THE THIRLWALL INQUIRY

OPENING STATEMENT OF
THE COUNTESS OF CHESTER HOSPITAL

Introduction

1 This is the written opening statement for the Countess of Chester Hospital NHS Foundation Trust (CoCH/the Trust) provided in response to the Inquiry's Note dated June 2024.

2 At the outset CoCH wishes to express its utmost sympathy for the suffering of the babies, parents and families arising from the events that the Inquiry is charged to inquire into. The Trust's thoughts have been with the babies, parents and families throughout the Police investigation and the criminal trial. They will continue to be in the Trust's thoughts during this Inquiry and beyond. It is profoundly sorry for their suffering.

3 At the time of preparation of this opening statement disclosure of witness statements and documentary evidence is ongoing. Statements from some significant witnesses have either only recently been disclosed (former executives) or are yet to be disclosed (some clinicians, managers and parents). So far as we are able, we set out below CoCH's provisional response to the issues raised in the Inquiry's June 2024 Note, but we recognise that in addition to disclosure being ongoing we do so before the Inquiry has heard any oral evidence.

4 We also recognise that we do not represent all of those who were responsible for decisions made concerning Letby. In this document we endeavour to avoid identifying potential individual failings and focus on institutional failings on the part of CoCH.

5 The disclosure of documents by CoCH has been and remains a challenging and time-consuming exercise. The Trust recognises that its document management and disclosure systems have not been as effective and robust as it would have wished, and others may have expected. It is accepted that having made disclosure of material in the past for the purposes of the police investigations (including into the actions of Letby) and the investigation conducted by Facere Melius it should have been possible to re-disclose that material directly to the Inquiry. CoCH is also conscious that it has not always been able to provide as complete and timely disclosure of documents as it would have wished in response to the requests for information and for this it apologises. Notwithstanding these difficulties, CoCH remains committed to assist the Inquiry in

any way it can and will continue to disclose relevant material in response to requests by the Inquiry.

6 The Inquiry will wish to identify any failings which permitted Letby's crimes to go unchecked and to identify where responsibility for such failings may lie. It is important that it does so. In doing so the Inquiry will, we are confident, acknowledge the clarity that is provided when actions are judged with the benefit of hindsight and will be cautious to make its assessment based on what was known (or should have been known) at the time by those whose actions are being called into question. Moreover, any analysis of the events which form the subject matter of this Inquiry should, we submit, recognise the rare and exceptional circumstances in which individuals found themselves. As has been said elsewhere, they had to *think the unthinkable*. But that is easily said with the benefit of hindsight. It is far more difficult to comprehend that an individual who was thought to be an able and trusted nursing colleague may be deliberately harming those in her care.

(a) When did the hospital know about suspicion or concerns?

7 Concerns first arose in relation to collapses and deaths on the neonatal unit following the deaths of Child A, Child C and Child D in short succession in June 2015. Over the following year, these concerns developed, and suspicions grew amongst the paediatricians that the cause of the increase in collapses and deaths could be the deliberate actions of a member of staff.

8 We do not seek to provide a complete account of each instance on which concerns about collapses and deaths on the neonatal unit were raised. Nor do we describe in detail developments in the state of knowledge of each member of the Trust's staff. These will be issues for the Inquiry to explore through the oral evidence. We therefore intend to identify some of the key instances when concerns and suspicions of deliberate harm were raised, particularly where such concerns went beyond those typically expected after a neonatal death. In parallel, routine incident reporting processes such as Datix, SBAR[1] or morbidity and mortality meetings give some insight into the understanding at the time. CoCH would however observe that the nature of the concerns about Letby's involvement may have led to a tendency to raise suspicions outside of formal processes, which were largely intended to address harm or issues in care arising from clinical factors. This too will be an issue for the Inquiry to explore through the oral evidence.

9 Key dates on which the Trust's awareness of concerns evolved include:

(a) on 22 June 2015, Dr Stephen Brearey observed that the same member of staff, Letby, had been present at the deaths of Child A, Child C and Child D **[C9]**. This was in the context of

[1] Completed by the neonatal risk facilitator after a death, SBAR (Situation, Background, Assessment, Recommendations) forms would then be reviewed at the Trust's Serious Incident Panel.

reviews undertaken by the clinicians to try and understand the three recent neonatal deaths in short succession;

(b) on 2 July 2015, there was a meeting attended by Ruth Millward, Alison Kelly, Eirian Powell, Debbie Peacock and Dr Brearey to discuss the deaths of Child A, Child C and Child D **[B7]**;

(c) on 22 October 2015, the minutes of the Women and Children's Care Governance Board record that there had been three unexpected neonatal deaths **[C49]**;

(d) on 23 October 2015, a review of neonatal unit mortality conducted by Eirian Powell identified Letby as present at all the events reviewed **[B11, C54]**;

(e) in November 2015, an obstetric led review noted *a perceived increase in number of Stillbirths and Neonatal deaths at the Countess of Chester Hospital (COCH) in 2015* **[B14]**. The review was discussed at the Quality, Safety and Patient Experience committee (QSPEC) on 14 December 2015 **[C77]** and the Women and Children's Care Governance Board on 18 December 2015 **[C84]**;

(f) on 19 January 2016, in a review of neonatal mortality for the year January 2015 to January 2016 undertaken by Eirian Powell, Letby was identified as having an association with each of the cases examined **[B40]**;

(g) on 21 January 2016, the increased mortality was discussed by Dr Brearey and Dr Nim Subhedar, and plans made for an external review of the care provided **[C103]**;

(h) on 25 January 2016, Dr Jo Davies emailed Mr Harvey stating: *We have had an increase in stillbirth and neonatal death for 2015.* Attachments to this email included the November 2015 obstetric review **[C105]**;

(i) on 2 February 2016, the minutes of the QPSEC on 14 December 2015 were received and noted by the Board, albeit the relevant papers appear to have only been made available to Board members on request **[INQ0015531]**;

(j) on 8 February 2016, a thematic review of neonatal mortality attended by Dr Brearey, Dr Subhedar, Eirian Powell and others noted *a higher than expected mortality rate on NNU in 2015* **[B49]**. The draft minutes were shared with Mr Harvey on 15 February 2016 **[C117]**; and

(k) by 2 March 2016, the thematic review included an action for Dr Brearey and Eirian Powell to review deaths occurring between 0000 and 0400 hours to *…identify any medical or nursing staff association with these cases* **[B68]**. Separately, Dr Brearey emailed Eirian Powell stating: *I think we still need to talk about Lucy — maybe when you are back and free the three of us can meet to talk about it* **[C121]**. The findings of the thematic review were forwarded to Mr Harvey and Alison Kelly on 21 March 2016 **[C123]**.

10 Accordingly, it can be considered that by March 2016, concerns as to collapses and deaths on the neonatal ward over the preceding nine months, as well as suspicions of deliberate harm by a member of staff, were known to senior individuals at CoCH.

11 Thereafter:

(a) by 4 May 2016, it was reiterated that there was a potential association between neonatal deaths and collapses and Letby's shift pattern. This knowledge in part informed the decision to remove Letby from night shifts on 7 April 2016 **[C128]**;

(b) on 11 May 2016, at a meeting attended by Anne Murphy, Mr Harvey, Dr Brearey, Eirian Powell and Alison Kelly, the handwritten notes record: *…absolute no issues with nurse, circumstantial, 1 dr also [illegible] across a number of cases, 6 babies – nurse Letby -> sudden deterioration…* **[C135]**;

(c) at a meeting on 16 May 2016, it is reported that *[Dr Brearey] intimated that he thought that a member of staff was causing the increase in mortality* and that Dr Jim McCormack stated *[Eirian Powell] was harbouring a murderess on the neonatal unit* **[C137, C138]**.[2] On the same date, Dr Brearey emailed the consultants stating *Naturally, we will be keeping close eye on things in the immediate future. If you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitatation (sic) on NNU, please could you let me and Eirian know. We will keep a record of these cases and review them as soon as practicable* **[C139]**;

(d) on 24 June 2016, after the death of Child P, Dr Brearey contacted the on call executive to outline his concerns, in particular at Letby continuing to have patient contact **[INQ0103104_0043 § 242]**;

(e) on 28 June 2016, Dr Brearey emailed Karen Townsend on behalf of the consultant paediatricians to the effect that Letby should not have further patient contact **[C159, C160]**;

(f) by 29 June 2016, the question of whether referral to the Police was necessary due to suspicions of deliberate harm by a member of staff was considered at a meeting of the Trust's executives attended by the Medical Director, neonatal consultants and Trust's Chief Executive **[C178, C179]**;

(g) on 30 June 2016, the same concerns were reiterated at a meeting attended by the Chair of the Trust's Board **[C191]**. That same day, the CQC were notified that *The Trust has identified an increase in the number of deaths of newborn babies (differing levels of prematurity) on our Neonatal Unit in 2015-16 and now in 2016-17 compared to previous years*... . An external review of the incidents was commissioned from the Royal College of Paediatrics and Child Health **[C164]**;

(h) on 5 July 2016, the Trust's non-executive directors were told in some form of concerns about the neonatal unit and the Trust's subsequent request to have the unit voluntarily reclassified as a Level 1 NNU **[INQ0102040]**;

(i) by 7 July 2016, CoCH issued a press release concerning the downgrade of the neonatal unit **[C227]**; and

[2] It should be acknowledged that Mr. McCormack disputes that these precise words were used **[INQ010335_0020 § 112]**.

(j) on 14 July 2016, at an extraordinary meeting of the Trust's Board of Directors, the Board were made aware of concerns of increased instances of deaths and collapses on the neonatal unit, as well as a correlation with one staff member **[C264]**.

The Trust's response to emerging concerns

12 It is, we submit, unsurprising that CoCH's initial response focussed on identifying clinical factors which may have accounted for the increased mortality. That was entirely consistent with the usual response to concerns about higher mortality rates. However, over time that approach ceased to be appropriate and needed to be reviewed as suspicions of Letby's involvement grew.

13 In considering the adequacy of the Trust's response, it is helpful to briefly set out some of the key aspects of that response:

(a) the 2 July 2015 meeting attended by Dr Brearey, Ruth Millward, Julia Fogarty, Alison Kelly and Debbie Peacock at which the Deaths of Child A, Child C and Child D were discussed;

(b) in response to further events, now including the deaths of Child A, Child C, Child D, Child E and Child I, on 23 October 2015 Eirian Powell circulated a document examining common factors in the deaths **[B11]**. This identified that Letby had been involved in the care of each baby. The thrust of concerns at this time however remained on the clinical care provided;

(c) Dr Sara Brigham's review of obstetric care in November 2015 **[B14]**;

(d) in January 2016, Eirian Powell's further staffing analysis which identified Letby's presence as a common feature across the cases examined. Combined with the review of deaths undertaken by Dr Subhedar and Dr Brearey on 8 February 2016, this resulted in production of the 'Thematic Review of Neonatal Mortality 2015-Jan 2016' ('the thematic review') **[B49]**; and

(e) on 2 March 2016, a further version of the thematic review was circulated to consultants. This identified sudden and unexpected deteriorations in some babies with no clear cause as well as an association with Letby **[INQ0003251]**. As observed above, Dr Brearey emailed Eirian Powell that day referencing the need to discuss Letby's association with the deaths **[C121]**.

14 Up to March 2016, the focus was largely on identifying a clinical explanation for events. When assessing the response to that point, it is important to keep in mind the realities of medical practice in a busy acute hospital. Whilst periods of elevated morbidity and mortality will occur from time to time, instances of deliberate harm by healthcare staff are exceedingly rare. When a period of elevated mortality is observed, its cause is therefore highly likely to be: (1) a product of random variation in outcomes; (2) due to clinical factors; or (3) insofar as it relates to staff, not rooted in criminality. Accordingly, CoCH submits that it was reasonable to initially look for clinical causes to explain the increase in deaths and collapses observed on the neonatal ward.

15 Following the thematic review:

(a) on 17 March and 14 April 2016, Eirian Powell contacted Alison Kelly by email in relation to the issues raised and the actions required in response **[C125 & C126]**; and

(b) in May 2016, there was a series of email correspondence and meetings including the Trust's executives, managers and clinicians. These raised concerns in respect of increased deaths on the neonatal unit and suspicions that Letby may be causing deliberate harm to patients.

16 Thereafter, following the deaths of Child O and Child P and the collapse of Child Q in June 2016, the Trust's substantive response included:

(a) in early July 2016, the Trust's own internal investigations. These included establishing a 'silver command' structure to investigate and manage the initial response to concerns regarding neonatal deaths. Such work appears to have included a review by Mr Harvey of mortality on the neonatal unit **[B140]** and a review of the care of babies who had been transferred out of CoCH by Dr John Gibbs and Ann Martyn **[B202]**. At approximately the same time, Alison Kelly and Ruth Millward authored a position paper ('the position paper') examining mortality on the NNU from 2013 to 2016 **[B165].** The products of these reviews make no reference to clinicians' concerns about Letby and identify various alternative possibilities to explain the increased mortality observed;

(b) from 1 to 2 September 2016, an invited service review undertaken by the Royal College of Paediatrics and Child Health (RCPCH). This reported in draft form on 18 October 2016 **[C388]** and in final form on 28 November 2016 **[B265]**;

(c) in light of the recommendations of that review, commissioning *...a thorough external, independent review of each unexplained neonatal death between January 2015 and June 2016*... . Dr Hawdon was approached in this regard on 8 September 2016 **[C348]** and reported her findings on 29 October 2016 **[B375]**;

(d) obtaining legal advice on the thresholds for notification of concerns to the police, notably from DAC Beachcroft **[F1 to F8, F16, F34]** and Simon Medland KC (now HHJ Medland KC) **[F19]**. Mr Medland ultimately met with Dr Brearey, Dr Ravi Jayaram, Dr Susie Holt, Dr Murthi Saladi, Dr Gibbs and Dr V on 12 April 2017; and

(e) on 27 April 2017, Dr Jayaram, Dr Holt, Stephen Cross, and Mr Harvey met with Child Death Overview Panel (CDOP) members DCS Nigel Wenham, Hayley Frame and Dr Rajiv Mittal **[C661]**. Following this, a meeting was held between Drs Brearey, Holt and Jayaram and DCS Wenham and DCI Paul Hughes on 15 May 2017 **[INQ0103231]**.

Was the Trust's response adequate?

17 We recognise that in seeking to answer this question we do so at a time when disclosure of documents and witness statements to Core Participants is ongoing and before the Inquiry has heard any oral evidence.

18 CoCH accepts that there are legitimate questions concerning its response to concerns about increased neonatal mortality and suspicions of Letby's involvement. In particular, there were opportunities to act once concerns about Letby's association with deaths were voiced following the March 2016 thematic review. CoCH identifies the following issues or themes which the Inquiry may wish to address.

19 First, no substantive action was taken between March and June 2016 to address the concerns articulated by the paediatricians from the beginning of March 2016 onwards. Letby was removed from night shifts in early April, ostensibly for her own welfare. She remained in a patient facing role throughout this period during which there was an absence of further measures which would properly have addressed the patient safety concerns raised by the thematic review.

20 Second, upon the escalation of concerns following the deaths of Child O and Child P and the collapse of Child Q in June 2016, the principal way in which the Trust responded was by commissioning external reviews undertaken firstly by the RCPCH and later by Dr Hawdon. However, there is a legitimate question as to whether either would have been capable of adequately investigating or addressing concerns of the type raised by the consultant paediatricians. Moreover, neither was asked specifically to consider the paediatricians' concerns regarding the actions of Letby. We address this further below when considering the actions of the Board.

21 Third, notwithstanding those limitations, the external reviews were interpreted by the Trust as being exculpatory of Letby and appear to have been deployed as evidence to dismiss the paediatricians' concerns.

22 Fourth, the increase in mortality was subject to a number of internal reviews between June 2015 and April 2017. Whilst CoCH would submit that these were reasonable early in the chronology, they became less so as concerns persisted. Later reviews appeared to be limited by an unwillingness to *think the unthinkable*, along with a failure to appreciate the unfairness and impracticality which arose from requiring colleagues to examine issues of potential criminality by their fellow employees.

23 Fifth, there was a failure to give appropriate weight to the views of the paediatricians who: (1) had direct appreciation of events 'on the ground' and; (2) were subject matter experts. Decisions were taken by individuals who were remote from events and who lacked the necessary expertise to properly interpret what was being observed. That failure coloured both an understanding of what was occurring, and the steps taken in response.

24 Finally, when considering whether the threshold for notification of the police had been met, the test applied appears to have been to a higher threshold than was appropriate.

(b) Information sharing with parents

25 A question raised by some witnesses is whether there was focus on the babies that died to the detriment of those who survived. The witness evidence from parents concerning information sharing for those whose babies collapsed and survived differs from those whose babies died. Although it is accepted that information sharing with those whose babies died was deficient (we address this further below) the evidence of those whose babies survived is that there was no or no meaningful contact from CoCH regarding concerns about the care that their baby had received. The effect of that failure was that the first they knew of such concerns was when they were told by the Police. CoCH recognises and apologises for the distress that this will have caused.

26 The Inquiry will wish to consider whether information should have been shared with the parents whose babies collapsed and survived, and if so, what information and when.

What were parents told at the time their baby collapsed?

27 The traumatic nature of the events surrounding the collapse of their baby or babies is laid bare in the police statements of the parents, the victim impact statements and, in the statements prepared for the purposes of the Inquiry. The statements demonstrate a mixed picture in terms of how the immediate events following a collapse or death were handled. Some parents express concern about the provision of information concerning the possibility of collapse or about relationships with individual members of staff **[A1061 & A1300]** or concerns about the neonatal unit **[A927]**. Others report favourably about their experience on the NNU **[A559, A727 & A1003]**, and the response of staff to the unfolding events **[A728]**.

28 Generally, the available witness evidence suggests that parents were told about any acute deterioration as soon as it occurred, that parents were present (so far as they wished to be) when attempts were made to resuscitate their babies and that they were involved in decisions surrounding withdrawal of resuscitation. Within the limits imposed by the unfolding and rapidly moving events (and accepting some individual misunderstandings or omissions) it is suggested that the information provided to parents at the time of and in the immediate aftermath of a collapse was appropriate in the clinical setting.

What were parents told later?

29 As above, we acknowledge that the evidence of the parents whose babies collapsed and survived is that there was no or no meaningful communication from the Trust. These submissions therefore address the experience of those parents whose babies died.

30 Generally, the consultant responsible for a baby's care would write to the parents after the death or collapse to provide an explanation of the events as they were understood at the time and to offer a meeting. Examples of letters in the core bundle are to be found at **[A191 & A309]**. Dr Brearey's conclusion (albeit only considering the detail of babies A, B, C & D) is that parents were

kept adequately informed of the immediate investigation into their baby's death **[INQ0103104_0018 §126]**.

31 However, at least one family describe a lack of contact following the death of two babies and several an absence of bereavement support **[A1195]**.

32 Accepting some individual misunderstandings or omissions, it is suggested that the approach of the consultants to providing parents with information or an opportunity to meet and discuss the care provided to their baby or babies was generally reasonable.

What were parents told about suspicions or investigations?

33 It does not appear that parents were told by CoCH of suspicions that their baby's death or collapse may be due to criminality on behalf of a staff member. CoCH submits that the considerations in respect of doing so are complex. Should concerns about criminality on behalf of a member of staff develop so that it is necessary to inform those concerned or their families of this, it is highly likely that notification of those same concerns to the police will be appropriate. However, an active or impending police investigation is likely to limit the extent to which it is appropriate to share information with patients or their families: the police would have legitimate concerns were parents in these circumstances to be told that suspected criminality was likely to result in a police investigation.

34 There were two clear opportunities for CoCH to notify parents about suspicions concerning raised neonatal mortality and the subsequent investigations. First, at the time that the admission arrangements for the NNU were changed at the request of the Trust in July 2016. Second, in February 2017 at the time of the publication of the RCPCH report.

35 There is some evidence of attempts to contact families at around the time of the downgrading of the NNU. One parent was told that an unsuccessful attempt had been made to contact her prior to the unit downgrade **[A223]**. Others seem not to have been contacted **[A1195]**. There is better evidence of successful and unsuccessful attempts to contact parents at the time of publication of the RCPCH report **[A355, A536, A858, A1194]** and following the publication of the RCPCH report there was more regular correspondence with the families: letters were sent on 8 February, 3 March, 21 April and 28 April 2017.

36 The Inquiry will appreciate that following the commencement of the investigation by Cheshire Police in May 2017 the police led on all communications and CoCH was asked not to contact the parents.

37 Some parents describe learning about suspicions or concerns about the NNU or about investigations into deaths on the NNU from the news media. CoCH cannot and does not seek to

defend this; every effort should have been made to contact those likely to be affected to ensure that they were informed at the earliest opportunity and certainly before material was put into the public domain. The experience described by one parent **[A223]** was entirely avoidable given that she remained a patient of CoCH. Likewise, the distress caused by the delivery of a letter by a black cab notifying a parent of the publication of the RCPCH review later that day on the Trust website **[A552]**. CoCH apologises unreservedly for the distress caused.

Failings on the part of CoCH

38 CoCH accepts that there were failings in the manner in which families were kept informed by the Trust about raised neonatal mortality and the steps taken in response:

(a) some families appear not to have had any contact at all;

(b) for others the contact was unsuccessful when better efforts would have been successful;

(c) the "silver command" established by the Trust in early July 2016 was reactive rather than proactive i.e. it appears to have been designed to respond to those calling the Trust with concerns following notification of the downgrade, rather than to communicate with those who it could reasonably have been known may already have been affected by the events that had led to the decision to downgrade;

(d) there was an excessive period between the notification of the RCPCH investigation on 7 July 2016 and its outcome in February 2017 during which the Trust appears not to have made contact with the families at all;

(e) accepting that the leak of the RCPCH report to the Sunday Times may have compromised the timings for notifying parents of the publication of that report, a timeframe whereby first contact was to be made on 3 February and the report was to be published on 8 February was unrealistic and compromised the prospects of informing families of the fact of the publication of the RCPCH report in advance of its publication;

(f) the letters sent by CoCH to the parents from 8 February to 28 April 2017 were brief and sometimes uninformative and put the onus on the parents to make contact with the Trust to discuss the contents rather than vice versa;

(g) although the extract of the Hawdon report was provided to families with an offer of a meeting to discuss it (and the RCPCH report) the extract would have been difficult to follow. An illustration of this is to be found at **[INQ0106954_0015 §35]**.

39 The Trust accepts that because of these failings it was not open and honest with the parents and for this it unreservedly apologises.

How should information be shared?

40 The current practice in terms of the Trust's duty of candour is described in a statement dated 16 July 2024 of Susan Pemberton, the Trust's Deputy Chief Executive and Executive Director of Nursing Quality and Safety that was provided in response to a request from the Inquiry. Mrs Pemberton explains that as with other NHS providers the Trust now manages incidents through

the Patient Safety Response Framework (PSIRF) which replaced the Serious Incident Framework. She exhibits the Trust's PSIRF policy and its current Duty of Candour and Being Open Policy. PSIRF is a contractual requirement under the NHS Standard Contract.[3]

41 As stated above, CoCH accepts that communications were inadequate and that it was not open and honest with parents about the investigations into the rise in neonatal deaths. The question of how to communicate with families in the circumstances which give rise to this Inquiry is, however, a complex one. The Inquiry may wish to consider what recommendations can be made as to how to balance the fundamental importance of openness and transparency against some of the potential harms of so doing. Relevant factors may include:

(a) at an individual level, patient choice and autonomy is furthered by openness and transparency;
(b) at a systems level, patient safety is likely to be furthered if healthcare providers are open and transparent;
(c) a risk of inaccuracy in communications, or alternatively a need for unhelpful vagueness, if disclosures are made at an early stage;
(d) a loss of confidence in services when concerns or suspicions are raised, which may be unjustified if investigations subsequently reveal such concerns to be baseless or otherwise explicable;
(e) a risk that people who require health services are thereby dissuaded from seeking medical attention, and the harm which may result;
(f) the impact such communications may have on any (potentially innocent) individual concerned, both from a wellbeing and an employment perspective, and
(g) the practicalities of notification. For instance, it may not be practical to inform family members of suspicions of criminality prior to notifying those same concerns to the police.

(c) Support for parents of babies in hospital

Was the bereavement practice in 2015/16 adequate

42 There is overlap with the issues addressed in the previous section of the Opening Statement. Support for bereaved parents started at the time of death of their baby. It would be provided by the nursing team and the bereavement staff. The consultant would be expected to speak to the family. The medical records in the core bundle indicate that there was a meeting between the family and the consultant or another member of the medical team. Later the consultant would write to the family with an offer to meet and discuss the babies' care. The bereavement team would continue to support the family with guidance about groups such as SANDS and BLISS. CoCH's position is that generally the support provided was consistent with what might have been expected. This is supported by the Neonatal Standards Review that the Trust conducted in July 2016 **[INQ0014431]**.

[3] **INQ0017495_0090 §356**.

43 In their statements provided to the Inquiry some parents have expressed the view that the offer to call the hospital chaplain was unwelcome. CoCH recognises that the offer of chaplaincy support or baptism for seriously ill babies is likely to be an intensely personal issue: for some it will be a welcome offer of support; for others it will be an intrusion on personal and private grief. The Trust accepts that it will not always be possible to judge the situation correctly, and acknowledges that it is important that it continues to review and learn from occasions when the offer of support is not welcome or other concerns are expressed **[A195, A198]**.

44 The Inquiry may want to consider whether the offer of a meeting with the relevant clinician is appropriate or whether the onus should be on the hospital to arrange a meeting for the parent to attend should they wish. The Trust acknowledges that it may not be possible to provide a "one size fits all solution" and that given the sensitivities, the current arrangement of an offer of a meeting may be a reasonable one.

45 The guidance available in 2015/16 included:

(a) Support for Parents of Babies with Suspected or Actual Poor Outcome **[INQ0014428 & INQ0014429]**. In addition to communication with the clinical team the minimum level of support expected for parents required the provision of written information about support groups (BLISS) and offer of referral for additional support (support worker, chaplain, health visitor or counselling service).

(b) Management of a Perinatal Loss on Delivery Suite **[INQ0009465]**.

(c) Perinatal Loss Guidelines **[INQ0014433]**. This included a checklist **[INQ0014434]** (including the emotional support that should be provided along with a bereavement pack) and a Bereavement Co-ordinator notification form **[INQ0014437]**.

46 Previously the bereavement office would refer families for bereavement counselling if this was requested. The Trust now has a bereavement midwife who visits families to provide direct support and signpost them towards counselling and other services.

47 The Trust's current guidance for staff in the event of a child death includes information on chaplaincy referral, child death review processes, family engagement and bereavement, a list of organisations providing bereavement support and a bereavement checklist **[INQ0014161]**.

48 If it would assist the Inquiry CoCH would be happy to provide a statement addressing the bereavement support currently available to parents.

(d) Advice and help

Sources of help and advice

49 CoCH observes that there are a wide variety of scenarios which could give rise to concerns in relation to the safety of a baby admitted to hospital. These may range from more straightforward safeguarding enquiries to scenarios of the type which form the subject matter of this Inquiry. Potential sources of advice for doctors and nurses who have concerns that deliberate harm is being caused by a member of staff to patients therefore include:

(a) internal support systems. In turn these may include colleagues, especially senior colleagues, or formal structures such as 'freedom to speak up';
(b) child safeguarding arrangements;
(c) sources of external peer review;
(d) medical defence organisations ('MDOs');
(e) trade unions;
(f) the CQC;
(g) the NMC or GMC; and
(h) the Police.

Sufficiency of the advice available

50 CoCH is unable to comment on the sufficiency of advice which may be provided by others. Nevertheless, the Trust makes the following observations about the support available to doctors and nurses in circumstances where they have concerns that a colleague may be causing deliberate harm to patients. Addressing each source in turn:

(a) Internal support: plainly, in the circumstances this Inquiry is charged with investigating, escalation to senior colleagues and the internal mechanisms for raising concerns did not provide sufficient help and advice so as to prevent harm to babies in hospital.
(b) Child safeguarding: the normal child safeguarding procedures do not appear to have identified the increase in mortality seen between the summer of 2015 and 2016. Three factors might be considered to have delayed CDOP's awareness of such concerns: (1) there was no clear mechanism by which clinicians could communicate their concerns to CDOP; (2) the clinicians did not initially consider CDOP to have a role in investigating mortality trends in hospital; and (3) CoCH was subject to two CDOPs split between Wales and Cheshire. Each CDOP therefore lacked a complete understanding of the overall mortality at CoCH in 2015-2016. However, once CDOP was provided with appropriate information in April 2017 there was an appropriate response;
(c) Peer review: the assistance conferred by external reviews appears to have been limited by a tendency to examine events from an assumption that there was a clinical cause for any increased mortality. Such reviews appear not to be equipped to advise on matters of potential criminality;

(d) MDOs: although the defence organisations generally provide an advice line, their primary purpose is to provide assistance for professional and litigation risk. CoCH is unable to say whether an MDO would be equipped to provide advice to members about how to act in the event of concerns about potential criminality.

(e) Trade unions: similarly, whilst trade unions may provide general advice to their members, they are fundamentally not engaged in child safeguarding. Further, CoCH notes that some have commented on a perceived conflict of interest between the RCN's role in supporting Letby as an individual engaged in an employment dispute, and its role in advising other members in respect of concerns which arose from Letby's conduct; and

(f) CQC: CoCH would observe that the CQC's predominant function is regulatory not advisory. Insofar as it was approached for assistance, expressions of concern which appear to have been made by paediatricians to the CQC were insufficient to lead to those concerns being satisfactorily addressed, and no significant assistance appears to have been rendered.

51 Where there are suspicions of deliberate harm being caused to patients by a member of staff, notification of the GMC, NMC and Police may be required. However, the scope of the advice which these bodies can be expected to provide is likely to be limited to whether, at the time they are consulted, their further involvement is necessary. They are unlikely to be equipped to provide any broader advice as to how a doctor, nurse or medical organisation might address such concerns, especially where those concerns are vague or incipient, or do not meet the threshold for their investigation.

Improvements and the role of external scrutiny

52 CoCH is not of the view that expanded external scrutiny would be advantageous in the circumstances the Inquiry is reviewing. There are already multiple external organisations that have a role in scrutinising hospitals. The risk of adding a further body is that lines of responsibility and accountability may be blurred. The Trust observes that the only external organisation properly empowered to investigate allegations of criminality is the Police.

53 CoCH's position is that robust internal processes are likely to be of principal safeguard where a member of staff may be causing deliberate harm to patients. The sufficiency of that internal support is likely to depend on the attitudes and capabilities of those tasked with providing it and the structures and cultures within which they work. The Inquiry will wish to consider whether it is possible to devise a protocol to guide when a referral to the police may be appropriate and whether staff can be trained to recognise signs of harm being caused to patients by staff, and how to act in such circumstances.

(e) The board; its role and skills

What was the board's involvement in the way concerns about Letby were raised by the hospital?

54 In 2015/16 the constitution of the Trust Board of Directors (the Board) was the Chairman, Sir Duncan Nichol, six Non-Executive Directors (NED) and eight Executive Directors – see Jane Tomkinson's first witness statement **[INQ0017158_014 § 58]**.[4]

55 Up to 5 July 2016, concerns about Letby appear to have been discussed between clinicians and managers within the NNU and some of the Executive Directors (sometimes referred to as the Executive Team or Executive Directors Group (EDG)). In June 2015 the EDG included Mr Chambers, Mr Harvey, Alison Kelly, Mr Mark Brandreth, Susan Hodkinson and Debbie O'Neill[5] **[C14]**. Mr Stephen Cross was often also part of the EDG but was a non-voting member of the Board.

56 On 5 July 2016 the downgrading of the NNU was mentioned during a private NEDs meeting prior to the Board meeting. The only record of this is in a handwritten note made by Ms Fallon **[INQ00102040]**. The first formal record of the Board being told about concerns about Letby was on 14 July 2016 at an Extraordinary Board Meeting **[C264]**. This meeting was also attended by Dr Brearey and Dr Jayaram who reported their concerns to the Board. Three actions appear to have been approved by the Board: (1) the data brought to the Board would be examined (2) the NNU dashboard would be monitored at the weekly executive meeting and (3) Mr Cross would sign off the draft terms of reference for the RCPCH review. The consultant paediatricians were not asked to sign off the terms of reference. At this meeting Mr Harvey is recorded as telling the Chair, Sir Duncan Nichol, that the *explicit concerns* would be discussed as part of the review **[C272]**.

57 The closest the terms of reference for the RCPCH review come to addressing explicit concerns is the request that the review panel consider *Are there any identifiable common factors or failings that might in part, or in whole explain the apparent increase in mortality in 2015 and 2016?* **[C311]**. The impact of this was that the RCPCH review team was not aware until 1 September 2016 that action had been taken against Letby on the basis of an allegation made by a member of the medical staff **[C334]**.

58 The minutes of the Board meeting in September and December 2016 do not record any discussions about neonatal mortality, Letby or investigations being undertaken even though (1) the RCPCH review having recently taken place (2) the Hawdon review being received on 29 October 2016 and (3) the final RCPCH report being received on 28 November 2016 **[C422]**.[6]

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[4] Ros Fallon was appointed as a NED on 1 May 2016 – **INQ0102042_0003 §14**.
[5] Debbie O'Neill explains that for much of the period being considered by the Inquiry she was on compassionate leave – see **INQ0106943_003 §§10&ff**.
[6] CoCH have disclosed these Board minutes to the Inquiry and MP reviewed them with INQ numbers of **0014818/9** but they do not appear on the CP workspace on Relativity.

There are references to a Board meeting on 4 October 2016 **[INQ0004212]**. Checks have been made on the Trust website for October 2016 and no material has been found tending to confirm that a Board meeting did take place.

59 On 10 January 2017 Mr Harvey presented a paper to the extraordinary Board meeting which referenced the RCPCH and Hawdon reviews and sought approval from the Board to assist Letby's return to work **[INQ0003239]**. Mr Chambers is recorded as informing the Board *There was an unsubstantiated explanation that there was a causal link to an individual, this is not the case and the issues were around leadership and timely clinical interventions* **[C448, C449]**. The minutes also record criticisms of the consultant paediatricians by executive and non-executive board members.

60 The Board received a further update from Mr Chambers on 7 February 2017 **[C489, C494]**. This included a report that the Hawdon review *did not identify a single causal factor or raise concerns regarding unnatural causes*.

61 Concerns about neonatal mortality having been raised at the extraordinary Board meeting on 14 July 2016, it would be expected that it would be made clear how they should be managed going forward. Mrs Hopwood may have had this point in mind when she asked how on-going discussions would be brought to the Board **[C272]**. The plan appears to have been that (1) it would be monitored by the EDG through the Neonatal Dashboard and (2) the Chair and Mr Andrew Higgins (as chair of QSPEC) would *be in very close contact with the review.*[7] Neonatal mortality was discussed at QSPEC meetings on 15 August **[C318]** and 19 September 2016 **[C356]**. At neither of these meetings was there mention of concerns about a particular individual and on 19 September 2016 Mr Harvey is recorded as reporting that the RCPCH review had not raised an immediate concern. The minutes of the QSPEC meetings on 17 October **[INQ0004347]** and 21 November 2016 **[INQ0004363]** make no mention of neonatal mortality.

62 It is apparent from the letter from the consultant paediatricians dated 10 February 2017 that they were not consulted about the decisions proposed by the Board in January 2017 and did not agree with them **[C499]**.

63 On 13 April 2017 the Board received a report from Mr Medland KC following his meeting with the consultant paediatricians earlier that day. Mr Medland's view is recorded as being *there is no evidence of a crime but the consultant view is to go to the police*. He proposed an alternative solution that the police member of CDOP was approached. This resulted in a meeting on 27 April 2017 attended by Mr Harvey, DCS Wenham, Hayley Frame (CDOP chair), Dr Jayaram and Dr

[7] The Terms of Reference of QSPEC are to be found at [**INQ0104202**]. The Board members who were also members of QSPEC from the summer of 2016 were Mr. Higgins (who chaired QSPEC), Sir Duncan Nichol, Rachel Hopwood, Ros Fallon, Mr. Chambers, Mr. Harvey, Alison Kelly and Susan Hodkinson.

Holt (and others), and in turn the letter from Mr Chambers dated 2 May 2017 seeking an investigation by Cheshire Police **[C677]**.

What was the Board's oversight of clinical and corporate governance?

64 Questions that arise from this brief summary and from the available witness evidence are:

(a) Why was neonatal mortality not considered by the Board between July 2016 and January 2017 given that (1) the Board had been alerted to the issue in July 2016 and (2) some members of the Board sat on QSPEC which addressed neonatal mortality in, at least, August and September 2016.

(b) Why was neonatal mortality not considered by QSPEC in October and November 2016?

(c) Was there appropriately open and transparent access to the RCPCH and Hawdon reports: some NEDs describe seeing only excerpts of the RCPCH report or not being permitted to keep a copy; the paediatricians were allowed to read but not retain the reports?

(d) Should the NEDs and the paediatricians have been provided with the RCPCH and Hawdon reviews before January and February 2017?

(e) Should the paediatricians have been asked to provide input into the terms of reference for either or both reviews?

(f) Did the Board correctly balance the requirement to put families first with any obligations towards Letby?

Did the Board have the relevant skills effectively to oversee clinical and corporate governance?

65 Recurring themes from the available documentary and witness evidence which the Inquiry may wish to explore are:

(a) Did the Board members have adequate experience of Board level NHS Trust management?

(b) Did the Board adequately hold the Executive Directors to account?

(c) Did the EDG provide the Board with the material to permit it properly to hold the EDG to account? Was the material provided excessive, unwieldy and appropriately analysed or distilled?

(d) Did the Board have sufficient and/or appropriate clinical or medical expertise? The EDG included a doctor (Mr Harvey, an orthopaedic surgeon) and one or more nurses (Mr Chambers was a qualified nurse but had primarily worked in NHS management and Alison Kelly had qualified and practised as a nurse). Until Ros Fallon was appointed in May 2016 there was no NED with clinical or medical expertise.

(e) Should the Board have sought or been provided with assistance from a subject matter expert?

(f) Did the Board have adequate training, specifically in whistleblowing, safeguarding and investigations.

(f) Management in the NHS and Regulation

66 In common with many NHS Trusts in 2015/16 CoCH operated a divisional structure. This is described in the first witness statement of Jane Tomkinson **[INQ0017158_0011 §44]**. It is not repeated here. The structure has been the subject of criticism because obstetrics and paediatrics were in different divisions. We address below under Remedial Actions the changes that have been made to the divisional structure of the Trust since 2015/16.

67 CoCH supports the recommendations made by Tom Kark KC in his review of the Fit and Proper Person Test (FPPT) published in February 2019. This includes recommendation 5 for the power to disbar directors for serious misconduct. Whilst some directors may be liable to disciplinary action by reason of membership of a professional body, this is not universal, and there is no organisation with the power to disqualify a director. Hence, it agrees with Mr Kark's recommendation for an independent regulator with the power of disqualification; see Jane Tomkinson's third statement **[INQ00017180_007 §25]**.

68 Board level appointments are now made in accordance with the Fit and Proper Person Test Framework published by NHS England on 2 August 2023 **[INQ0012645]**.

(g) Culture

69 CoCH cannot comment on the culture within other neonatal units or the wider NHS.

70 The firm view of the Trust is that culture must be set from the top. It is the Board that determines the culture within the hospital, promoting respectful, honest and open dialogue. If there is a positive culture employees will feel empowered to speak up in the knowledge that they will be supported. The culture that operates within the Trust can be assessed by triangulating information from a range of sources including staff surveys, safety huddles, management escalations as well as those provided under the Freedom to Speak Up (FTSU) policy including how frequently is the FTSU policy used and what information is provided.

71 CoCH accepts that the written statements that the Inquiry has received about the culture on the neonatal unit in 2015/16 paint a mixed picture; some describe good working relationships between doctors and nurses, and supportive and empathetic leadership; others describe the opposite and a more concerning picture where there was an inability to make one's voice heard.

72 The current Trust Board is determined to promote a good, open and transparent culture within the hospital. It promotes an 'open door' policy. It has established a Speak Up Champions network including champions on each unit as part of its wider Freedom to Speak Up initiative. We address this further below under Reflections and remedial action.

(h) Previous inquiries

73 CoCH does not wish to add to the comprehensive table of recommendations provided by the Inquiry.

(i) Reflections and remedial action

(1) Facere Melius

74 As part of the exercise of reflecting on and learning from the events of 2015/16, in 2019 the Trust commissioned a review of its corporate governance arrangements. This review was undertaken by Facere Melius and was followed up with work to build the foundations of good governance **[INQ0099135_0012 §61]**.

75 Following this the then Chairman, Sir Duncan Nichol and the then Chief Executive, Susan Gilby commissioned Facere Melius to conduct an independent and substantive investigation of the events following the increased mortality rate on the neonatal unit between June 2015 and June 2016. This was commissioned shortly before the first Covid-19 lockdown – the terms of reference were agreed in early March 2020. Facere Melius has provided a draft of its report to the Inquiry and the Inquiry made the report available to the Trust and other Core Participants as part of the disclosure process. The Trust had not previously seen a copy of the report. The report is in draft form as it has not been through a Maxwellisation exercise because, it is understood, Cheshire Police had instructed Facere Melius not to undertake this exercise in view of the on-going criminal proceedings **[INQ0000684_0008 §1L.12]**.

76 Mr Darren Thorne explains that the report took 44 months to prepare because of the combined impact of the Covid-19 pandemic, the police investigation, Letby's criminal trial and a complex landscape of stakeholders **[INQ0099135_0013 §69]**.

77 In addition to the substantive investigation Facere Melius was commissioned to provided additional governance training and support, leadership programmes and governance reviews **[INQ0099135_0012 §62]**.

(2) Divisional structure

78 A criticism made of CoCH in 2015/16 was that paediatrics and obstetrics were within different divisions in the then divisional structure: paediatrics and neonatology were within the Urgent Care Division and maternity services within the Planned Care Division. In September 2022 the Trust Board approved a new divisional structure that brought Paediatric and Neonatal Services and Maternity Services into one division ("Women and Children's Division") with a single leadership team. This Division is also known as "perinatal services". Its remit is pregnancy and the year following birth. The divisional leadership team (Director of Midwifery, Divisional Director & Associate Medical Director) are members of the Operational Management Board (OMB) which was established by the Trust Board in January 2023. The OMB provides assurance to the Trust Board that there is effective Divisional management. The divisional leadership team are line

managed by executive team members in line with the Ockenden recommendations. In contrast to the previous position where the Women & Children's Governance Group reported to QSPEC (and not direct to the Board), the Women and Children's Division also reports directly to the Trust Board on perinatal quality, performance and safety metrics with the Director of Midwifery regularly attending the Board to provide updates directly.

(3) Service provision

79 In her first statement Jane Tomkinson describes the current provision of perinatal services in the hospital **[INQ0017158_0010 §38]**. A new neonatal unit was opened in 2021. As a larger and modern space, it is possible to facilitate Family Integrated Care (FICare). This is a framework for practice that is promoted by the British Association of Perinatal Medicine (BAPM) and is designed to promote a culture of partnership between families and hospital staff in the delivery of neonatal care. Dr Brearey explains that under FICare parents are integral to caring for their baby and staff take on more of a mentoring role. However, central to delivery of effective neonatal care is the trust that must exist between doctor, nurse and patient **[INQ0103104_0086 §457]**.

80 In addition, a new Women & Children's Unit is under construction. This is expected to open next year and will bring all women and children's services under one roof.

(4) Service oversight

81 The Trust has created a post for a Clinical Lead for Neonatal Risk with dedicated time within the role to oversee risk management. The post is held by a consultant paediatrician who reports to the Neonatal Incident Review Group (NIRG). The NIRG meets monthly to review all Datix reports, themes and learning. Following the change in the divisional structure all Datix reports are reviewed by obstetrics and paediatrics together (as the Women and Children's Division). Previously, Datix reports would be reviewed by the two specialties separately.

82 In June 2022 the Trust joined the Maternity Safety Support Program (MSSP).[8] Since then the Trust has made significant improvements and is now exiting the program. In July 2024 the Trust along with the Maternity Improvement Advisor and Regional Chief Midwife agreed that the criteria for leaving MSSP had been successfully met.

83 From March 2023 perinatal services have been reviewed on a monthly basis by the Perinatal Assurance and Improvement Board (PAIB). This is chaired by the Director of Midwifery and its members include the other two members of the Women and Children's Division leadership team.[9] The PAIB provides assurance against expected local and national standards.[10]

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[8] https://www.england.nhs.uk/mat-transformation/maternity-safety-support-programme/
[9] Terms of reference **[INQ0014132]**
[10] Illustration of the standards against which PAIB measures performance **[INQ0014133]**.

84 Since May 2023 the Maternity Neonatal Voices Partnership (MNVP) has been working with families to arrange visits to collect independent feedback and to encourage families to complete a feedback survey tracking their maternity and neonatal journey. This provides an opportunity for parents to report concerns.

85 The Trust has introduced an allocated executive and non-executive safety champion for the neonatal unit and maternity services. The former is Mrs Pemberton, the Deputy Chief Executive and Director of Nursing Quality and Safety and the latter is a NED. This is intended to provide an alternative route by which concerns can be raised or escalated **[INQ0017160_0009 §27g]**. There are monthly safety champion walkarounds and an exit interview process that permits staff to raise concerns.

86 Since the changes listed under (2) and (3) above have been implemented CQC has conducted an unannounced inspection **[INQ0017434]**. This saw an improvement in the rating given to children's and young people services and maternity services, albeit still below the level that the Trust would wish to attain. The feedback from the CQC following this inspection together with recommendations from a "well-led" peer review was presented to the Board on 26 March 2024.

(5) Freedom to Speak Up (FTSU)

87 Speak out Safely has been replaced by FTSU. Although there were Speak Out Safely initiatives and whistleblowing policies in 2015/16, there was no Speak Out Safely champion. As part of a revised FTSU initiative the Trust now has a FTSU Guardian and 30 FTSU champions, one on each unit.[11] At Board level there is an executive and non-executive lead for FTSU **[INQ0017158_0024 §88g]**..

88 The effectiveness of FTSU is monitored through a quarterly update to the Executive Directors Group on issues and trends, twice yearly to the People and Organisational Development Committee and twice yearly to the Board of Directors. The update to the Board of Directors is delivered by the FTSU Guardian.

89 On the neonatal unit there is a Professional Nurse Advocate who can assist in voicing concerns or providing confidential support **[INQ0017160_0004 §15]**.

(6) Regional and national actions

90 In addition to local changes made to the delivery of maternal and neonatal services at CoCH, changes have been made at a regional and national level. These are set out in the witness statements from other Core Participants and other individuals and organisations that have been obtained by the Inquiry and we anticipate that this issue will be addressed comprehensively by others. From the perspective of CoCH we would highlight:

[11] The FTSU Guardian is a dedicated post with no other responsibilities.

(a) The publication of the Three Year Delivery Plan for Maternity and Neonatal Services as explained by the Chief Nursing Officer, Dame Ruth May **[INQ0018077_0004 §13]**.

(b) The Local Maternity and Neonatal System which is intended to make maternity and neonatal care safer, more personalised and more equitable for women, babies and families as explained by the Deputy Chief Nursing Officer Duncan Burton **[INQ0018080_0012 §45]**.

(c) The Maternity Safety Support Programme – see Dame Ruth May **[_0012 §52 & _0028 §129]**. By way of update to Dame Ruth's evidence at **[_0013 §53]** CoCH joined the MSSP programme in June 2022 and following improvements made by the Trust is in the process of exiting the programme.

(d) The plans for the safe reinstatement of a level 2 neonatal unit at CoCH within the North West Neonatal Operational Delivery Network (NWNODN) as discussed in witness statements of Professor Powis **[INQ001749_0145 §§580-595]** and Louise Weaver-Lowe **[INQ0018081_0012 §38 & §§45-47]**.

(e) The review of mortality data by the NWNODN Clinical Effectiveness Group and Neonatal Steering Committee as discussed by Louise Weaver-Lowe **[_0018 §56-57]**.

91 The changes and remedial action summarised above is in a PowerPoint presentation prepared by CoCH entitled *Neonatal Unit Development 2023* **[INQ0009430]**.

(j) Recommendations

92 We address below some themes in terms of recommendations that are apparent from the material disclosed by the Inquiry. These may provide valuable safeguards which may serve to prevent or impede an individual from acting as Letby did – for instance the proposal for controlling the access to insulin on wards. However, as stated above under (g) Culture, the Trust's firm view is that the most important and powerful safeguard against similar actions in the future is the operation of an open, honest, and responsive culture within the organisation. The Trust agrees with Sir Robert Francis KC that this can only and must come from the top.[12] The leader with the qualities that Sir Robert identifies will have the respect and trust of those they lead and will engender the confidence in those they lead to speak out when required to do so. The matters that we address below may be important adjuncts. But they cannot and will not make up the shortfall in an organisation deprived of high-quality leadership.

(1) CCTV

93 We recognise that the statements from the families almost without exception support the use of CCTV. The evidence from the clinical staff is more finely balanced. We suggest that the Inquiry may wish to address the following points when considering whether there should be CCTV observation of neonates in hospitals:

[12] **INQ0101079_0087**

(a) the benefits which CCTV could realistically provide. Many staff have observed that CCTV may provide limited insight into the actions of a member of staff beyond establishing who had been at the cot side at any given time. Others remarked on the use of shields to protect babies from natural light which would, by necessity, also shield the child from CCTV;

(b) issues of privacy and dignity. These would relate to babies, their parents, other visitors and staff. It is likely that there would have to be either an acceptance that CCTV would create images of, for instance, intimate personal care or breast feeding, or the introduction of systems intended to prevent such activities being recorded;

(c) whether, if it is felt that CCTV confers a benefit justifying its introduction, that logic would not also extend to other environments in which particularly vulnerable patients are cared for. Such setting may include wider paediatric wards, adult intensive care facilities, inpatient psychiatric settings and elderly care wards;

(d) the technical requirements of CCTV systems, e.g. the extent of their coverage and their resolution;

(e) whether the data produced by such systems could be adequately protected in circumstances where data protection generally, and in the NHS in particular, is a concern;

(f) whether footage would in effect form part of the medical record (and so need to be stored in the long term) or whether it would be treated as simple security footage. Assuming it is the later, it is likely to be destroyed after a short period, and so may be of limited benefit in investigating allegations arising some time after the event in question. Conversely, if footage is stored in the long term, there are likely to be collateral implications, for instance in matters of clinical negligence; and

(g) who would have access to and responsibility for reviewing such footage. The question arises as to whether it would be expected that colleagues would have access to footage for the purpose of reviewing safety incidents, or whether it would be restricted to certain groups of individuals e.g. senior managers or the Police.

(2) Insulin

94 Several witnesses have remarked on the benefits of controlling access to insulin on wards. Whilst CoCH would support any reasonable measure which increased the safety of babies in its care, the Inquiry may wish to consider:

(a) whether, if there is logic to restricting insulin on wards, this would also extend to other drugs which can confer severe harm in overdose;

(b) similarly, if that logic holds on neonatal intensive care units, whether it extends to other healthcare settings;

(c) the practical consequences of restricting access to drugs, e.g. on the ease of prescribing or dispensing medications;

(d) the purpose of existing controlled drug arrangements in healthcare settings. Put simply, are these intended to prevent the misuse of drugs (including by staff and patients) or to protect patients from harm by staff; and

(e) accordingly, the mechanisms which would be required (statutory or otherwise) to enact such a policy were it felt to be desirable.

(3) Regulation of managers

95 CoCH supports Tom Kark KC's recommendations for the formation of a regulatory body to oversee senior NHS managers **[INQ0107016_0016 §67 & INQ0017979_0138]**.

(4) Protocol for when to refer concerns to the police

96 CoCH would support Professor Bowers proposal for a protocol for determining when employers should refer matters to the police **[INQ0106946_0015 §11A]**.

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30 August 2024