NURSING AND MIDWIFERY COUNCIL
OPENING STATEMENT

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1. The Nursing and Midwifery Council's (NMC) thoughts and condolences during this process are with the families and loved ones of the babies who were killed or harmed by Lucy Letby (LL). Having a baby is one of the most important moments of any parent's life. Having that baby's life intentionally taken away or knowing that an individual attempted to take that life away is a truly devastating experience that should never happen. The impact on the parents and families who have lost babies or those who now have children with lifelong injuries is heartbreaking.

2. The NMC is the regulatory body for individual nursing and midwifery professionals in the UK. Its principal functions are to establish standards of education, training, conduct and performance for nurses, midwives and nursing associates, and to ensure the maintenance of those standards. As the regulator of nurses, midwives and nursing associates in England, the NMC maintains the register of professionals eligible to practise, and investigates concerns about individual nurses, midwives and nursing associates. Further detail about the NMC's structure and functions is contained in the witness statement of Andrea Sutcliffe dated 2 February 2024 **[INQ0002412].**

3. The NMC has provided four witness statements to the Inquiry which provide more detail in respect of the matters addressed in this opening statement:

   a. Three witness statements of Andrea Sutcliffe, then Chief Executive and Registrar of the NMC, dated 2 February 2024 **[INQ0002412]**, 12 April 2024 [**INQ0017808]** and 7 May 2024 **[INQ0018088].**
   b. One witness statement of Helen Herniman, Acting Chief Executive and Registrar of the NMC, dated 7 August 2024 **INQ0107926**

4. This document uses the headings identified in the Note on Core Participant Opening Statements to address the matters of interest to the Inquiry.

When did you know about the suspicion or concerns at the Countess of Chester Hospital and was your response at the time good enough?

5. The NMC's Employer Link Service (ELS), which was set up following the Mid Staffordshire NHS Foundation Trust Public Inquiry Report and launched fully in April 2016, was informed by Alison Kelly (AK) at the Countess of Chester Hospital (CoCH) on 6 July 2016 that there was a rise in neonatal mortality rates at the hospital, and that concerns had been raised about LL. The ELS remained in contact with AK during 2016 and, at a meeting on 29 November 2016, was informed that the Royall College of Paediatrics and Child Health (RCPCH) was conducting a review into the deaths. They indicated that there were no immediate risks to patient safety and that LL had been moved from the neonatal unit.

6. In May 2017, the NMC received a press release from the CoCH saying that Cheshire Police had announced an investigation into neonatal deaths at CoCH. The ELS contacted AK on 18 May 2017, who informed them that LL had not been arrested or charged, or even named as suspect but had been placed on restricted duties in a non-clinical role.

7. On 3 July 2018, the NMC became aware through regular media monitoring that LL had been arrested in connection with multiple deaths at CoCH. The ELS contacted AK again and asked her to initiate a fitness to practise referral to the NMC within 48 hours. That referral was made on 5 July 2018, and the NMC opened a fitness to practise case on that day. It conducted an immediate interim order risk assessment on 5 July 2018 when it first received the fitness to practise referral for LL. Detailed risk assessments and consideration of the interim order position were made on and around 5 July 2018, 30 May 2019, 11 to 13 June 2019, 18 July 2019, 11 November 2020 and 12 November 2020. In line with its guidance on managing third party investigations [INQ0002573], its substantive fitness to practise investigation was on hold whilst it awaited the outcome of the police investigation.

8. On 6 July 2018, the ELS was informed by AK that LL's bail conditions restricted her from working in any healthcare environment. This was confirmed to the NMC by the police on 20 July 2018, *'LL is not to work in any healthcare setting or to have unsupervised contact with anyone under the age of 16'*. The NMC continued to engage with the police around bail conditions and the police confirmed again on 24 May 2019 to the NMC that LL's bail conditions included a prohibition on engaging in healthcare services. On 11 and 13 June 2019, the police informed the NMC that the bail conditions prevented employment (paid or otherwise) with babies or children under 18 in a healthcare setting (or otherwise). On 30 July 2019, CoCH confirmed that LL was suspended on full pay and had no other employment.

9. On 12 November 2020 LL was charged by the police. The NMC applied for an interim fitness to practise order and on 20 November 2020, an NMC panel imposed an interim order

suspending LL from working as a nurse for a duration of 18 months. In interim suspension order for 18 months is the maximum duration the order can be granted (without court order for an extension). This order was extended by the High Court on 12 May 2022 for 12 months and again on 3 May 2023 for 12 months. On 18 August 2023, LL was found guilty of numerous counts of murder and attempted murder, she was struck off the register by an NMC Fitness to Practise panel on 12 December 2023.

10. No other referrals were made to the NMC in respect of nurses connected with the neonatal unit at CoCH between June 2015 and June 2016. The NMC checked to see whether three individuals named during coverage of LL's trial were professionals on the register, but none were, so no steps could be taken in respect of their fitness to practise.

11. The NMC received a referral in respect of AK from doctors at CoCH on 20 May 2020, but the NMC's investigations were stayed for a period following advice from the police to allow them to conduct their investigations. Fitness to practise proceedings in respect of AK are ongoing. The NMC applied for an interim conditions of practise order in respect of Ms Kelly on 27-28 March 2024, but on 28 March 2024 no order was made.

The NMC ELS response

12. The NMC has reflected on its approach to managing the initial concerns raised by AK and has identified that:

    a. ELS advised AK on 6 July 2016 that there was insufficient information at the time to make a referral, but that if the police concluded that LL was involved, then a fitness to practise referral would be needed. The NMC considers that the advice provided by ELS was appropriate. Although these were potentially extremely serious concerns, ELS was informed that CoCH was investigating and had not reached any final decision about the next steps. It was reasonable for the NMC to wait until CoCH had made a decision about a police referral before taking any further steps. Without direct contact with the clinicians, or more detail about the underlying issues and the deaths, and with the assurances provided by CoCH that there were no concerns about the competence of individuals or teams, at the time of the call there was no reason for the NMC to form the view that LL was a person of particular interest to the police, or that there was evidence to suggest she was directly involved.

    b. Although the NMC considers that it was reasonable to wait until CoCH had made a decision about next steps after it first spoke to AK on 6 July 2016, it recognises that it would have been better to have been more proactive and to ask for an update on what decision had been made within a few days of AK making initial contact. The NMC also

considers that ELS could have contacted AK before May 2017 to satisfy itself that CoCH was taking all appropriate steps to protect patients and to ensure concerns were being fully investigated. The NMC has also acknowledged that there were some gaps in communication between the ELS and CoCH and record keeping could have been better.

c. Throughout its engagement with CoCH the NMC relied on the information that AK gave it. It recognises that its engagement was not as proactive as it could have been, and it did not probe on CoCH's decision not to refer to the police and whether the next steps they decided to take were appropriate. Although no fitness to practise referral was made in July 2016, the NMC recognises that it could have contacted the General Medical Council (GMC) or the Care Quality Commission (CQC) to discuss the concerns raised or have advised CoCH to ask the consultants to contact the NMC.

d. AK was the Director of Nursing (DoN) at CoCH when concerns were raised with the NMC about LL. AK, as the DoN, was its main contact for ELS until 19 May 2021. On 20 May 2020, the NMC received the fitness to practise referral for AK; the case was placed on hold while the police investigation into the neonatal deaths and LL took place. Nevertheless, AK remained their contact at CoCH until she left CoCH in May 2021, although any inquiries about the AK referral were directed to a more senior member of the Trust. The NMC recognises that retaining AK as the contact at CoCH after her own referral to the NMC is unlikely to have been appropriate.

13. The following changes have occurred in the ELS and its ways of working since LL's conviction:

a. The team has increased in size from four Regulation Advisers (RAs) in 2016 to 12 currently.

b. Record keeping has improved to ensure all interactions are able to be recorded.

c. A standard operating procedure for the ELS advice line has been created. This includes guidance on escalating certain categories of cases to other regulators and also details a strengthened process for internal escalation.

d. There are monthly peer-to-peer review sessions of advice provided by ELS to ensure consistency between RAs.

e. There are monthly peer review meetings between RAs in ELS and clinical advisors to discuss complex cases or those where there are differing reviews.

f. There are monthly benchmarking meetings where ELS RAs, clinical advisers and staff from the Screening Team review cases and agree next steps.

g. The NMC is now actively involved in discussions around emerging risks and issues both regionally and nationally and works cross-collaboratively with other partners and regulators.

h. The NMC is a signatory of the cross regulatory emerging concerns protocol for England.

i. The NMC is also formalising its approach for ensuring that the ELS are aware when senior leaders at Trusts are under fitness to practise investigations.

The fitness to practise response

14. The NMC has also reflected on its approach to managing the LL and AK cases:

a. It conducted an immediate interim order risk assessment on 5 July 2018 when it first received the fitness to practise referral for LL and continued to undertake regular interim order risk assessments. On each occasion, a decision was made not to apply for an interim order for the reasons set out in paragraph 56 of the reflective statement of Helen Herniman. These decisions aligned with the NMC's understanding, derived from the caselaw, of the evidence required for an interim order to be imposed as well as its application of the guidance in place at the time.

b. The NMC has acknowledged that its interim order guidance at the time was insufficiently clear that it was possible to apply for an interim order in the most serious cases even where the registrant had not been arrested and there was very limited evidence available to the NMC. The NMC has revised its guidance on interim orders. The updated guidance was published in March 2024.

c. If this amended guidance had been in place at the time, an application for an interim order suspending LL may have been made sooner (for example at the point of arrest rather than charge), and an interim order may have been applied at an earlier stage. There would then have been a right on the part of LL to appeal any interim order to the High Court. The NMC understands that prior to being charged, LL was not working with children or babies, and from August 2016 was on non-clinical duties.

d. The NMC has also instigated a new process of holding case conferences in complex or sensitive cases to ensure that expertise from a range of areas including lawyers,

clinical advisors and safeguarding is gathered. The NMC is also preparing a new framework for its fitness to practise process which will improve the quality and accountability of interim order decision-making. Work also continues to determine the best way to incorporate clinical advice and safeguarding advice into the fitness to practise process generally.

e. The NMC acknowledges that the bail sheets should have been requested from the police sooner, rather than the NMC relying on information provided in emails from the police and CoCH about LL's bail conditions which were not always accurate or comprehensive. Further training and guidance has been provided to relevant staff members on their statutory powers to obtain information from the police and work is ongoing with NPCC to sign a memorandum of understanding to facilitate better working relationships.

Advice and help. What advice or assistance is available to nurses and doctors from their unions, regulators or any other organisation in circumstances where they are worried about the safety of any baby in hospital? Is this sufficient and can it be improved? Should there be greater scrutiny of hospitals by external organisations when concerns are raised by nurses and doctors?

15. The NMC professions, like other health and care professionals, have a responsibility to be candid, to be honest when mistakes happen and to speak up when things go wrong and the NMC issues guidance on duty of candour [**INQ0002568**]. It also issues guidance on raising concerns **[INQ0002567]** which recognises the important role that clinical leaders play in promoting an open culture where staff are accountable and encouraged to raise concerns to ensure the public are protected.

16. The NMC operates a referrals helpline to help those who are considering raising a concern. It also offers support through its Public Support Service (PSS) which was launched in October 2018 and provides support to people who have made, or are involved in, a fitness to practise referral. This includes nurses and doctors. The service plays a key role in ensuring that raising a concern with the NMC is accessible for all. The PSS helps to ensure that the NMC fully understands the concerns being raised with it and is able to support people's needs to enable them to engage with the fitness to practise process. The PSS can help individuals understand the role of the NMC it also supports people to deal with the impact the process can have on them which includes:
    a. carrying out needs assessments to identify adjustments or additional needs;
    b. supporting witnesses throughout the process and at hearings;
    c. tailored support plans;
    d. providing specialist support for those with complex or multiple needs;

e. making referrals to our support advocacy service or communication intermediaries.

17. The NMC also operates a Fitness to Practise Careline and it signposts to other support networks. The ELS offers advice to employers about whether to make a referral, and the telephone helpline and website offer advice to individuals about what steps to take in respect of a concern, including asking the employer to investigate, and making a referral to the NMC.

18. The NMC is a member of the National Joint Strategic Oversight Group (NJSOG), and the National Perinatal Safety and Surveillance Group (NPSSCG), which are both convened by NHS England. NJSOG is a forum of healthcare regulators that meet to consider national policy and risks and exchange learning, intelligence and information at a national level. The NPSSCG supports the timely identification and escalation of concerns from regional teams and insight from regulators and national bodies to inform actions. Members of NMC's ELS also attend Regional Quality Groups. They are actively involved in discussions around emerging risks and issues on both a national and regional level in England and are signatories to the emerging concerns protocol which is another avenue for patient safety risks to be escalated.

19. The NMC welcomes the findings of the Inquiry as to whether the aforementioned avenues of advice and assistance are sufficient and can be improved upon. The NMC does not hold specific views on whether there should there be greater scrutiny of hospitals by external organisations when concerns are raised by nurses and doctors. The NMC welcomes the investigation by the Inquiry on this matter and will offer its assistance and cooperation with any findings or recommendations made by the Inquiry.

Management in the NHS and Regulation. Were senior managers held accountable for decisions made? Was this good enough to keep babies safe? What is the current position, and could it be improved? How should accountability of senior managers be strengthened? Should they be regulated?

20. There are ongoing fitness-to-practise proceedings concerning AK, and it would not be appropriate for the NMC to comment on related matters while they are ongoing, as that could prejudice the process.

21. As the regulator for nursing and midwifery professionals as individuals, the NMC is limited in its ability to comment on the effectiveness of hospital governance and management structures in keeping babies safe and ensuring the quality of care. All NMC registered professionals, regardless of their role or level of seniority, have a leadership role to play and a requirement to speak up according to its duty of candour guidance. Leadership involves skilled communication and our standards and Code reflect the need for its registrants to prioritise people, to treat them as individuals and uphold their dignity while listening and responding to their preferences and

concerns. The NMC expects its professionals to treat people with kindness, respect and compassion; both the people they care for as well as their interdisciplinary and multiagency teams and colleagues in all settings.

22. As outlined above, the NMC's professions, like other health and care professionals, have a responsibility to be candid, to be honest when mistakes happen and to speak up when things go wrong. The NMC's guidance on raising concerns recognises the important role that clinical leaders play in promoting an open culture where staff are accountable and encouraged to raise concerns to ensure the public are protected and the NMC investigates failures to adhere to this guidance through its fitness to practise process.

23. In broad terms, the NMC notes that concerns about the culture of a hospital or unit are likely to be best investigated by bodies which have a remit that is wider than the actions of individual professionals.

24. The NMC's view is that any proposed changes to the current structure of professional regulation will need to be carefully considered to ensure that they are properly scoped to address an identified risk and do not duplicate existing regulatory controls. Any changes to the structure would also need to work across England, Wales, Scotland, and Northern Ireland.

Culture. What is your current view about culture in hospitals and in neonatal units in particular and what requires exploration in oral evidence on this topic.

25. Recent inquiries and reviews have continued to find that poor working cultures in hospitals and maternity units have devastating impacts on those receiving care and their families. The NMC recognises that its professions may find themselves working in challenging cultures and it is clear through its guidance on context that it will look beyond the actions of the individual to understand the role that other people, the culture and environment played when considering fitness to practise concerns.

26. Whilst the NMC does not hold specific views on culture in hospitals, it knows through its annual leavers survey[1] that retirement, poor health and burnout are the top three reasons why professionals leave the register. Lack of support from colleagues or senior members of staff and experiences of bullying, harassment or discrimination are also cited as reasons for leaving the register. Most of those who leave the register would not recommend a career in nursing or midwifery which could be a further indicator of the poor working cultures leavers have experienced.

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[1] Registration data reports - The Nursing and Midwifery Council (nmc.org.uk) (March 2024)

27. On the issue of culture, the NMC acknowledges that there is work to be done in respect of its own culture. The NMC Independent Culture Review dated July 2024 highlighted safeguarding concerns and found that people working at the NMC have experienced racism, discrimination and bullying. The Independent Culture Review is clear about the link between the NMC's regulatory performance and its culture. It found that one affects the other, and that has created a pressurised environment for NMC colleagues which has contributed to poor behaviours and concerning case outcomes in some instances. The Review found that these issues have seriously undermined the NMC's collective efforts to reach quick, fair and safe decisions across its casework. The NMC apologises for the failings identified in the Review and has accepted all the recommendations made. The NMC has committed to delivering a culture change programme and acknowledges that there is much more to do to improve culture and the pace and quality of the fitness to practise casework.

Previous inquiries. The table of recommendations by previous inquiries. Do you have any further additions or amendments in respect of this? Do you want to add any further comments to the table?

28. The NMC monitors ongoing inquiries and reviews into major failings in care and scrutinises recommendations made to ensure that, at Executive Board level, the NMC is aware of any developments that may be of relevance to the organisation, and that recommendations directed at the NMC are followed up. The NMC's Council receives a formal update on learning and thematic review of public inquiries each year, which details the themes arising from relevant statutory and non-statutory inquiries and reviews and the actions taken by the NMC to address those themes and any specific recommendations.

29. As outlined in the Inquiry's table, the NMC has taken specific actions as a result of previous inquiries and reviews including:
    a. Allitt Inquiry: The NMC introduced a requirement for applicants to make good health and character declarations when the NMC was established in 2001.

    b. Ayling Inquiry: The NMC developed Memoranda of Understanding (MOU) with the Association of Chief Police Officers (ACPO) the Criminal Prosecution Service (CPS) and the General Medical Council (GMC) at the time and is currently working with the National Police Chiefs Council (NPCC) to develop an MOU.

    c. Mid Staffordshire Public Inquiry: The NMC made significant changes to its fitness to practise process including introducing case examiners and the power to review no case to answer decisions. It also introduced ELS; a new process for revalidation; strengthened elements of the Code including a stronger focus on compassionate care, added a new section on raising concerns and candour; and made changes to the

education standards. The Code (the professional standards that nurses, midwives and nursing associates must uphold in order to be registered to practise in the UK) is also structured around 4 themes: prioritise people, practise effectively, preserve safety and promote professionalism and trust. The NMC also introduced MoUs and joint working protocols to improve data and information sharing between partners and improved the information provided to the public and employers on the fitness to practise process. The NMC also issued joint guidance with the GMC regarding the duty of candour which not only focuses on the duty to be open and honest with patients but also on the need to be open and honest within organisations in reporting adverse incidents or near misses that may have led to harm.

d. Gosport Independent Panel: The NMC accelerated its introduction of its Public Support Service.

e. The Shipman Inquiry (Fifth report): The NMC introduced independent fitness to practise panels.

f. Paterson Inquiry: The NMC has worked to develop a shared data platform with GMC and CQC.

30. In November 2018, as a result of recommendation from the Gosport Independent Panel, the Government made a commitment to reform the legislative framework for professional regulators. This commitment was made again when responding to recommendations from the Paterson Inquiry. Regulatory reform will bring significant changes to the way in which the NMC progresses fitness to practise concerns for the benefit of patient safety. The NMC continues to work with government on planned reform to our legislation to ensure that reform happens.

31. The NMC has reviewed the document prepared by the Inquiry and offers the following further information and comments:

Allitt Inquiry

a. Recommendation 9 stated that consideration should be given to how GPs might, with the candidate's consent, be asked to certify that there is nothing in the medical history of a candidate for employment in the NHS which would make them unsuitable for their chosen occupation. The Inquiry's summary outlined the detail of our current health and character requirements and stated there was no mention of GP certification.

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b. As outlined in the first NMC statement of Andrea Sutcliffe (paragraphs 76-74), all applicants to the NMC register are required to make a self-declaration as to their health and character so we can ensure they can practise safely and effectively.

c. If someone indicates they are not managing their condition or disability, but they believe they are still able to practise safely and effectively, the NMC requests further information and a supporting statement with a person's application. The NMC recommends that an applicant speak to their GP, occupational health department or a medical professional as soon as possible. The declaration must be signed by a NMC registrant, who as a registered healthcare professional overseeing a student's education, is accountable to us and to their AEI for what they declare. The Code also requires, as part of promoting professionalism and trust that professionals on the Register must maintain the level of health they need to carry out their professional role.

d. The NMC also asks internationally trained applicants to provide contact details for a registered medical practitioner to give a supporting declaration about their health. This could be their GP or family doctor, or occupational health practitioner. The registered medical professional that an applicant nominates must confirm they have carried out the health assessment in the last six months and that they are qualified to complete their health declaration. The NMC is only able to assess a registration application once this information is received.

Mid Staffordshire

32. There were three recommendations which focused on our educational approach where it appears that the Inquiry was unclear as to the actions taken by the NMC:

a. Recommendation 188: consider introducing of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.

b. Recommendation 189: we along with other professional and academic bodies work towards a common qualification assessment/examination.

c. Recommendation 190: national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.

33. The NMC's initial response and commitments made in 2013 and 2014 to the Mid Staffordshire recommendations focused on the fact that the education standards required students be tested for aptitude in literary, numeracy and communication skills and assessed as to health and good character on admission to programmes.

34. The NMC committed to undertaking a full evaluation of its education standards in 2014 and to have particular regard to the issues of caring and compassion to give us a proper evidence base for any further revisions to these standards including the need for an aptitude test.

35. In December 2015, the NMC commissioned IFF Research (an independent agency) to evaluate its pre-registration standards. With regards to aptitude testing and entry criteria, there was broad agreement that the entry criteria was an appropriate baseline of requirements (i.e. aptitude in numeracy, literacy, IT skills, good health and character and appropriate academic and professional entry requirements). However, most stakeholders suggested one or two additional criteria – most frequently it was suggested that compassion should be added (as it was felt that this cannot be taught) and / or motivation (as there was concern that some apply to education programmes for the wrong reasons). There was a call for the NMC to consider adding to the standards a requirement that AEIs conduct values-based recruitment (in particular, ensuring that motivation and compassion are considered) and for supporting guidance on this to be issued.

36. In 2016 the NMC launched a programme of change for education and undertook a major review of all pre-registration nursing and midwifery education and proficiency standards. Its new standards for nursing and midwifery education and standards of proficiency were published in 2018 and 2019 respectively. These state that programme learning outcomes must reflect the standards of proficiency, which in turn emphasise the importance of compassionate and person-centred care.

37. A further targeted review of specific programme standards was undertaken in September 2021 as a result of no longer being in the EU, need to be compliant with European legislation. This yielded similar results to the above. It identified broad agreement that the entry criteria provide an appropriate baseline of requirements but that it required greater specificity in areas, including compassion and / or motivation for the intended profession / field of nursing practice.

38. The NMC also makes the following additional comments on further activity it has done in relation to specific inquiries:

    a. Independent Investigation into Maternity and Neonatal Services in East Kent: The NMC published new standards in April 2023 and launched a series of communications to support the application of its future midwife standards.

b. Ockenden Review: The NMC wrote to approved education providers to clarify its position on continuity of carer. It introduced a new standard requiring midwifery students to have placement experiences at more than one provider and incorporated student feedback into quality assurance processes.

c. Williams Review: In response to recommendation five on reflective material, the NMC along with other healthcare regulators signed a joint statement on the 'benefits of becoming a reflective practitioner[2]' which was in direct response to this recommendation. As part of regulatory reform, DHSC propose providing regulators with a power to require information from registrants, but that this will exclude reflective material. While we agree that regulators should not have the power to request reflective notes, we have concerns that this could result in clinical notes being excluded, which would have significant implications for our investigations. We have been working with DHSC to ensure that the proposed drafting is sufficiently narrow but also fulfils this recommendation.

d. Independent Inquiry into Child Sexual Abuse: The NMC is updating its internal safeguarding training to incorporate the learning from that report.

Reflections. In light of the events at the Countess of Chester hospital between 2015- 2016, please explain how your organisation has reflected on how such murders and injuries to babies may have been prevented? What issues do you consider require exploration in oral evidence in respect of any changes?

39. The NMC has reflected on the events at CoCH and has scrutinised all its internal processes in light of those events and outlined its learning in the reflective statement of Helen Herniman dated 7 August 2024.

40. The NMC was only made aware of concerns about LL after she had been removed from the neonatal unit at CoCH, and so the NMC has not identified any steps it could have taken that would have prevented harm to the babies who were injured or murdered.

41. The NMC will listen closely to the evidence adduced by the Inquiry and continue to reflect on ways in which it could improve to ensure that such a tragedy is not repeated.

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[2] Benefits-of-becoming-a-reflective-practitioner-joint-statement.pdf (emap.com)

Recommendations. What do you wish to contribute by way of oral evidence to the consideration of recommendations on how to help keep babies safe? What is your current position on CCTV observation of neonates in hospitals.

42. As the regulator of nursing and midwifery professions, our Standards and Code are designed to ensure nurses and midwives are capable of safe and effective practice. The NMC does not at this stage have views on organisational measures to help keep babies safe. The NMC will listen closely to the evidence and reserves the right to contribute proposals for recommendations by way of the oral evidence of its witnesses and closing submissions.

43. The NMC welcomes the investigation undertaken by the Inquiry and will cooperate with any recommendations made which impact on the NMC to ensure that babies in hospitals are kept safe in the future.