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2 HARE COURT

21 February 2025

Dear Chair,

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 (CCRC) 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.

In writing this letter, we are mindful of the impact that these terrible events have had upon the families of those babies and the significant period of time that they have had to wait for the outcome of the criminal trials and this Public Inquiry. However, it is imperative that time is taken to pause and reflect on recent developments which directly relate to matters at the heart of this Inquiry.

We understand from what has been publicly stated by the CCRC that:

1) A preliminary application has recently been made to the CCRC by Ms Letby's legal representatives, received on 3rd February 2025.
2) This application relates to all of her convictions arising from the period of June 2015 and June 2016 whilst at the Countess of Chester Hospital.
3) The CCRC has begun work assessing the application and it anticipates further submissions being made.
4) The CCRC is not able to determine how long it will take to review the application.

It is further understood that this application is supported by the opinion evidence of an international panel of 14 independent experts who have considered the medical evidence presented at Ms Letby's trial. These experts are distinguished and recognised leaders in their field. They include: Neena Modi, an eminent Professor of Neonatal Medicine at Imperial College, a past president of the Royal College of Paediatrics and Child Health, a past president of the British Medical Association and the current president of the UK Medical Women's Federation and; Shoo K. Lee, Professor Emeritus at the University of Toronto, Honorary Physician at Mount Sinai Hospital and President of the Canadian Neonatal Foundation. He was formerly Paediatrician-in-Chief at Mount Sinai Hospital, Head of the Division of Neonatology at the University of Toronto and the Hospital for Sick Children, Head of the Department of Newborn and Developmental Paediatrics at Sunnybrook Hospital, and Canada

Research Chair (Tier 1) and Scientific Director of the Institute of Human Development, Child and Youth Health at the Canadian Institutes of Health Research.

This new evidence merits and is therefore being given serious consideration by the CCRC. We provide to the Public Inquiry what we understand is a summary document which contains detailed biographies of the experts on the panel, their methodology, as well as a summary analysis of the medical evidence. A copy is enclosed herewith. We understand the full report will be provided shortly.

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:

1) There is a real risk that you would be a breach of your duty to act fairly under section 17(3) of the Inquiries Act 2005.
2) 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).

The Public Inquiry's Terms of Reference (including the Introduction) are set out below:

> ***Introduction***
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> *On 21 August, after a trial at Manchester Crown Court, Lucy Letby was sentence 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 NHS foundation Trust.*
>
> ***Terms of Reference***
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> *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.

As is clear, the Terms of Reference are conditional on Ms Letby's criminality and that being the cause of the deaths and unexplained collapses of babies present on the Neonatal Unit in the Countess of Chester Hospital between June 2015 and June 2016. The focus of the Inquiry's work has been entirely shaped by this; its investigation, evidence gathering and questioning of witnesses.

There now appears to be a real possibility that there are alternative explanations for these deaths and unexplained collapses, namely poor clinical management and care and natural causes. These alternative explanations, given the terms of reference, were not explored by the Public Inquiry. For example, there was no independent expert evidence about the adequacy of the medical care and treatment of the babies. On the contrary, those responsible for the clinical management and care of these babies have been repeatedly referred to as experts, their views described as expert opinions and their credibility unquestioned during the course of the Inquiry proceedings. Whereas those individuals who looked to the management and care provided to the babies on the Neonatal Unit as a possible explanation for the deaths and unexplained collapses in 2015 and 2016 were subject to highly critical questioning about their failure to accept the reality of Ms Letby's criminality and act accordingly.

To continue to make findings on the evidence heard, given the filter through which it was drawn, is to breach the duty to act fairly to those individuals and witnesses, as required under section 17(3) of the Inquiries Act 2005. It also defeats the very purpose of the Public Inquiry which must be to fully and fearlessly understand the circumstances in which these babies came to die or suffer unexplained collapses. If there is evidence to indicate that there is an alternative explanation, then it would be wrong

for the Public Inquiry to ignore it. Nor would it be appropriate, without more, to make a determination about its evidential value. That is now a matter for the CCRC. Until there is clarity as to Ms Letby's involvement, as determined by a proper and legitimate appellate process, the proceedings must be paused.

It is understood that the Public Inquiry has already expended in the region of £9 million. Failing to pause proceedings, in these circumstances, runs the risk of incurring further significant costs to the public purse by continuing oral hearings and producing an Inquiry Report which may be based on a fundamentally false premise as to the cause of deaths and unexplained collapses of babies at the Countess of Chester Hospital. Where the choice is delay or the possibility of the Inquiry continuing only to find that it has done so on a basis which is unsound, then the only reasonable course of action, albeit a regrettable one, is to pause proceedings until the appellate process has run its course.

Yours sincerely

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