen. Whatever the cause, and there may be more than one, this finding ought to be factored into the appraisal and development of managers throughout their careers.

Endnotes

1 **INQ0098717/5**

2 **INQ0098717/6-7**

3 **INQ0098714**

4 **INQ0098717/8-11**

5 **INQ0098717/11**

6 **INQ0098717/11**

7 **INQ0098717/12**

8 **INQ0098717/12**

9 **INQ0098717/13**

10 **INQ0098717/13**

11 **INQ0098717/14**

Appendix 4. Witnesses who gave oral evidence

Unless stated otherwise, all those listed below worked at the Countess of Chester Hospital at the relevant time.

Witness	Title	Date of oral evidence
Dee Appleton-Cairns	Deputy Director of People and Organisational Development	05/11/2024
Dr Cassandra Barrett	Junior doctor (paediatric specialty trainee)	02/10/2024
Sir Rob Behrens CBE	Parliamentary and Health Service Ombudsman	10/12/2024
Dr Rosie Benneyworth	Interim Chief Executive, Health Services Safety Investigations Body	08/01/2025
Kate Bissell	Neonatal nurse (band 6)	10/10/2024
Professor John Bowers KC	Expert witness to the Inquiry	05/12/2024
Dr Shirley Bowles	Consultant chemical pathologist	09/10/2024
Dr Stephen Brearey	Consultant paediatrician and Clinical Lead, neonatal unit	19/11/2024

Witness	Title	Date of oral evidence
Louis Browne KC	Legal adviser (barrister) to the Countess of Chester Hospital	04/12/2024
Tracy Bullock	Chief Executive, Mid Cheshire Hospitals Foundation Trust	09/01/2025
Lorraine Burnett	Director of Operations	05/11/2024
Helen Cain	Acute Hospitals Inspector, Care Quality Commission	14/11/2024
Tony Chambers	Chief Executive (December 2012 to September 2018)	27/11/2024
Elizabeth Childs	Specialist adviser for Care Quality Commission and Inspection Chair	14/11/2024
Dr Alan Clamp	Chief Executive, Professional Standards Authority for Health and Social Care	07/01/2025
Hayley Cooper (Griffiths)	Royal College of Nursing representative	06/11/2024
Kathryn De Beger	Occupational Health Manager	09/10/2024
Professor Mary Dixon-Woods	Expert witness to the Inquiry	26/09/2024
Sharon Dodd	Paediatric Liaison and Child Death Overview Panel Nurse Representative, Cheshire and Wirral Partnership NHS Foundation Trust	18/11/2024

Witness	Title	Date of oral evidence
Helené Donnelly OBE	Ambassador for Cultural Change and Lead Freedom to Speak Up Guardian for the Midlands Partnership Foundation NHS Trust	04/12/2024
Dr U	Paediatric registrar	07/10/2024
Dr V	Consultant paediatrician	07/10/2024
Dr ZA	Consultant paediatrician	07/10/2024
Chris Dzikiti	Interim Chief Inspector of Healthcare, Care Quality Commission – corporate witness	14/01/2025
Sue Eardley	Head of Invited Reviews, Royal College of Paediatrics and Child Health	07/11/2024
Ros Fallon	Non-Executive Director	03/12/2024
Yvonne Farmer	Neonatal practice development nurse (band 7), neonatal nurse (band 6)	16/10/2024
Father L and M (read in)		24/09/2024
Dr Alan Fletcher	National Medical Examiner for England and Wales	12/12/2024
Julie Fogarty	Head of Midwifery	15/10/2024
Ann Ford	Head of Hospitals Inspections, Care Quality Commission	15/11/2024
Hayley Frame	Independent Chair, Pan Cheshire Child Death Overview Panel	18/11/2024

Witness	Title	Date of oral evidence
Sir Robert Francis KC	Expert witness to the Inquiry	30/09/2024
Dr Joanna Garstang	Clinical Associate Professor of Child Protection, School of Nursing, University of Birmingham – overview witness on safeguarding and child death processes	26/09/2024
Dr John Gibbs	Consultant paediatrician	01/10/2024
Dr Susan Gilby	Acting Chief Executive (September 2018 to April 2019), Chief Executive (April 2019 to December 2022)	24/02/2025
Dr Christopher Green	Director of Pharmacy and Medicines Management	06/11/2024
Yvonne Griffiths	Deputy Manager, neonatal unit	16/10/2024
Ian Harvey	Medical Director	28/11/2024 and 29/11/2024
Dr Jane Hawdon	Consultant neonatologist, Barts Health NHS Trust	12/11/2024
Helen Herniman	Acting Chief Executive and Registrar, Nursing and Midwifery Council – corporate witness	08/01/2025
Andrew Higgins	Non-Executive Director	03/12/2024
Sue Hodkinson	Director of People and Organisational Development	26/11/2024
Simon Holden	Chief Financial Officer	03/12/2024
Dr Susie Holt	Consultant paediatrician	03/10/2024

Witness	Title	Date of oral evidence
Rachel Hopwood	Non-Executive Director	03/12/2024
Ashleigh Hudson	Neonatal nurse (band 5)	10/10/2024
Julie Hughes	Inspector, Care Quality Commission	15/11/2024
Rt Hon. Jeremy Hunt MP	Secretary of State for Health	09/01/2025
Dr Howyada Isaac	Named Doctor for Safeguarding	18/11/2024
Dr Paul Jameson	Chair, Medical Staff Committee	08/10/2024
Ken Jarrold CBE	Health service manager and Chair of Working Group that produced Code of Conduct for NHS Managers	07/01/2025
Dr Ravi Jayaram	Consultant paediatrician, Lead Clinician for Children's Services	13/11/2024
Tom Kark KC	Barrister and author of the Kark Review	17/01/2025
Alison Kelly	Director of Nursing and Quality, Executive Lead for Safeguarding	25/11/2024
Dr Camilla Kingdon	Former President, Royal College of Paediatrics and Child Health – corporate witness	12/12/2024
Professor Marian Knight MBE	Professor of Maternal and Child Population Health and Lead, National Confidential Enquiries into Maternal Deaths and Morbidity, MBRRACE-UK	07/01/2025

Witness	Title	Date of oral evidence
Dr Rachel Lambie	Paediatric and neonatal registrar	02/10/2024
Annemarie Lawrence	Risk midwife (band 7)	22/10/2024
Nicola Lightfoot	Deputy Manager, children's ward	15/10/2024
Stuart Lythgoe	Director of Operations for the Hospital Consultants and Specialists Association	05/12/2024
Alexandra Mancini	Reviewer for Royal College of Paediatrics and Child Health Invited Review	11/11/2024
Patricia Marquis	Director for England, Royal College of Nursing – corporate witness	13/01/2025
Elizabeth Marshall	Neonatal assistant (band 4)	10/10/2024
Dr Huw Mayberry	Paediatric registrar	02/10/2024
Dr Jim McCormack	Consultant obstetrician and gynaecologist	08/10/2024
Anne McGlade (née Martyn)	Manager, children's ward	16/10/2024
Dr Michael McGuigan	Consultant paediatrician	08/10/2024
Claire McLaughlan	Reviewer, Royal College of Paediatrics and Child Health	11/11/2024
Janet McMahon	Project Lead, then Patient Experience Lead, then Risk and Patient Safety Lead, Women and Children's Division	22/10/2024

Witness	Title	Date of oral evidence
Dr Jo McPartland	Consultant paediatric pathologist, Alder Hey Children's NHS Foundation Trust	12/11/2024
Simon Medland KC	Barrister	21/11/2024
General Sir Gordon Messenger	Co-author of *Leadership for a Collaborative and Inclusive Future* (the Messenger/ Pollard report)	08/01/2025
Dr Anna Milan	Principal Clinical Scientist, Liverpool University Hospitals NHS Foundation Trust	09/10/2024
Ruth Millward	Head of Risk and Patient Safety	04/11/2024
Dr Rajiv Mittal	Consultant paediatrician and Designated Doctor for Safeguarding and Child Deaths, Integrated Care Board	20/11/2024
Alan Moore	Assistant Coroner, then Senior Coroner for Cheshire	04/12/2024
Mother A and B		16/09/2024
Mother and Father G (read in)		18/09/2024
Mother and Father J		23/09/2024
Mother and Father K		23/09/2024
Mother and Father N (read in)		24/09/2024

Witness	Title	Date of oral evidence
Mother and Father O, P and R (read in)		25/09/2024
Mother C		16/09/2024
Mother D		17/09/2024
Mother E and F		18/09/2024
Mother H		19/09/2024
Mother I (read in)		17/09/2024
Anne Murphy	Lead Nurse for Children's Services	21/10/2024
Fiona Murphy MBE	Corporate Director of Nursing, Northern Care Alliance for End-of-Life Care and Bereavement	14/01/2025
Dr Matthew Neame	Paediatric registrar	02/10/2024
Dr Elizabeth Newby	Consultant paediatrician	03/10/2024
Tony Newman	Regulation Adviser, Employer Link Service, Nursing and Midwifery Council	12/12/2024
Sir Duncan Nichol CBE	Chair of the Board	02/12/2024
Nurse T	Neonatal nurse (band 6)	14/10/2024
Nurse W	Neonatal nurse (band 6)	14/10/2024
Nurse ZC	Children's nurse (band 5)	14/10/2024
Dr Benjamin Odeka	Specialist adviser for Care Quality Commission	14/11/2024
Ed Oliver	Non-Executive Director	03/12/2024

Witness	Title	Date of oral evidence
Ian Pace	Legal adviser (solicitor) to the Countess of Chester Hospital and Associate, Employment and Pensions, DAC Beachcroft	21/11/2024
Debbie Peacock	Risk and Patient Safety Lead, Women and Children's Division	22/10/2024
Kathryn Percival-Calderbank	Senior neonatal practitioner (band 6)	10/10/2024
Mary Potter	Specialist adviser for Care Quality Commission	14/11/2024
Eirian Powell	Manager, neonatal unit	17/10/2024
Professor Sir Stephen Powis	National Medical Director, NHS England – corporate witness	17/01/2025
Dr Oliver Rackham	Consultant paediatrician and consultant on the neonatal transport team	26/11/2024
Sybille Raphael	Director, Protect	05/12/2024
Karen Rees (Moore)	Head of Nursing, later Associate Director of Nursing, Urgent Care Division	21/10/2024
Nicholas Rheinberg	Senior Coroner for Cheshire	06/12/2024
Dr Murthy Saladi	Consultant paediatrician	03/10/2024
Lucy Sementa	Human Resources specialist	06/11/2024

Witness	Title	Date of oral evidence
Dr David Shortland	Clinical Lead, Royal College of Paediatrics and Child Health Invited Review Programme	11/11/2024
Lyn Simpson	Executive Regional Managing Director (North), NHS Improvement	21/11/2024
Paula Sindall (née Lewis)	Specialist safeguarding children's nurse	18/11/2024
Corinne Slingo	Legal adviser (solicitor) to the Countess of Chester Hospital and Head of Healthcare Regulatory, DAC Beachcroft	21/11/2024
Professor Judith Smith	Professor of Health Policy and Management, the Health Services Management Centre, University of Birmingham	09/01/2025
Professor Sir David Spiegelhalter OBE	Expert witness to the Inquiry	15/01/2025
Dr Nim Subhedar	Consultant neonatologist, Clinical Lead, Cheshire and Merseyside Neonatal Network	20/11/2024
Melanie Taylor	Neonatal nurse (band 6)	10/10/2024
Dr Sean Tighe	Chair, British Medical Association Local Negotiating Committee	08/10/2024

Witness	Title	Date of oral evidence
Jane Tomkinson OBE	Acting Chief Executive (December 2022 to February 2024), Chief Executive (from February 2024)	13/01/2025
Karen Townsend	Divisional Director, Urgent Care	04/11/2024
Professor Stephen Turner	Current President, Royal College of Paediatrics and Child Health – corporate witness	12/12/2024
William Vineall	Director, NHS Quality, Safety and Investigations, Department of Health and Social Care – corporate witness	15/01/2025
Annette Weatherley	Deputy Chief Nurse, University Hospital of South Manchester NHS Foundation Trust and Independent Chair of Grievance Panel	07/11/2024
Detective Chief Superintendent Nigel Wenham	Deputy Head, Public Protection Directorate, Cheshire Constabulary	20/11/2024
James Wilkie	Non-Executive Director	02/12/2024
Sian Williams	Deputy Director of Nursing	05/11/2024
Dr Nicholas Wilson	Reviewer, Royal College of Paediatrics and Child Health	11/11/2024

Appendix 5. Chair's rulings

i. Livestreaming

1. A summary of the effect of this ruling is available on the Inquiry website.

2. Public hearings are scheduled to begin at Liverpool Town Hall in September of this year. On 30 April, I wrote to the Core Participants and Media inviting written submissions on the issue of whether or not, in addition to conducting the hearings in public, the inquiry should transmit proceedings to Core Participants and the Media via live links to locations remote from the hearing room and/or broadcast proceedings via livestream to the world at large. The note is at appendix 1 to this ruling.

3. Consideration of the issue takes place in the context of court orders made in R v Letby. There are three orders made in the Crown Court pursuant to sections 45 and 46 of the Youth Justice and Criminal Evidence Act 1999 ('YJCEA'), and an order of the Court of Appeal

made pursuant to section 4(2) of the Contempt of Court Act 1981 at the hearing of an application for leave to appeal in April of this year. It may be that by the time of the substantive hearings in this inquiry the order of the Court of Appeal will have fallen away. The orders of the Crown Court remain in force and may only be revoked by the court that made the orders or an appellate court.

4. In short, the order of Steyn J made on 15 January 2021 under ss.45 and 46 YJCEA deals with the identification of babies as being concerned in proceedings and the identification of parents as being witnesses in those proceedings. The order of Goss J made on 7 October 2022 under s.46 YJCEA concerns the identification of several clinical NHS employees (nurses and doctors) as being witnesses in those proceedings, and the order of Goss J made on 2 March 2023 under s.46 YJCEA, concerns the identification of a further NHS doctor as being a witness in those proceedings. The orders bind the inquiry as well as the media and the public.

5. I directed that submissions should deal with the following factors:

    a) The importance of the open justice principle in the particular context of s18 of the Inquiries Act 2005;

b) The need to avoid any risk of breaching orders of the Crown Court;

c) The need for all witnesses to give their best evidence to the Inquiry;

d) The need to avoid impeding the ongoing clinical responsibilities of any witnesses who still work in frontline NHS services;

e) The need to avoid prejudicing criminal investigations or proceedings; and

f) The practical effect of any suggestions made.

6. I heard submissions from Mr Peter Skelton, KC, on behalf of the parents of babies A, B, I, L, M, N and Q; from Mr Louis Browne, KC on behalf of the parents of babies D, J and K, from Mr Richard Baker, KC on behalf of the parents of babies C, E, F, G, H, O and P, from Mr Andrew Kennedy KC on behalf of the Countess of Chester Hospital NHS Foundation Trust and Mr Jude Bunting KC on behalf of nine media groups (1) Guardian News & Media (who publish The Guardian and The Observer); (2) BBC; (3) ITN; (4) Telegraph Media Group (who publish The Daily Telegraph); (5) Associated Newspapers (who publish the Daily Mail and Metro); (6) News Corp UK & Ireland (publishers of The Sun and The Times; (7) Reach plc (who publish The Daily Mirror and

many local newspapers); (8) Sky News and (9) Pressdram who publish Private Eye. All had provided written submissions in advance.

7. NHS England ('NHSE') provided written submissions. They saw no difficulty with livestreaming or live links subject to the need for witness-specific special measures, any other restrictions considered necessary by the Inquiry "including specifically to take account of the need to avoid any risk of breaching orders of the Crown Court and/or the need to avoid prejudicing criminal investigations or proceedings" (paragraphs 6(b) and 6(e)) respectively of the Inquiry's Note re Preliminary Hearing).

8. Ms Kate Blackwell KC, for the senior manager Core Participants, wrote to the inquiry to indicate that the senior managers were neutral on the issue of live linking/livestreaming.

9. My note was sent for information to Cheshire Police and the Crown Prosecution Service who acknowledged it, indicated their support for the inquiry, reminded me of the existence of the court orders and of the ongoing police investigations (although with an erroneous understanding that the Crown Court orders would fall away after the retrial. They will not).

10. In response to the written submissions, Counsel to the Inquiry, Ms Rachel Langdale KC, provided written submissions and made brief oral submissions after the advocates for the parents and the media to which I shall refer later in this ruling.

Definition of Terms

11. For the purposes of this ruling livestreaming means the live transmission of the proceedings of the inquiry from the hearing room to the world at large. Using live links/live-linking means the live transmission of the proceedings of the inquiry to individuals who have been given a non-transferrable link to observe the inquiry at a venue remote from the hearing room, within the hearing venue or elsewhere (e.g. at home, at the offices of a solicitor, the offices of a media organisation).

12. I shall deal in order with the factors set out in my note.

Open Justice and Section 18 of the Inquiries Act 2005 (the Act)

13. This inquiry is of profound importance. The Terms of Reference require an examination of matters of deep public concern. This will include close scrutiny of many events, the conduct of people

involved and the decisions they made – as well as consideration of broader issues affecting the NHS. The principle of open justice applies not only to the hearings but also to the inquiry's processes.

14. The reasons for the development of the principles of open justice (both at common law and in statute) are well known. It is not necessary for me to rehearse the development of those principles, save to note that between the Clothier Inquiry in 1993 into events at Grantham hospital where Beverly Allitt, a nurse, murdered babies and now, there has been a shift away from private to public inquiries in cases of huge public concern**.**

15. **In R (Wagstaff) v Secretary of State for Health [2001] 1** WLR 292, the Divisional Court (Kennedy LJ and Jackson J) heard a challenge by families of the victims of Harold Shipman on the legality of a decision of the Secretary of State for Health to set up an inquiry using a general power to provide NHS services under Section 2 of the National Health Service Act 1977, rather than a specific power to establish a statutory Public Inquiry. The Health Secretary's decision was quashed for a number of reasons and he was directed to reconsider. In due course a statutory Public Inquiry took place. The court in Wagstaff relied on the observations of Clarke LJ in **The**

Thames Safety Inquiry (into the sinking of the Marchioness) endorsing the observations of Sheen J in the inquiry into the sinking of the Herald Of Free Enterprise: "it is of great importance that members of the public should feel confident that a searching investigation has been held, that nothing has been swept under the carpet and that no punches have been pulled."

16. The following additional uncontroversial propositions may be derived from the authorities:

    a. Holding hearings in public engenders public confidence because it allows scrutiny both of the process, including the conduct of the tribunal, and of the evidence.

    b. Evidence may come to light as a result of open hearings.

    c. Hearing evidence in public makes uninformed and inaccurate comment about the proceedings less likely (see Lord Woolf in **R v Legal Aid Board ex parte Todner [1999] QB 966**).

    d. When a witness gives evidence in public (whether in a court or some other quasi-judicial process, including an inquiry) the evidence is more likely to be candid than if given in private.

e. The media are the eyes and ears of the public. Through careful observation and fair and accurate reporting those who are unable to attend hearings are informed as to the process, the submissions and the evidence, leading to greater public understanding.

17. As was said by Ms Langdale KC in her account of the work of the inquiry at the Preliminary Hearing, there has been some fine journalism covering the criminal trial. Documentaries and podcasts as well as detailed fair and accurate court reporting have informed the very large number of people who were intensely interested in the criminal proceedings.

18. Section 18(1)(a) of the Act provides that, subject to any restriction under s.19, "[the Chair] must take such steps as she considers reasonable to ensure that members of the public [including reporters] are able – (a) to attend the inquiry or to see and hear a simultaneous transmission of proceedings at the inquiry". As Counsel to the Inquiry points out, the duty is satisfied if either there is attendance in the Hearing Room or there is 'simultaneous' transmission. All Core Participants who dealt with this issue were in favour of the public and media attending

the hearing by being present in the hearing room. Counsel to the Inquiry make the same submission.

19. As I indicated during the oral submissions that is my intention and the hearing venue has been chosen with that in mind. There will be seats in the hearing room for members of the public and for the media. Partitioning will be provided for families who wish to be present in the hearing room, but away from the public gaze. Rightly, no one argued that such an approach would not satisfy my duty under s(18)(1)(a). It more than satisfies that duty and, it follows, the requirements of open justice. Subject to any applications for special measures, witness evidence will be given in the hearing room, in public.

20. Section 18(2) of the 2005 Act makes clear that no recording or broadcast of the hearings is allowed, save as requested by or with the permission of the Chair (and subject to any conditions the Chair may set). My discretion is to be exercised in the context of the Crown Court orders.

The need to avoid breaches of the orders

21. Publication which would breach Section 45/46 YJCEA order is defined in s.63 YJCEA:

> "**publication**" includes any speech, writing, relevant programme or other communication in whatever form, which is addressed to the public at large or any section of the public (and for this purpose any relevant programme shall be taken to be so addressed), but it does not include an indictment or other document prepared for use in legal proceedings
>
> "**relevant programme**" means a programme included in a programme service, within the meaning of the Broadcasting Act 1990.

22. I accept the submissions of Counsel to the Inquiry, with which no one disagreed, that, whether by publishing to the public at large a livestream, or a live-link, or a live-note (simultaneous transcript), the inquiry would be a 'publisher' of that transmission at common law (meaning "*any person who publishes*": see the discussion of Warby J in *Aitken v Director of Public Prosecutions* [2015] EWHC 1079 (Admin) at [38]-[73]). The inquiry is legally liable for its publications but has a broad statutory immunity against civil actions pursuant to s.37(1) of the Act. However, as counsel pointed out, such

immunity does not extend to immunity from criminal prosecution (e.g. under s.49 YJCEA for breaches of ss.45/46 Orders) or contempt of court, and the inquiry must not breach the ss.45 and 46 YJCEA Orders by including any matter which could identify (as witnesses or otherwise concerned on criminal proceedings) the subjects of those Crown Court orders in any 'publication' as defined by s.63 YJCEA.

Submissions on behalf of the parents

23. All three leading counsel for the families submitted that in addition to the proceedings being heard in public, the hearings should be livestreamed, that is broadcast to the world at large. Live links to invited participants would not suffice. They submitted that the public has come to expect livestreaming because that has occurred in a number of recent and current high-profile inquiries. They described it as "the modern approach" and "the new norm". Counsel went so far as to say that a decision not to livestream would be a "derogation from that norm." I do not accept that. Each inquiry is different. It is for the Chair to determine how to exercise his or her discretion, taking account of all the factors in play. The norm, or more accurately, the fundamental principle, is open justice.

24. I entirely understand, as Counsel for the parents submitted, that the parents want people (as well as Letby) to be held publicly accountable for what happened to their children. The Terms of Reference at Part B direct me to make detailed findings about what happened and whether the people involved should have acted differently and whether that would and should have prevented deaths and injury. Those involved have received very searching requests for statements with which they must comply. They will be subject to detailed scrutiny, giving evidence, in public. Where they are accountable I will hold them accountable, publicly. Whether I direct livestreaming worldwide or live links or neither will have no effect on the rigour of my approach, nor on the approach of all who have responsibility for helping me to get to the truth.

25. Counsel for the parents accept that livestreaming to the world at large would involve publication, as defined in the Act. They submitted that the risk of breach of the Crown Court orders could be managed by having a delay on the livestream of (variously) between 15 minutes and one hour. A breach can occur when a witness refers to a person by their name, often through inadvertence. It can also occur where pieces of information which, individually, appear irrelevant

to a named person, but when taken collectively identify a person. This is known as jigsaw identification.

26. I accept that a delay in broadcasting, of up to 15 minutes, would allow the inquiry to remove a name, inadvertently mentioned, but a delay even of that length affects the ability of the press to report simultaneously and can disrupt the hearing by diverting attention from the evidence.

27. As well as suggesting that on occasion a delay on broadcasting of up to an hour may be appropriate, I was referred by Counsel for the parents to the approach taken in the Undercover Police Inquiry, a huge, long running inquiry. There, a separate legal team scrutinises the live evidence in order to ensure that orders made by the Inquiry Chair are not breached on publication. There, what is at stake (I understand) is the safety and privacy of people involved in the inquiry. The suggestion was that I should direct that the same or a similar approach be taken by this inquiry. I cannot accept that. It is not reasonable to look to the public purse to fund another team of lawyers to carry out a specialist exercise in order to facilitate livestreaming to the world when open justice is already secured in the arrangements for a public hearing. The fact that this was suggested indicates that the advocates

recognise that the risk of breaches is real. I do not accept that this is a risk the inquiry should take. Not only is there a significant risk to the inquiry itself, I take account of the human cost of a breach. For a parent, who has already suffered so much, to be identified online, is unthinkable. I do not need to spell out the consequences for people who have made it clear from the outset that their privacy must be respected and protected. The proposed applications for special measures on behalf of the parents who may give evidence reinforce my view.

28. The final submission from all three counsel for the parents was the most eye catching. It was to the effect that livestream broadcasting would reduce or dispel toxic and offensive conspiracy theories. This submission was unsupported by evidence and I reject it. Searching for truth is not a characteristic of conspiracy theorists. Like those who promulgate fake news they search for information which supports their world view. When they find none, they manufacture it, often using and distorting video footage to be found on the internet. I say no more about their activities.

Submissions from Counsel to the Inquiry

29. Counsel to the Inquiry submitted that I should exercise my discretion and allow simultaneous transmission of the proceedings to all Core Participants, their lawyers and the media (on application and with appropriate undertakings) via live links to other rooms in the same building as the hearing room and to locations remote from the hearing venue – e.g. solicitors' offices, media offices, homes. This would not involve publication within the meaning of the Act (because it is not to the public at large or to a section of the public). It would allow Core Participants to participate in the way they chose. It would be open to the media to report proceedings as they occur and to make application to broadcast excerpts. It would be open to witnesses to make applications for special measures, as appropriate.

30. Mr Bunting KC firmly supported the suggestion that live links should be provided, with no delay, to Core Participants and the media. He did not suggest that this was in any way a derogation from open justice. His submissions were to the contrary effect. He reminded me that the media know the identities of all the people who are the subject of the orders, as their representatives were there when the orders were made.

31. Most parents had indicated, through counsel, that they would choose to participate from a location away from the hearing venue. Others wanted to be in the Hearing Room. Of critical importance was that wherever they were, they should have instant access to proceedings so that they could instruct their lawyers whenever necessary. The arrangements suggested by Counsel to the Inquiry would permit that.

The need for all witnesses to give their best evidence to the Inquiry

32. As I said earlier, it is generally accepted that a person giving evidence in public is more likely to be candid than someone who is giving evidence privately. There is little information about whether there is a difference in the quality of evidence when the witness knows it is being broadcast live across the world or, perhaps worse, to family, neighbours, work colleagues, and so on.

33. I accept Mr Skelton KC's submission that the hardest part of giving evidence, particularly for those who have not previously done so, is being required to speak publicly in an unfamiliar room full of unfamiliar people with everyone looking at you. He recognised that the overlay of knowledge that the evidence is being broadcast to the whole world would bring an additional layer of stress.

However, he did not think that this knowledge would "tip the balance" by which was meant, I infer, that it would tip a witness over the edge into being unable to give their best evidence. In my view the extent to which broadcasting of all the inquiry hearing to the world affects a witness probably depends on a number of factors, including the personality of the witness, what they are going to say and how they think people hearing it will respond. I would accept that the thought of being observed by family, neighbours, work colleagues or others is unlikely to settle nerves.

34. It is unsurprising that many of the staff at the hospital, when informally asked about giving oral evidence, responded with anxiety and concern. Some of them gave evidence at the criminal trial so their experience has been of a very adversarial process. In their written submission the legal team for the Hospital observed that there was a "*real risk that witnesses feel inhibited by the knowledge that their evidence is being livestreamed or broadcast*". That is a reasonable observation. The submission continued, "*that they may be less inclined to speak frankly and with candour; and may be more defensive than they otherwise would. This could have a detrimental impact on the Inquiry's ability to fulfil its terms of reference*". This passage

unsurprisingly attracted considerable adverse comment, as was inevitable. Mr Kennedy readily acknowledged it was badly written. I make it plain that, notwithstanding their nerves, I expect all witnesses, doctors and nurses included, to tell the truth, to make every effort to assist the inquiry when giving evidence and to reflect thoughtfully on what happened. Candour and frankness should be a given. This extends to the witnesses for the corporate bodies, including the DHSC and NHSE.

35. Whilst I accept that knowing evidence is being broadcast live to the world may increase nervousness, I do not have a sufficient evidence base upon which I can rely to determine whether or not it would detrimentally affect the quality of the evidence given. Nor do I know whether a witness would be affected in the same way or differently knowing evidence is being transmitted live to certain individuals and may be broadcast at some stage. For those reasons, I leave that issue out of account in coming to my decision.

The need to avoid impeding the ongoing clinical responsibilities of any witnesses who still work in frontline NHS services

36. I would expect the inquiry team to give advance warning of hearing dates so that witnesses with clinical responsibilities can attend to give their evidence whilst keeping disruption to a minimum. I have already dealt with the need to achieve best evidence. There is nothing to add under this heading. Applications for special measures may be made and I will consider them in due course.

The need to avoid prejudicing criminal investigations or proceedings

37. All parties are aware of ongoing investigations and proceedings. The inquiry maintains a close liaison with Cheshire Police. There is no reason to think that this factor adds anything to the points made earlier under headings a-c.

CONCLUSION

38. I accept the submissions of Counsel to the Inquiry. As well as avoiding the problems arising from the live broadcast of evidence that I have described, the transmission of proceedings via live links reduces the risk of breaches of the Crown Court orders to the same level as hearing the proceedings in public. The links will be

granted on application and on undertakings to all Core Participants and the media. The links would be permitted to rooms in the same building as the hearing room or to locations remote from the hearing venue.

39. Using links allows the transmission of proceedings to continue without delay, so that simultaneous reporting may take place. Control of the footage would remain with the inquiry (unlike worldwide streaming over which I would have no control).

40. I accept that, although not necessary to achieve open justice, this process would add to the quality of the participation by Core Participants. They can watch proceedings without being in the room. The proceedings can be recorded so they can watch at a time convenient to them. This is of particular importance to parents who are working or have caring responsibilities. It also makes it easier for the media to report fairly, accurately and in a timely fashion. In addition, there will be a live transcript in the hearing room. The transcript (redacted where necessary) will be uploaded to the inquiry website at the end of the day, or as soon as possible after that.

41. Mr Bunting KC made it plain on behalf of the media that he agreed with the suggestions made by Counsel to the Inquiry. It formed no part of the

oral submissions of the media that there should be worldwide livestreaming, nor was it suggested that a failure to order this was in some way a derogation from open justice.

42. Mr Bunting KC asked that there should be a process developed so that decisions could be made about the broadcasting of clips from the hearings without interrupting the flow of the inquiry. I am content that such a process be developed. It should be designed to achieve swift decisions at minimal additional cost.

43. Counsel to the Inquiry also submitted that the use of mobile phones in the Hearing Room should not be permitted – so that they would not be used to take photographs or to record (via audio or video or both) any part of the hearing. They submitted that the media should be permitted to use laptops. I have reflected on that submission and taken account of the submissions about it from the parents and of the media.

44. I agree that those two groups may use mobile phones in the Hearing Room, as well as the lawyers for the Core Participants. Obviously, phone calls may not be made during hearings but I accept that the parents, who will not be sitting next to their lawyers, may need to message them and vice versa. I also accept that they will not seek to record proceedings or take photographs.

As to the media, I accept that mobile phones are essential tools for reporters. I was assured that they would not seek to record proceedings or to take photographs and I shall make directions to that effect in respect of all attendees. I accept the submission that the public should not be permitted to use their mobile phones in the hearing room and I shall make a direction to that effect. I do that to protect the integrity of the hearings, and because it will be impossible to police the difference between harmless messaging and messaging that risks undermining any of the court orders.

45. I am satisfied that these arrangements will allow effective participation in and public scrutiny of these proceedings.

Thirlwall LJ
Chair
24 May 2024

Appendix 1

THIRLWALL INQUIRY PRELIMINARY HEARING - 16 MAY 2024

1. For the substantive hearings there will be a hearing room to which the public will have access (either in the room or via live link to another room in the same building).

2. The technology is available to allow:

   (a) live links to venues controlled by the Inquiry which are remote from the hearing room (within the same building or elsewhere) to allow the public and press to attend the Inquiry without being in the hearing room.

   (b) live links issued for remote viewing (e.g. from the offices of NHS and media organisations) in accordance with a simple application process, including undertakings. No recording or copying or onward transmission of a live link will be permitted without the express authorisation of the Inquiry.

   (c) livestreaming online, worldwide.

3. No decisions have yet been taken as to whether some, or all, of the evidence should be transmitted by live link or broadcast via

livestream. Any parents of the babies named on the indictment who give evidence are likely to be permitted to do so subject to special measures.

4. All hearings will be transcribed. Transcripts will be made available online, and will be uploaded as soon as possible after the close of proceedings on any given day.

Submissions

5. Written submissions are invited from CPs and media organisations in respect of the nature and scope of any transmission or broadcast of the substantive hearings.

6. It is **directed:-**

   i) that any such submissions be sent by email to the Solicitor to the Inquiry by no later than **4pm on 9 May 2024**. Written submissions are not required but oral submissions at the Preliminary Hearing will not be permitted unless written submissions are received in accordance with this direction.

   ii) that whilst the overall content of the submissions is a matter for counsel, the submissions must deal with the following factors:

a) The importance of the Open Justice principle in the particular context of s18 of the Inquiries Act 2005;

b) The need to avoid any risk of breaching orders of the Crown Court;

c) The need for all witnesses to give their best evidence to the Inquiry;

d) The need to avoid impeding the ongoing clinical responsibilities of any witnesses who still work in frontline NHS services; and

e) The need to avoid prejudicing criminal investigations or proceedings.

f) The practical effect of any suggestions made.

7. Special measures for those who require them will be available as described in the vulnerable witness protocol. There may be other circumstances in which particular measures need to be taken to achieve best evidence. This will be considered on a case-by-case basis nearer to the substantive hearings.

Thirlwall LJ, Chair
30 April 2024

ii. Media Broadcast Protocol

This ruling deals with paragraph 11 of a draft Media Broadcast Protocol.

Background

1. On 29 May 2024 I issued a ruling on the question whether hearings in this Inquiry should be livestreamed or whether I should permit live links. I had heard submissions at a preliminary hearing. I decided against livestreaming and in favour of the provision of live links to Core Participants and the accredited media. The transcript of the hearing is at **link**.[1] My ruling is on the Inquiry website at **link**.[2]

2. At the preliminary hearing the nine media organisations who were represented by Jude Bunting KC did not seek livestreaming nor did any other media representative. They were content with the provision of live links. In the course of her argument Rachel Langdale KC, Counsel to the Inquiry, submitted that were I to

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1 **https://thirlwall.public-inquiry.uk/wp-content/uploads/2024/09/Thirlwall-Inquiry_16-May-2024_Preliminary-Hearing.pdf**

2 **https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-documents/Ruling-on-Livestreaming.pdf**

decide in favour of live links, I might consider the release to the media of clips for broadcasting. This was echoed in submissions made by Mr Bunting. At paragraph 42 of my ruling, I recorded his request "that there should be a process developed so that decisions could be made about the broadcasting of clips from the hearings without interrupting the flow of the Inquiry." I agreed that such a process be developed, "designed to achieve swift decisions at minimal additional cost."

3. The Inquiry legal team and representatives of the media have been in discussions about the development of a media broadcast protocol in respect of the broadcast of clips of the proceedings of the Inquiry by accredited media. I am grateful to all for the work that has been done. The draft protocol runs to 19 paragraphs with a short appendix. It has been seen by all Core Participants, none of whom has made any observations on it, save as I set out below.

4. The broadcasters accept that in the exceptional circumstances of this Inquiry (which they acknowledge is of profound importance) they will abide by the protocol, but they object to the inclusion of Paragraph 11 which they say should be deleted. It is upon that objection that I am asked to rule. I do so on the papers, having

received written submissions from Mr Bunting on behalf of the broadcasters and from Kate Blackwell KC on behalf of four former senior managers whom she represents: Ian Harvey, Alison Kelly, Tony Chambers and Sue Hodkinson.

5. Paragraph 11 of the draft protocol reads –

> "*In general, in respect of any given outlet or title operated by a media organisation, broadcasts of clips of witness evidence will be limited to no more than 5 minutes per day for any individual witness. This restriction can be varied or disapplied upon application to the Chair, and shall not apply if a witness confirms in writing their consent to broadcast of their evidence in full*"

6. The broadcasters submit that, in their editorial assessment, some of the witnesses' evidence in this Inquiry will require longer than five minutes of broadcast footage per day. They base their assessment on their experience of reporting on the criminal trial and on their reporting of other public inquiry hearings. They inform me that the BBC 24 hour news channel broadcast "long sections" of the evidence of Paula Vennells at the Post Office Horizon IT Inquiry, which is being livestreamed. Whilst long sections of evidence do not, on the face of it, come within the description of a clip, nothing turns on that. The point is that

broadcasters may from time to time want to broadcast more than five minutes of the evidence of a witness on any one day.

7. Miss Blackwell points to the second part of paragraph 11 which allows for applications to vary or disapply the five minute limitation. I accept that there may be situations when a longer excerpt might be appropriate. The provision for an application to vary or disapply allows for such situations.

8. In my judgment there are at least three reasons which lead me to conclude that in allowing broadcasting I should maintain paragraph 11 of the protocol. First, it is imperative that the Inquiry hears from witnesses who are able to give best evidence. It is reasonable to assume, as a general proposition, that for a witness waiting to give evidence to the Inquiry, the prospect of the broadcast of a five minute clip of evidence is less intimidating than the prospect of broadcasts of unlimited and uncertain duration. Of course, the reality may be different in the light of the evidence given, but my concern is that the witnesses be reassured in advance so that they can give best evidence. That the assumption is reliable is borne out by Miss Blackwell's assurance at paragraph 8 of her submissions that no applications for special measures have been

made on behalf of any of the senior managers in the light of the contents of paragraph 11 of the protocol. This includes the possibility that the five minute limit may be waived. She reasonably adds that if paragraph 11 is removed in its entirety this position will have to be reviewed.

9. I do not accept the broadcasters' proposition that a witness' concerns about broadcasting would not justify special measures. That is a fact specific decision in each case.

10. I am satisfied that the five minute limitation will reassure witnesses and allow them more easily to engage with and give evidence to the Inquiry.

11. Second, the order for live links instead of livestreaming was based in part on the risk of breaches of the Crown Court orders. I am satisfied that the risk of breach is lower the fewer and shorter clips that are broadcast.

12. Third, as I said in the ruling, the Inquiry retains control of the footage (subject to the application of the protocol) which should give some reassurance to those who are concerned about conspiracy theorists and the use to which they may put broadcast footage.

Practicalities

13. The broadcasters accept that paragraph 11 permits an application to the Chair to disapply or vary the five minute limit but they say that repeat applications would be impractical. There is no basis for saying that at this stage. The process should be simple and straightforward and can be refined in the light of experience.

14. I reject the submission that removing paragraph 11 would allow swift decisions at minimal additional costs. That course would not give effect to paragraph 42 of my ruling.

15. Accordingly, paragraph 11 shall remain in the protocol.

16. This decision having been made on the papers it is open to the broadcasters to seek a hearing. It will be listed in London at the same time as any contested applications for special measures, 10.30am 6 August 2024.

Thirlwall LJ
Chair
28 July 2024

iii. Application to pause the Inquiry

1. The hearing of the evidence of the last witness in this case was listed for Monday, 24th February at 10 o'clock. On the late afternoon of Friday, 21st February, Ms Blackwell, her junior and her solicitor wrote to me on behalf of Mr Harvey, Ms Kelly, Mr Chambers and Ms Hodkinson seeking a pause to the Inquiry. They rely on section 17 of the Inquiries Act 2005. They wrote at the same time to the Secretary of State to seek a suspension under section 13 of the same Act.

2. It is necessary at this stage only to read the first paragraph of the letter, which reads as follows: "*We formally write to ask you to exercise your duty under section 17(3) of the Inquiries Act 2005 and pause the current public inquiry proceedings pending the outcome of the Criminal Cases Review Commission's consideration of an application made by Lucy Letby in respect of her criminal convictions for murdering seven babies and attempting to murder seven others between June 2015 and June 2016 at the Countess of Chester Hospital.*" I turn then to the final line of the final page which reads, "*the only reasonable course of action, albeit a regrettable one, is to pause proceedings until the appellate process has run its course.*"

3. I arranged for the letter to be sent over that weekend to all Core Participants. I directed that the hearing on Monday the 24th would not be affected by the request and that where any Core Participant wished to make any submissions in respect of the request to pause, they should be added to closing submissions which were already listed for this week, beginning 17 March, in Liverpool. I extended the time for written submissions to accommodate the additional work required.

4. On the following Friday, 28th February, in the early evening Mr David Davis MP wrote to me also seeking a pause to the Inquiry.

5. This Monday morning, about half an hour before the hearing was due to start, I received a long letter from a firm of solicitors, Bhandal Law, who represent Ms Letby. The solicitors asked me to suspend the Inquiry, "*to wait for the outcome of the review to take place*". That is a reference to the CCRC, the Criminal Cases Review Commission, to whom Ms Letby has made a preliminary application that her case should be referred back to the Court of Appeal Criminal Division.

6. The history of her convictions at two trials and the dismissal of her two applications for leave to appeal her convictions has been set

out on earlier occasions and I do not repeat it. As matters stand, Lucy Letby is serving 15 whole life sentences for offences of murder and attempted murder.

7. I have approached the Inquiry on the basis that Lucy Letby is guilty of the crimes of which she has been convicted. That she is guilty is the consequence of the convictions under the law of this country. It is not for me in the discharge of my duties under the Inquiries Act 2005 to seek to explore alternative theories about the deaths of children, unless the Terms of Reference require me to, which they do not.

8. Requests to the Secretary of State for Health and the Secretary of State for Justice were sent on 30 July 2024 from a number of experts with a request that the Terms of Reference should be amended in the light of doubts about the convictions. The Secretary of State for Health replied refusing the request. Such an amendment would have led to this public inquiry being used as a vehicle for a collateral attack on the convictions, cutting across the criminal justice system, including the process for challenging convictions via the CCRC and ultimately the Court of Appeal Criminal Division.

9. On 24th September 2024, part way through the hearings of this Inquiry, I received an application from a firm of solicitors then representing Lucy Letby. They applied on her behalf for Core Participant status. I refused that application. My decision was not the subject of any legal challenge, and it will be uploaded to the website of this Inquiry later this week.

10. Until 21st February this year there was no suggestion by any of the Core Participants that this Inquiry should be paused or suspended, or the Terms of Reference changed. What seems to have prompted the letter of Friday, 21st February, was a press conference which took place on 4th February. This was, I believe, the second press conference which had been organised by Ms Letby's team. The first took place just before Christmas. On 4th February it was announced by Ms Letby's barrister that a preliminary application had been sent to the CCRC on 3rd February. Summaries were released of reports by a number of experts from across the world, across a range of disciplines. They had, I understand, been provided with medical records of the babies on the indictment. They had then carried out their own review of the records, at the end of which they concluded that there was no medical evidence of murder or deliberate harm. At the

press conference, full reports were promised by the end February. It is now said that they will be provided to the CCRC this week.

11. In a statement on their website, in February, the CCRC say that they have received a preliminary application from lawyers for Lucy Letby. They say that it is not possible at this stage to determine how long it will take to review the application and note that a significant volume of complicated evidence was presented to the court during Letby's trials. The CCRC say that they expect more submissions from Ms Letby's team. They also say that they will not be commenting on their own progress. I was told by Miss Blackwell during the hearing that a commissioner has been allocated and the current legal team is to meet him or her soon.

12. A brief word about the medical records of the babies on the indictment and of their mothers. I do not doubt that such records are relevant to the application to the CCRC and have rightly been provided to them. They were relevant to this Inquiry and were rehearsed as necessary with advance notice to the parents and, of course, with their consent. It is apt, I think, to remind ourselves of the observation of Mr Baker KC yesterday when he said: "*Whatever side of the*

debate people are on, people should remember that the dead and harmed are not public property to be dissected on television or on the internet."

13. In the light of the reports which are described as "*fresh evidence*", Ms Letby's solicitors asked me to suspend the Inquiry under section 13 of the Inquiries Act 2005. This section of the Act applies not to me but to the Secretary of State. I assume a letter has by now been sent to him to that effect and I say no more about the solicitors' letter sent on Monday morning.

The law

14. The power to suspend a public inquiry rests with the Secretary of State, here the Secretary of State for Health and Social Care. Section 13(1) provides that: "*The Minister may at any time, by notice to the Inquiry Chair, suspend the Inquiry for such period as appears to the Minister to be necessary to allow for -- (a) the completion of investigation into any of the matters to which the Inquiry relates, or (b) the determination of any civil or criminal proceedings arising from those matters.*"

15. In considering the wording of section 13 in the Supreme Court, a case reported as In the matter of an application by *JR222 for Judicial Review*

(Appellant) (Northern Ireland) Lord Stephens, Justice of the Supreme Court, made the following observations at paragraph 60 to 65:

> "*(a) the purposes of a suspension were limited to those set out in subsections 1(a) and 1(b) of section 13.*
>
> *(b) the existence to suspend an Inquiry presupposes the ability to continue an Inquiry while criminal proceedings are ongoing.*
>
> *(c) the power to suspend is vested in the Minister who must consult the Chair of the inquiry before doing so.*
>
> *(d) the period of suspension is until the day specified in the notice or until further notice is given by the Minister.*
>
> *(e) if the Minister suspends an inquiry he must provide his reasons and lay a copy of the notice before the relevant Parliament or Assembly.*"

16. Having considered two possible interpretations of section 13(1) and applying the ordinary principles of statutory interpretation as set out in *R (Project for the Registration of Children as British Citizens) v Secretary of State for the Home Department*, Lord Stephens concluded that: "*The true interpretation is that section 13(1) naturally reads as one question which must be*

considered and answered as a whole. On this basis necessity applies to both the purposes in section 13(1)(a) and (b) to the period of suspension." Ms Langdale submits that it follows that the threshold for suspension of an inquiry under section 13 is a high one.

17. In addition to the power to suspend the Inquiry, of course, as I was reminded by a number of counsel yesterday, it is the Secretary of State who has the power to set up the Inquiry, to set the Terms of Reference in consultation with the Chair, and each of them has pointed out to me that before exercising the power to suspend the Secretary of State must consult the Chair.

18. It is against that legal backdrop that the former executives seek to make their application under section 17 of the Inquiries Act, describing it as a duty which requires me to pause.

19. Section 17(1) provides that: "*The procedure and conduct of the Inquiry are such as the Chair may direct.*" And 17(3) that: "*In making any decision as to the procedure or conduct of an inquiry, the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or to others).*"

20. The DHSC, the Department of Health and Social Care, makes no submissions either on the law or the detail of the request. This is unsurprising, given that the Secretary of State has a role under section 13 of the Act, as I have identified.

21. NHS England make three points on the law.

22. First, that the power to suspend the Inquiry rests with the Secretary of State under section 13 of the 2005 Act, not with the Chair under section 17 of the 2005 Act.

23. Second, if the Secretary of State is considering exercising the power under section 13, he would be required to consult with the Chair.

24. Third, he submits that I may use the occasion of these submissions, i.e. the submissions being made by counsel for the Core Participants, to obtain the positions of the Core Participants in the Inquiry to inform any representations that I may seek to make to the Secretary of State in the event of a consultation with me about a request to suspend.

25. On the facts, NHS England adopts a neutral position.

26. The RCPCH make no submissions on this issue.

27. On behalf of the CQC, Ms Richards submits, at paragraph 92 of her submissions, that section 17 contains no express power to pause an inquiry, but, as I've set out above, provides that the procedure and conduct of an inquiry are as the chairman of the inquiry may direct, and that in making any decision the chairman must act with fairness and with regard also to the need to avoid any unnecessary costs. She says it may be arguable that section 17 empowers a Chair to "*pause*" an inquiry where it would be unfair to continue. For the purposes of this ruling, I shall proceed on the basis that it is at least arguable that I have that power.

28. Ms Richards, like Mr Beer on behalf of NHSE, then suggests that halting an inquiry is principally a matter for the Minister under section 13, that the Minister's powers under section 13 are highly circumscribed and can only be exercised following consultation with the Chair where it is necessary for one of the statutory purposes to which I have referred. That a ministerial decision to suspend is subject to such a high bar suggests that a similar decision by an Inquiry Chair should be similarly constrained. Ms Langdale makes the same point on behalf of the Inquiry.

29. Ms Richards submits that the fact that parallel investigations are ongoing, does not, without more, require a Minister to suspend an inquiry and it follows, therefore, that the mere fact of parallel proceedings would not, without more, require the Chair to do so on grounds of fairness.

30. She goes on to say, assuming that section 17 does empower the Chair to pause the Inquiry, this would require the Chair to consider whether it would be fair to all the participants in the Inquiry to suspend it for an indefinite period pending a decision by the CCRC as to whether the case should be referred to the Court of Appeal in circumstances where, as things stand, there is a conviction and matters have proceeded no further than a reference to the CCRC.

31. Mr Kennedy, on behalf of the Countess of Chester Hospital, in his written document set out subsections 17(1) and (3) and submitted that:

> "*the Chair may proceed to consider the evidence received and conclude the Inquiry in line with the section 17(3) duty.*"

32. He made two observations:

> "*(a) To pause the Inquiry pending the outcome of the CCRC application process and any further process that may subsequently be initiated would be to effectively suspend*

it for an indeterminate period. That period could be lengthy. Any pause therefore risks preventing the Inquiry from fulfilling its Terms of Reference in a timely manner. Those Terms of Reference were decided by the Secretary of State, and it can be in neither the public interest nor the interests of those involved in the Inquiry process for the fulfilment of those Terms to be frustrated for a long period.

(b) Letby's convictions result from a full and lengthy judicial process. Those convictions stand. Leave to appeal on the basis of new medical evidence has already been considered and refused. Whilst the Trust does not comment on the strength of the application made by Letby's legal team to the CCRC, it observes that it cannot be fair, reasonable or proportionate to postpone the Inquiry based on the mere possibility that her case will be referred to the Court of Appeal. That possibility will always exist. Were her case in fact to be referred to the Court of Appeal by the CCRC on its merits, the Trust may wish to revisit its stance."

33. On behalf of Family Group 2 and 3, Mr Baker submitted that the power to suspend, which is effectively, he says, what is being sought here, rests only with the Minister and not with the Chair.

34. Returning to the letter from Ms Blackwell, at page 2 she says:

> "*Where there is a real possibility as appears to be the case here, that Ms Letby's convictions may be referred by the CCRC to the Court of Appeal and there quashed, we submit that the public inquiry proceedings must be paused. To ignore the appellate proceedings which have now commenced would be wrong for the following reasons. Firstly, there is a real risk that you would be in breach of your duty to act fairly under section 17(3) of the Inquiries Act 2005 and, two, there is a real risk that you would be in breach of your duty to have regard to the need to avoid any unnecessary cost under section 17(3).*"

35. One preliminary point in respect of that submission. There are, at the moment, no criminal proceedings afoot. An application to the CCRC does not begin appeal proceedings. That comes later, if there is a reference to the Court of Appeal Criminal Division. Everyone agrees that it is not for me to assess the application being

put before the CCRC. I have seen some of the summary reports submitted, but I have not seen the application, nor would I expect to. At the same time, Ms Blackwell submits that the effect of the reports, which are in fact so far untested, means that there is a real possibility that the convictions will be referred to the CACD and there quashed.

36. Set against that assertion are the submissions of Mr Skelton, who points out there is nothing new in the reports and that the analysis is flawed, and those of Mr Baker who conducted a detailed forensic review of much of the medical evidence. I express no view on the merits of the application to the CCRC. It is clear that this will be a very lengthy process for the CCRC and, were a referral to take place, the Court of Appeal Criminal Division.

37. It is inevitable that the pause being sought is of a length which is entirely outside of my control, but it appears on the face of it to be a very lengthy one. This is rather more than an adjournment granted, for example, to allow the parties to deal with disclosure or to support a witness and so on, the sorts of pauses which are entirely routine in inquiries. This increasingly looks in effect like a suspension.

38. As I say, for the purpose of this request I will assume that I have the power to pause where fairness requires it, as Ms Richards suggests.

39. Turning, then, to the two limbs of the submission, it is convenient to deal first with costs.

40. I have to have regard to the need to avoid unnecessary costs, and that is something that I have had in my mind and in my actions since I was appointed to chair this Inquiry.

41. The Inquiry has completed its evidence well within the time estimated and, as a result, it is running at a lower cost than had been originally thought. What remains is the report writing and, in all likelihood, some warning letters in respect of potential criticisms. That will be followed, of course, by the costs of publication, but the main costs have already been incurred.

42. If the report is not written now but written at some point in the future, it is inevitable that the costs will be greater. Experience has shown us that the longer the time between the completion of a case, particularly one involving a great deal of evidence, and the judgment or ruling, the longer it takes to provide the judgment or ruling. It follows that there will be additional costs in the event of a pause.

43. In the meantime (i.e. during the pause), a slimmed down secretariat would be required while the Inquiry remains in being and in suspension or pause. Whether the same staff could be retained is rather doubtful, and so it may well be that it is necessary to set up a fresh team for warning letters and publication. All of that would add to and not reduce costs. I am quite satisfied, therefore, that, having regard to the need to avoid unnecessary costs, this is not a matter which supports the application for this pause.

44. That leaves the question of fairness.

45. I have set out what is required of me. There was no suggestion from any of the Core Participants at the time I opened the hearings that it was unfair to observe that the convictions stood, nor was it suggested that it was unfair to work on the basis of the convictions, notwithstanding what I then described as "*noise*".

46. The process of the Inquiry has been conspicuously fair. Every Core Participant has been sent in advance an outline of the questions to be asked and the documents to be looked at, and no one has been taken by surprise by the documents. All counsel had the opportunity to ask questions of their clients and of other

witnesses. Any requests to ask questions were agreed by Counsel to the Inquiry, and I was not required to adjudicate on a single application.

47. The Inquiry does not become unfair because there is a possibility, as is asserted, that all the convictions are unsafe.

48. It is important to repeat what I have said on a number of earlier occasions. I completely accept and have approached the Inquiry in this way; that it is essential to guard against hindsight when judging the actions of people eight, nine and ten years ago. That is not going to change once I move into the report writing stage.

49. As I have said before, it is not the actions of Lucy Letby that I am scrutinising, it is the actions of all those who were in the hospital and within the Terms of Reference whose actions I am reviewing, what they did at the time in the light of what they knew at the time, and in the light of what they should have known at the time.

50. There are already large numbers of concessions about what was not done that should have been done. Those significant concessions come from the organisations, the hospital, including the doctors, and the managers have made a number of concessions, including that they should have communicated better with parents and should

have provided pastoral care for the consultants. But perhaps principal and most obvious among the concessions made by just about everyone is the acknowledgement that there was a total failure of safeguarding at every level, and that will not change. It is a matter which has been debated at some length in the course of the Inquiry and one that, it seems to me, inevitably will feature in any report.

51. There were some submissions that one type of witness was treated differently from other types of witness, doctors as opposed to managers. I am not going to make any observations about that issue in this ruling. It seems to me that it is appropriately dealt with in the course of a report when I am reviewing the whole of the evidence but not at this stage.

52. I remind myself of the submission made by a number of people that fairness to all the parties is required, not just to a single set of Core Participants. I am not satisfied that there is any unfairness in the current situation.

53. I am satisfied that the process has been fair.

54. At the very end of her submissions, Ms Blackwell suggested that I might consider a hybrid approach. This would be to publish the report in respect of Parts A and C but not Part B until

the resolution of the criminal cases. I accept that from the perspective of her clients Part B is the most contentious and potentially difficult but the reason why Herculean efforts were made by everyone to be ready for Part B so it could be heard immediately after Part A and before Part C was because they flow one from the other. The experiences of the parents cannot be separated from the actions of the people in the hospital. Equally importantly, recommendations are bound to come out of my findings. I have already said as much. If Part B were omitted, there is a risk that recommendations lose their anchoring in the facts. It is a point well made that the impetus for implementation will be reduced in the absence of findings of fact.

55. Accordingly, for all the reasons that I have rehearsed during the course of this somewhat lengthy extempore judgment, the application is refused.

56. I should say that, of course, the question of the timing of the publication of the report is, as always, a matter for me and I will always keep that under review, as I would do in any other Inquiry.

57. That concludes my ruling.

Thirlwall LJ
Chair
19 March 2025

Appendix 6. Inquiry process

Use of ciphers

A6.1. During the criminal proceedings in *R v Letby*, reporting restriction orders were made under sections 45 and 46 of the Youth Justice and Criminal Evidence Act 1999 to protect the identities of the babies named on the indictment, their parents and certain members of staff at the Countess of Chester Hospital. Those orders remain in force and applied throughout the Inquiry. Accordingly, in this Report, the babies who were named on the indictment for the criminal trials of Letby are referred to by the ciphers used during the criminal trials. The parents of each of the babies are similarly referred to by ciphers, as are a number of former members of staff at the Countess.

A6.2. The Chair made two restriction orders under sections 17 to 19 of the Inquiries Act 2005. The first, made in August 2024 and amended

in September 2024, related to hearings held between 16 and 26 September 2024, which concerned Part A of the Inquiry's Terms of Reference. It provided for special measures and protected the identities of the parents who gave evidence.[1]

A6.3. The second, made in August 2024 and amended in September and October 2024, related to hearings regarding Part B of the Inquiry's Terms of Reference, which commenced on 30 September 2024. It granted anonymity and special measures to a witness referred to as Nurse ZC and special measures for nine other witnesses, all of whom were members of staff at the Countess of Chester Hospital.[2]

A6.4. This Report maintains the ciphers used during the Inquiry hearings.

Documents, statements and Core Participants

A6.5. Following the establishment of the Inquiry, documents were obtained under the Inquiries Act 2005. The Inquiry identified potential witnesses and obtained 383 witness statements and 227 questionnaire responses under Rule 9 of the Inquiries Rules 2006.

A6.6. The Chair designated Core Participants as follows: 25 parents, 6 organisations and 4 former Board-level managers at the Countess.

Disclosure

A6.7. Over the course of the Inquiry, more than 92,666 documents (1,043,441 pages) were received by the Inquiry. Of those documents, 15,318 (comprising 303,060 pages) were deemed relevant to the Inquiry's Terms of Reference and were disclosed to Core Participants.

A6.8. A six-stage disclosure process was followed:

i. Disclosure requests were issued under Rule 9 of the Inquiry Rules 2006. The Chair also issued four notices for disclosure under section 21 of the Inquiries Act 2005.

ii. Materials were provided to the Inquiry in electronic format, uploaded to a disclosure management database, and a unique reference number was allocated.

iii. Materials received were reviewed by the Inquiry legal team for relevance to the Inquiry's Terms of Reference. Redactions were applied to material that contained

sensitive information deemed irrelevant to the Inquiry's Terms of Reference, personal data (within the meaning of UK data protection legislation), legally privileged information and to the names protected by reporting restriction orders.

iv. Relevant materials were returned through the disclosure management database to the material provider before they were disclosed to Core Participants. Material providers had the opportunity to review proposed redactions and make further suggestions.

v. Relevant materials were disclosed on the disclosure management database to Core Participants. Documents were disclosed on a rolling basis in the run up to the hearings.

vi. During the Inquiry hearings, some material disclosed to Core Participants was displayed on screens in the hearing room and adduced into evidence. Once this happened, the page(s) of the document referred to was uploaded onto the Inquiry's website.

A6.9. The Inquiry counsel team identified a preliminary list of witnesses to be called. It was circulated to all Core Participants with an invitation to suggest addition or removal of any witness.

A6.10. The Inquiry's hearings began on 1 September 2024. All witnesses who gave evidence are listed in Appendix 4. The oral evidence was transcribed and is also on the website. The Inquiry sat for 60 days, across 16 weeks, and heard evidence from 134 witnesses.

A6.11. In accordance with the provisions of the Inquiry Rules 2006, Counsel to the Inquiry, Rachel Langdale KC, and members of her counsel team asked questions of the witnesses. In preparation for that exercise, the Inquiry legal team liaised with counsel for all Core Participants to identify which issues they wanted to be explored with witnesses, and which documents they wanted them to be referred to. Wherever counsel for Core Participants wished to ask questions themselves, they were permitted to do so. Counsel observed all time limits whenever necessary to complete the evidence within five months, and submissions a month later in March 2025.

References

A6.12. Materials referenced in the report have been published on the Inquiry website to assist the reader to follow key findings and issues. References provided in respect of any findings made are not intended to be exhaustive and the evidence has been examined as a whole.

Endnotes

1 Restriction Order Part A, 1 August 2024, amended 20 August 2024 and 13 September 2024 (**https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-documents/Restriction%20Order%20Part%20A%20-%20Amended%2013%20September%202024.pdf**)

2 Restriction Order Part B, 1 August 2024, amended 4 September 2024 and 11, 17 and 31 October 2024 (**https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-documents/Special-Measures-Order-Witnesses-updated-31-October.pdf**)

Appendix 7. Inquiry team

The individuals listed below have all worked on the Inquiry at some time between October 2023 and September 2026. Some have been involved throughout, others for periods ranging from a few weeks to a few months.

Counsel
Rachel Langdale KC, Counsel to the Inquiry
Olivia Bennett
Andrew Bershadski
Clare Brown
Greg Callus
Craig Carr
Helen Crowell
Nicholas de la Poer KC
Nia Frobisher
James Hargan
Tom Hickman KC
Alex Ivory
Hari Kaur
Christina Lyons
Thomas Russell
Sam Stevens

Solicitors
Tim Suter, Solicitor to the Inquiry
Sarah Ellson
Niamh Fox
Annabel Holloway
Georgia Hughes
Martin McElroy
Olivia Pointon
Claudia Richardson
John Sheridan
Nicole Simpson
Martin Sleight
Bethany Thompson
Paralegals
Ayse Atas
Jessica Clorley
Christopher McQueenie
PA to the Chair
Isobel Rowlands
Clerk to the Chair
Kelly McQueen
Secretariat
Lorna Yates, Secretary to the Inquiry
Harriet Askew
Lily Boulter
Nicola Bridgens
Laura Crichton
Karmen Kaarlõp
Lax Kuganeethan
Maev MacCoille

Secretariat

Alex Marinkovic

Ciarán Whitehead

Appendix 8. Core Participants and legal representation

Families of babies named on the indictment – Family Group 1	
Counsel	Peter Skelton KC
	Shahram Sharghy
	Leanne Woods
Solicitors	Tamlin Bolton, Switalskis then Irwin Mitchell
	Tim Annett, Irwin Mitchell
Families of babies named on the indictment – Family Groups 2 and 3	
Counsel	Richard Baker KC
	Alex Jamieson
	Sara Sutherland
	Rochelle Rong
Solicitors	Richard Scorer, Slater & Gordon
	Linda Schermer-Jones then Kerry Goulden, Oliver & Co
	Sara Stanger then Carla Duprey, Bond Turner
	Elen Roberts, Mackenzie Jones
	Emma Scourfield, Harding Evans then Slater & Gordon
Royal College of Paediatrics and Child Health	
Counsel	Fiona Scolding KC
Solicitor	Stuart Merchant, Bevan Brittan

Department of Health and Social Care	
Counsel	Neil Sheldon KC
	Jonathan Dixey
	Robert Cohen
	Jennifer Wright
Solicitors	James McArthur and Georgia Bain, Government Legal Department
Countess of Chester Hospital NHS Foundation Trust	
Counsel	Andrew Kennedy KC
	Thomas Hayes
Solicitor	Emma Stockwell, Hill Dickinson
Nursing and Midwifery Council (NMC)	
Counsel	Victoria Butler-Cole KC
	Samantha Jones
Solicitor	Zahra Anderson Nanji, NMC
Care Quality Commission (CQC)	
Counsel	Jenni Richards KC
	Andrew Deakin
Solicitor	Ross Clark, CQC
NHS England	
Counsel	Jason Beer KC
Solicitor	Charlotte Harpin, Browne Jacobson then DAC Beachcroft
Tony Chambers, Ian Harvey, Sue Hodkinson, Alison Kelly	
Counsel	Kate Blackwell KC
	Alex Tampakopoulos
Solicitor	Anna Naylor, Weightmans

Correct as at August 2026

Appendix 9. Acronyms

BAPM	British Association of Perinatal Medicine
BMA	British Medical Association
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CPAP	continuous positive airway pressure
CQC	Care Quality Commission
CRP	C-reactive protein
DHSC	Department of Health and Social Care
eMAR	electronic Medication Administration Record
FTSU	Freedom to Speak Up
GMC	General Medical Council
HR	Human Resources
HSSIB	Health Services Safety Investigation Body
ICB	Integrated Care Board

INWO	Independent National Whistleblowing Officer (Scotland)
IUGR	intrauterine growth retardation
JAR	joint agency response
LADO	Local Authority Designated Officer
MBBRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MOSS	Maternity Outcomes Signal System
MoU	Memorandum of Understanding
NEC	necrotising enterocolitis
NGO	National Guardian's Office
NHS	National Health Service
NMC	Nursing and Midwifery Council
NPPG	Neonatal and Paediatric Pharmacy Group
NRLS	National Reporting and Learning System
OSCE	Observed Structured Clinical Examination
PALS	Patient Advice and Liaison Service
PICANET	Paediatric Intensive Care Audit Network
PRUDiC	Procedural Response to Unexpected Death in Childhood

QIS	Qualified in Specialty
QSPEC	Quality, Safety and Patient Experience Committee
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and Child Health
RSPRT	resetting sequential probability ratio test
RSV	respiratory syncytial virus
SBAR	Situational Background Assessment Recommendation
SSB	Safeguarding Strategy Board
StEIS	Strategic Executive Information System
SUDIC	Sudden Unexpected Death in Infancy and Childhood
SWAN	Sign/Words/Actions/Needs
TPN	total parenteral nutrition
UVC	umbilical venous catheter
WTE	whole-time equivalent

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