
**INVESTIGATION REPORT INTO THE GRIEVANCE RAISED
BY LUCY LETBY REGARDING HER REDEPLOYMENT
FROM THE NEONATAL UNIT.**

NHS: STRICTLY PRIVATE AND CONFIDENTIAL

Report to: Annette Weatherley

From: Dr Christopher Green

HR Support provided by: Lucy Sementa

Date of Report: 22.11.16

Contents

1. Introduction and background.....	3
2. Process of Investigation:.....	4
Interviews.....	4
Supporting documents:.....	5
3. Findings:.....	6
Timeline of events.....	6
5. Overall summary of findings:.....	17
6. Recommendations:.....	18
Returning LL to the Neonatal Unit.....	18
Trust Management Team.....	18
Lucy Letby.....	Error! Bookmark not defined.
7. Appendices.....	19

1. INTRODUCTION AND BACKGROUND.

Lucy Letby qualified as a Children's Nurse from the University of Chester in September 2011 and began working for The Countess of Chester (COCH) Trust within the Neonatal Unit on 3rd January 2012. She became a Neonatal Practitioner in March 2015 following completion of the 'Development of Special and Intensive Care of the New born' course at Liverpool John Moore's University/Liverpool Women's Hospital. Lucy is line managed by Eirian Lloyd Powell, Ward Manager of the Neonatal Unit.

During the course of 2015 and the early part of 2016, concerns were raised by the consultants at COCH regarding an increase in deaths in the Neonatal Unit at the Countess of Chester Hospital. Concerns were raised by the consultant medical staff to Trust Executives, namely Ian Harvey, Medical Director and Alison Kelly, Director of Nursing. During the early part of 2016, a review of neonatal deaths at the unit had been carried out by Dr Steven Brearey, Consultant Paediatrician and this had been shared with both Eirian Lloyd Powell and Mr Harvey. Following this, it had been agreed to put in place, a review date of three months.

In July 2016, Lucy Letby was redeployed on a temporary basis to the Risk Team at COCH.

Lucy Letby submitted a Grievance on 7th September 2016 raising the following queries:

- The proposed plan of supervision of practice and repetition of competencies was not followed for any other member of staff, nursing or medical and I wish to know why and if this was ever the true intention of the Trust
- Was I being investigated on a personal level and what is it that the external review may indicate in relation to me returning to NNU
- The reasons for me being instructed not to have contact with my NNU colleagues for an extended period of time
- Why the external review panel did not know about my circumstances and why so much emphasis has been put on waiting for the review when it is not looking at anything pertinent to my situation
- I would like the Trust to outline to me how its values such as being 'open and honest' and 'we respect each other' have been adhered to, in my situation
- I would like to know exactly what I have been accused of/what allegations have been made and by who and how the Trust has dealt with this
- I also wish to be informed of any evidence the Trust may have and the process which they have followed
- I would appreciate assurances from the Executive team that this has been dealt with appropriately and that my confidentiality is being maintained
- How will the Trust support me to return to NNU on a personal and professional level?

Lucy Letby stated in her Grievance that the outcome she is seeking is to return to her full role within the NNU with a full apology for her treatment and a full explanation of the events that have occurred.

Given the nature of the grievance and the potential involvement of the Trust Executive Team it was decided that grievance should be formally investigated by senior member of the Trust's management team, Dr Christopher Green, Director of Pharmacy and heard by an external reviewer Annette Weatherley, the Deputy Chief Nurse at the University Hospital of South Manchester. It is known that Alison Kelly, Executive Director of Nursing and Quality has previously worked at UHSM, however, Ms Weatherley is not a former colleague or associate of Alison Kelly.

2. PROCESS OF INVESTIGATION:

The investigation was carried out by Dr Christopher Green, Director of Pharmacy and Medicines Management and Mrs Lucy Sementa, HR Specialist.

Interviews

The following people were interviewed:

Name	Role	Represented by	Date of Meeting	Note taker	Appendix No.
Lucy Letby	Staff Nurse, Neonatal Unit	Tony Millea (RCN)	14.10.16	Penny Weaver (PW) (P.A. to CG)	2
Mr Ian Harvey	(Executive) Medical Director	NA	20.10.16	LS	3
Alison Kelly	Executive Director for Nursing and Quality	NA	20.10.16	PW	4
Sue Hodkinson	Executive Director for Human Resources and Organisational Development.	NA	20.10.16	LS	5
Sian Williams	Deputy Director of Nursing and Quality	Sam Walker	20.10.16	LS	6

Hayley Cooper	RCN Rep.	NA	18.10.16	LS	7
Karen Rees	Divisional Lead Nurse, Urgent Care	NA	20.10.16	PW	8
Eirian Lloyd Powell	Ward Manager, Neonatal Unit (NNU)	NA	28.10.16	PW	9
Yvonne Griffiths	Deputy Ward Manager Neonatal Unit (NNU)	NA	17.10.16	LS	10
Ravi Jayaram	Clinical Director, Women's and Children.	Tom Carver (BMA)	11.11.16	Karen Beard (KB) (P.A. to Richard Baird, Divisional Director)	11
Steve Brearey	Consultant Paediatrician.	Jenny Bremner (BMA)	11.11.16	KB	12

The investigation began in October 2016 and was concluded in November 2016.

Supporting documents:

Appendix 1: Grievance raised by LL.

Appendix 1b: Supplementary document provided by LL on 14.10.16

Appendix 13: Email from Ravi Jayaram regarding suspicions around foul play and potential methods behind that

Appendix 14: Email trail amongst consultants highlighting differences of opinion between consultant and nursing teams provided by EP on 28.10.16

Appendix 15: Eirian Powell personal notes submitted 28.10.16

Appendix 16-18: Letters from SH/AK to LL following fortnightly review meetings.

Appendix 19: Email from ELP regarding Lucy's redeployment 09.08.16

Appendix 20: Email from SH to HC regarding concerns 22.09.16

Appendix 21: Email from HC to SH regarding acknowledgement of grievance receipt 20.09.16

Appendix 22: Email from RJ to colleagues regarding neonatal air embolism submitted by ELP on 28.10.16

Appendix 23: Letter from SW to LL summarising meeting regarding clinical supervision 14.07.16.
Appendix 24: Letter from KR to LL summarising meeting regarding redeployment 18.07.16
Appendix 25: Email from ELP to NNU staff regarding LL supervision 15.07.16
Appendix 26: Email from YG submitted 18.10.16
Appendix 27: Competency Update Sheet submitted by ELP
Appendix 28: Trust Grievance policy
Appendix 29: Trust Disciplinary Policy
Appendix 30: Trust Guidelines for the Conduct of Formal Investigations
Appendix 31: Trust Speak Out Safely Policy
Appendix 32: GMC 'Raising a Concern'

3. FINDINGS:

Timeline of events (corroborated by statements and evidence included in appendices)

Concerns were raised during 2015 by consultants to the Board regarding an increase in the number of deaths on NNU.

A Thematic Review was undertaken by a medical professional from the Liverpool Women's Hospital during February 2016.

In May 2016 there was unfortunately the death of two triplets on the unit, the third triplet being sent to Arrowe Park Hospital for ongoing care. Following this, a decision was taken to downgrade the unit from a Level 3 to a Level 2 care unit, that is, the unit would be closed to the sickest babies until a review had assessed potential concerns about care on the unit. After this second death, Yvonne Griffiths (YG) reported that Dr Steve Brearey (SB) had called Eirian Lloyd Powell (ELP) to express concerns about Lucy Letby (LL) and as a result, LL was moved from nights onto day shifts.

On Wednesday 13th July, LL received a text from YG informing her to go into the office for an update. YG reports that she did not divulge the true purpose of this to LL because she did not want to alarm her unduly and because she did not want LL to worry about it, prior to arrival at the unit.

On Thursday 14th July, LL was asked to report to (Sian Williams) SW office with ELP to discuss the increase in neonatal mortality and the perceived commonality of LL being on duty and with the deaths. LL was informed that she had been on duty for the majority of the deaths and this had raised a warning flag that the Trust wished to address. As a result of

the increase in the number of deaths, SW informed LL that there was to be a review of nursing and medical competencies and that her competencies would be reassessed and her practice would be supervised. LL was informed by SW that her association with neonatal deaths featured more prominently than others and therefore the process would begin with her. SW summarised the content of the meeting and intended course of action in a letter to LL (A23) dated 14th July 2016.

ELP emailed all NNU staff (A25) on the 15th July to inform them that all members of NNU staff were to undergo periods of clinical supervision, and that LL would be the first to undergo this process.

On Monday 18th July, LL met with YG and Yvonne Farmer to discuss supervision and training, following which LL met with Linda Guatella, HR Business Partner and Karen Rees (KR), Lead Nurse, Urgent Care. LL was then informed by KR that she was not in fact going to undertake competencies and supervision, but was to be redeployed to the PALS team for a period of 4-6 weeks while external reviews took place. The content of the meeting is summarised in a letter from KR to LL (A24) dated 18th July 2016.

On the 5th August, LL attended an unplanned meeting with KR and was supported by Hayley Cooper (HC, RCN Rep) and was informed that the external review had been delayed.

Further meetings with KR took place on the 12th August and 2nd September; LL was on leave from 15th August to 29th August.

On the 6th September, LL met with KR and HC and was informed that a letter from the RCN highlighted that LL had been redeployed due to concerns raised by consultants.

On the 9th August, ELP emailed all NNU staff (A19) to inform them that "There were currently opportunities for staff to be seconded across the Trust. It is therefore come at an opportune time for us and we were able to second Lucy. Lucy is seconded to the Risk & Patient Safety Office for a period of 3 months."

On the 7th September, in accordance with the Trust Policy, LL raised a Grievance which is shown in Appendix 1. HC contacted Sue Hodkinson (SH) on the 20th September via email to query progress and the grievance was acknowledged by letter on the 23rd September. AK and SH agree that there was a delay and this was acknowledged in writing to LL in the letter dated 11th October 2016, Appendix 16.

Further meetings took place with KR and HC over the course of the next month until the 5th September when LL and HC met with KR, AK and SH. At this meeting LL was informed that the intention was to get her back onto the NNU but that this was unlikely to occur until

the results of the review are back. These meetings were then scheduled to occur on a fortnightly basis and are continuing to date.

Specific Queries Raised by Lucy Letby

The proposed plan of supervision of practice and repetition of competencies was not followed for any other member of staff, nursing or medical and I wish to know why and if this was ever the true intention of the Trust.

- All NNU staff were informed that the intention was for them to undergo a period of clinical supervision and for them to redo their clinical competencies. This is supported by ELP's email to all neonatal staff (A25).
- All parties agree that LL was informed on 14th July 2016 by SW that this process would begin with her.
- It is reported by ELP, KR, AK and YG that this plan was not achievable because of staffing as evidenced by the email from YG to CG dated 18th October 2016 in which the difficulty in providing clinical supervision is noted (A26).
- SW explained that she "was not aware of any staffing issues that would have prevented LL from being supervised" that she would not have advised Lucy this was the plan if she had known it was not going to be implemented. However she further stated that she thought "the Consultants were uncomfortable that she would be on the unit" (A6)
- IH stated that "the consultants were not prepared to have the nurse on the unit" (A3)
- SH stated that "my recommendation was to keep her on the unit but, from there, concerns were raised by the medical staff so we decided to redeploy her" (A5)
- ELP has provided evidence that competencies have been revisited for the nursing staff working on NNU (A27)
- Supervision of practice and revision of competencies for the medical staff was raised with Ian Harvey who described that the ways in which Medical competency is assessed as being fundamentally different to that of nursing staff. (A3). He stated that it was not feasible to record revision of competencies in the same way as for nursing staff and that it was an ongoing process but was underway.

I have found no evidence to suggest that the intention on 14th July 2016 was not to revisit competencies and to introduce supervision for LL, for which time she would remain on the unit. This is supported by witness statements of AK, SH, KR, IH and emails from ELP (A25) and YG (A26).

I conclude that the proposed plan of repetition of competencies has been implemented on NNU, although not the proposed plan for clinical supervision as originally outlined to Lucy on 14th July 2016. Based on the evidence, I believe that the genuine intention of the Trust at the time was for the planned clinical supervision for LL and that this has been identified as being impractical to implement and superseded by the undertaking of the external review and 'deep-dive' forensic report. SW suggested that the Consultants had applied further pressure

following this agreement to have LL removed from the unit which is supported by SH's and IH's statements. No periods of clinical supervision have been undertaken on NNU as originally outlined.

I therefore conclude that both staffing shortages and continued concerns from the Consultants contributed to LL's redeployment from the NNU. Although supervision was not undertaken for either LL or the rest of the nursing staff on NNU I conclude that this was the true intention of the Trust on 14th July 2016.

The reasons for me being instructed not to have contact with my NNU colleagues for an extended period of time

- When questioned regarding the above, KR stated "I think this may have been my fault. I didn't want her talking to all the unit staff....LL wasn't refused contact. That wasn't the intention anyway." (A8)
- ELP supported that KR had suggested contact was not made between LL and colleagues on NNU but recalls that it was for "a couple of weeks" (A9)
- In relation to this, SH stated that "it surprised me what she thought she was allowed to do" (A5)

The Trust Disciplinary Policy (A29) states the following in relation to exclusion from duty: *They (the employee) should not contact any member of staff connected with the matter which led to their exclusion, nor should they approach any other staff seeking information relevant to the case. This does not mean that the employee cannot have normal social contact with other employees of the Trust outside of work; however the employee must not discuss anything relating to the situation/case in question.*

Whilst it is clear that LL was **not** excluded from duty, it is also clear that she was being redeployed away from her substantive role pending the outcome of the external review. It could be argued that the same principles in relation to the above apply and that this should therefore have been explained to LL clearly on 18th July 2016.

I have found no evidence that the Trust's executive team stipulated that LL was to have no contact with the unit.

I conclude that, although the intention was not to prevent LL from having normal, social contact with colleagues from the NNU, that LL reasonably believed this was the instruction, leaving her isolated from her social and work support network.

Was I being investigated on a personal level and what is it that the external review may indicate in relation to me returning to NNU and

Why the external review panel did not know about my circumstances and why so much emphasis has been put on waiting for the review when it is not looking at anything pertinent to my situation

- AK stated that she had been “completely open” with the Review Panel regarding LL’s perceived commonality with the deaths on the unit (A4).
- AK further stated that the Execs team wished to give LL “the benefit” of meeting with the Review Panel.
- AK further advised that although the Terms of Reference for the Review did not identify that they would look at the specifics of LL’s situation, that if the panel felt there was a necessity to call the police or that the unit was unsafe, that the Trust would have been made aware of this verbally and immediately.

I conclude that the overarching purpose of the External Review (and the additional commissioned ‘deep-dive’ forensics review) is to explore circumstances and detail around patient safety on the Neonatal unit. I do not find that there was a specific brief to investigate LL, however the review panel were made aware of potential concerns. With respect to the commonality identified between LL being on duty and the collapses/deaths of the babies on Neonatal unit, I conclude that the Execs team feel that the Review will provide confirmation and reassurance that there is no direct link between the two. This would provide support for LL in relation to assuring both herself and the Trust of her clinical competence and, it is anticipated, assuage the concerns raised by the Consultants to the Executive team.

I would like the Trust to outline to me how its values such as being ‘open and honest’ and ‘we respect each other’ have been adhered to, in my situation.

- In relation to not undertaking full disclosure to LL, SH stated “In hindsight, did we do the right thing? At the time we thought so.” (A5)
- SW stated “I used the phrasing that I was asked to use by AK and SH” (A6) and described that informing LL of this decision [redeployment] was the hardest thing she had ever done.
- KR stated “It could have been handled better and I think AK and SW acknowledge that now.” (A8)
- IH stated “To protect LL from these allegations, we felt this redeployment was the best course of action” and believes the process had “fallen down” with communication. (A3)
- SH stated “I am concerned with how open we were with Lucy. The reason we weren’t was there being such vehement feeling without substantiation.” (A5)
- When LL was asked if she thought the Trust was trying to protect her, LL responded “I think they should be open and honest, I had a right to know.” (A2)
- ELP explained that, at the time, she believed LL had understood the nuance that the concerns raised were not solely around her clinical competence but subsequently became aware that this was not the case. (A9)

The Trust Guidelines for the Conduct of Formal Investigations (A30) states: *If necessary the investigation will be carried out under the terms of strict confidentiality, i.e. by not informing the subject of the disclosure until (or if) it becomes appropriate to do so. This may be appropriate in cases of suspected fraud or when there would be the possibility of irreparable damage to the working relationship of the people concerned.*

Whilst it is clear that LL was **not** under any formal investigation, the principles of this have been applied to LL's case in respect of both the potential damage that knowledge of the Consultants' alleged accusations may have had on LL's working relationships and on her health and wellbeing in general. In all the interviews involving managers and Executives, there has been a general acknowledgement that LL was not provided with the information relating to the consultants' accusations regarding her. There is also a consensus with these individuals that if 'we did the wrong thing, it was for the right reasons.'

Whilst I recognise that the Board found themselves in a difficult position, I conclude that the Trust have not been open and honest with Lucy in relation to the circumstances surrounding her redeployment and have not demonstrated the Trust Value 'we respect each other'.

I also wish to be informed of any evidence the Trust may have and the process which they have followed

During the course of this investigation I have not been made aware, nor has there been any allusion to, any evidence relating to any alleged wrongdoing by LL. There has been repeated reference to a commonality between the dates and times that LL was on duty and the collapse/deaths of a significant number of the babies but these is nothing to support that there is additional information or data beyond this, that has not been shared with LL.

I would appreciate assurances from the Executive team that this has been dealt with appropriately and that my confidentiality is being maintained

- LL alleged that colleagues had been questioned regarding whether there was, or had ever been, a personal relationship between herself and SB. The Trust Guidelines for the Conduct of Formal Investigations suggest establishing if the complainant has a grudge against the person whom the allegations are against. SH stated that an informal discussion was had involving herself, AK and KR during which this was discussed but that it "didn't leave the room". KR stated that "Nobody asked me...people look for a reason {for the accusations}..." SH further stated in response to this concern (A20) "We can categorically state...that nothing has been commissioned by the Executive team in relation to the concerns you have raised..."
- SH stated that LL had been advised the External Review draft report had been received by the Trust before either SH or IH were aware of this and has no knowledge of how this occurred.

- KR, SW, ELP, YG all confirmed they had heard rumours of highly inappropriate and insensitive comments being made on the unit but these did not name LL.
- IH stated that he had felt it necessary to raise concerns with one of the consultants regarding highly inappropriate comments relating to 'killing' reportedly heard on the unit (A3)
- ELP sent an email to all NNU staff (A19) regarding LL's redeployment which appears to have been accepted by the unit – YG stated that a member of staff had bumped into LL and asked when she was coming back (A10).

I have not found any evidence that LL's confidentiality with regard to the circumstances surrounding her redeployment has not been upheld. There are obvious concerns regarding the alleged comments made on the unit but IH stated that this had been addressed and there is no suggestion of any similar remarks being made following this. Critically, these did not name LL and were not directly heard by any of the individual's interviewed as part of this process.

I conclude that the Trust has not failed to protect LL's confidentiality with regard to the circumstances regarding her redeployment.

I would like to know exactly what I have been accused of/what allegations have been made and by who and how the Trust has dealt with this

- Analysis undertaken by both SB and ELP is reported to have identified LL as being on duty during the collapses/deaths of a significant number of the babies. ELP has unequivocally stated that this does not reflect the full picture, stating that on one occasion LL had only just arrived and was taking of her coat and that a number of the babies had significant congenital abnormalities. This view is not shared by RJ who advised that the deaths were of particular concern because "these were babies who were getting better and were stable who suddenly collapsed". (A11)
- ELP described that her review identified a medical professional as featuring in a significant number of cases as well as LL and claims that this information was initially intentionally withheld by the consultants from AK (A19). IH and AK both confirmed they had reviewed the full version and IH stated that number of instances in which the medic was on duty was much less significant than the commonality identifiable relating to LL.
- The Trust has commissioned significant reviews of the cases through a number of internal and external methods and reports that the decision to downgrade the unit was precautionary.
- SH reported that the Trust has also taken significant advice from other Trusts within the network and legal counsel on this matter.
- The General Medical Council guidance around raising a concern regarding patient safety states: *You do not need to wait for proof – you will be able to justify raising a concern if you do so honestly, on the basis of reasonable belief and through*

appropriate channels, even if you are mistaken. You must be clear, honest and objective about the reason for your concern. You should acknowledge any personal grievance that may arise from the situation, but focus on the issue of patient safety. (A32)

- The Trust Speak Out Safely Policy states *When staff wish to express their concern about patient care they should normally do so to their line manager. If, for any reason, staff feel unable to follow this approach, they should contact their Staff Representative, Head of Service, Professional Manager/Lead or an Executive Director of the Trust.* (Appendix 31)
- ELP recalled that in a meeting on 16.05.16 that SB "intimated during this meeting that he thought a member of staff was causing the increase in mortality" and that in the same meeting, Jim McCormack pointed at ELP and said "you are harbouring a murderer." (A9 and A15)
- IH stated that "SB presented the case that we had to consider the unthinkable, with no other cause identifiable. More meetings with consultants have taken place and they seem to think the same way." (A3)
- KR reported that there had been a suggestion of foul play by RJ, in that it had been suggested that air embolism or twisting of tubes might have been the cause of death. This is supported by the email sent by RJ to colleagues in which he makes specific reference to "given the concerns we raised around foul play", "with air embolus being considered among the pathology" and "this may end up with the police being involved" (A13). RJ also emailed colleagues (A22) on the 30th June 2016, to signpost an article around neonatal air embolism.
- KR stated she had heard of SB's concerns regarding LL through Karen Townsend (Urgent Care Directorate Manager) who had a one-to-one with RJ. She recalled that she had approached SB directly to ask what evidence he had against LL and his response was 'gut-feeling' and 'a drawer of doom'. (A8)
- KR stated that she met with AK and they agreed there was insufficient basis to exclude LL from the unit. (A8)
- KR recalls she was contacted at home by SB following the death of one of the triplets during which conversation she felt he was applying pressure on her to exclude LL from NNU. (A8)
- IH and ELP both described that they felt SB's concerns were based on 'gut feeling' rather than evidence (A3 and A9)
- YG described the attitude of the Consultants as "a witch hunt" in relation to LL.
- The Trust's Disciplinary Policy states: *If there appears to be a criminal act, the Chief Executive will consult the Police before invoking the Disciplinary Procedure.* (A29)
- IH stated "It felt purely circumstantial...we wanted more if we were going to call the Police". IH expanded on this and described that the Executive team felt strongly that if they raised concerns with the Police without foundation, LL would have been arrested which would have resulted in a "bomb-site"(A3)
- AK stated that "it was talked about if we needed to go to the Police" (A4) and ELP and YG both feel strongly that the group of consultants had 'threatened' to call the

Police if LL was not removed from the unit. IH stated that there was “a block to that [supervised practice] as the consultants were not prepared to have the nurse on the unit and if we do, the Police will be called” and further confirmed that there was “an unwritten threat to call the Police.” (A3) SB and RJ refute this. SB was asked ‘at no time did the consultants as a group or individually suggest that if the executive board took no action the police would be called?’ to which he responded “No” and further asked ‘it was suggested that police would be called if LL not removed from unit. Do you recall that discussion?’ and SB again answered “No” (A12). RJ also denied that this was how conversation around calling the Police was had and in response to being asked if there was ‘a suggestion that if Lucy was not moved then the police would be called?’ stated “No. A discussion took place that if no explanation found, then the police may have to be involved. Don’t recall any discussion as explicit as that.” (A11)

- When asked about his concerns regarding LL, SB stated only “the association with her being on shift and the death of the babies.” (A12)
- RJ stated that “All that was said was that we had concerns. We noted the association with Lucy being present. Decisions made were entirely those made by Senior Management – no Clinicians were involved in the decision to remove Lucy from the unit. It was a Board decision.” (A11)
- When asked if she knew any specific allegations made by the consultants, SH stated “I didn’t hear any phrases and I haven’t had any direct conversations with the consultants...” (A5)
- SH, in an email to HC (A20), dated 22nd September to “reiterate that your member (LL) is not under any formal investigation or disciplinary sanction by the Trust.”

No party refutes that concerns were raised by the Consultants, in particular SB, to the Executive team around a perceived commonality between LL’s presence on the NNU and the collapse/deaths of babies. I acknowledge that these concerns were raised through the appropriate channels in line with both the Trust Speak Out Safely Policy and the guidance proffered by the GMC (i.e. through the Executive team). However, I do not find that the consultants concerns, when reiterated to the Executive team were “clear, honest and objective” (GMC guidance). The evidence suggests that, whilst the Executive team acknowledged and appreciated these concerns, their preliminary fact-finding did not produce any information that prompted them to initiate either a formal internal or Police investigation. I believe the intention was to continue to review this for the agreed 3 month period, prior to the loss of two triplets on the unit.

I conclude that no formal allegations have been made with relation to LL from any party. I have been unable to confirm the exact wording of any ‘accusations’ in relation to LL however the members of both the management team and the Executive team are clear that the accusations were that there was a direct link between LL’s presence on the NNU and the increase in deaths on the unit and that it was suggested by some of the paediatric consultants that that this link was due to knowingly deliberate action by LL.

In response to 'how have the Trust dealt with this', I conclude that the Trust have considered the concerns of the consultants in line with both the Disciplinary and Speak out Safely policies and believed that there was insufficient basis on which to undertake either a formal internal investigation or to initiate a police investigation.

I consider that there were a number of potential options available to the Trust:

- to initiate an internal investigation under the Trust Disciplinary Policy. I find that, given the nature of the allegations that this was not feasible as, if there was sufficient evidence the police should have been contacted in line with the Policy.
- to contact the police as above and request an investigation. I find that the Executive Board did not feel there was sufficient evidence to undertake this action.
- to exclude LL from duty whilst the External Review and 'deep-dive' forensic review was undertaken.
- to redeploy LL as an alternative to exclusion.

I recognise that the nature of these accusations was extremely sensitive and that by allowing these accusations to become publicly known, that extensive and irreparable damage is likely to have been done to LL on both a personal and professional level and to the reputation of the Trust. I conclude therefore the action of removing LL from NNU while the External Review and 'deep-dive' forensic reviews were undertaken was within a range of reasonable responses available as it was believed that these reports would provide further information that would clarify any concerns regarding any deliberate action resulting in patient harm. Given the number of meetings in which these concerns are believed to have been discussed and the subsequent action taken by IH to address rumours coming from NNU, I believe it is inevitable that these accusations became known to LL and I conclude that LL should have been made aware from the outset. Furthermore, I find that LL was not provided the opportunity to respond to the concerns as raised by the consultants, which I consider she had the right to do.

How will the Trust support me to return to NNU on a personal and professional level?

- ELP described LL's practice as "second to none". The documentation she has provided (A15) supports this and she is adamant in her view regarding LL returning to the NNU – "I want her back".
- YG referred to LL's standard of work, attitude and documentation as "excellent" and stated "It would be easy for her to walk away...but I hope she returns to the unit...we would be delighted." (A10)
- The feedback from the unit has reflected there were no concerns with LL's clinical competence and no 'red flags'.
- SW stated that "the feedback was that she was excellent" and ELP described how they had assigned the sickest babies to LL because of the high standard of her care.

- SH, IH and AK all stated that the intention is for LL to return to the unit, however all confirmed that it would need to be a full board decision.
- SH described that the aim would be to give LL back "some control" in relation to how she returned to the unit, once the Board had agreed this move. (A5)
- IH stated that LL's return to NNU would be influenced by the final reports for both the external review and the 'deep-dive' forensic report reflecting and confirming the initial findings – that there was "nothing to tie her to anything untoward". (A3)
- IH also suggested a period of supervision would be necessary following LL's return to NNU given she has been absent from clinical practice for some time.
- SB stated that he would have 'issue' if LL was returned to the unit as he didn't feel the concerns the consultants had raised to the Executive team had "been fully answered" and stated that these were concerns around the "association with her being on shift and the deaths of the babies". He stated that he had escalated these concerns to the Execs back in July 2015. (A12)
- SB acknowledged that it was "conceivable" that the findings in the report could alleviate his concerns.
- RJ stated that "If the Executive Board felt it was appropriate for her to return then she would be back working on the unit. If subsequently there were further associations we would raise concerns but that would be speculation." (A11)
- YG expressed concerns regarding how SB might respond to LL returning to the unit. (A10)
- In relation to these concerns, IH stated that this would be "something I will have to manage, both as Medical Director and as a team of Execs."

LL is described as an excellent nurse by her nursing colleagues and managers. She is described as helpful and accommodating, often switching shifts or duties to support the unit. External consultants visiting the unit for transfers are reported to have commented positively on her professionalism and quality of care. LL is also described as being well trained and competent. Her nurse management colleagues Eirian Powell and Yvonne Griffiths have no concerns about her clinical or professional activities and would welcome her back to the unit. I am confident that support on a personal and professional level from them would be both willingly and extensively provided.

I conclude that the Executive Team are also working towards the aim of returning LL to the NNU, pending the outcomes of the external review and the forensic 'deep-dive' report. I believe the specifics of this will be discussed and agreed with LL. I have found no evidence to suggest that this redeployment would not be supported by the Trust as an organisation, although I have reservations regarding how the Consultants will respond to this decision.

5. OVERALL SUMMARY OF FINDINGS:

It is clear to me that the Trust management team, particularly the Trust Executive Team, found themselves in an unprecedented situation with no mutually satisfying courses of action available to them.

ELP recognised that there had been an increase in the number of deaths on NNU but felt that this could be explained given lifestyle changes, congenital complexities and advances in healthcare which influenced the nature of the patients on the unit. No satisfactory explanation for the rise in deaths on NNU was identified by the Consultants. It is clear to me that the Trust were keen to take action to explore this rise in response to Consultant concerns and that this was undertaken within the guidelines set out in the policies and guidelines that underpin the Trust.

I conclude that the decision to redeploy Lucy was fundamentally due to the impracticality of supervising her on NNU but reinforced by pressure applied by the Consultants to the Trust. The Trust Executive Team and Trust Board, in the absence of firm, objective evidence to explain or dispel the concerns of the Consultants found themselves in a situation where it is conceivable, if unthinkable, that to leave LL on the NNU may have exposed patients to harm. I find, on the balance of probability that the consultants as a group and specifically SB and RJ, asserted that they would call the police if LL was not removed from the unit and that this was something the Executive Board wished to avoid, in the interests of both Lucy and the Trust. Conflicting statements were provided by SB and RJ, who both deny that this "unwritten threat" took place. However, I found no evidence to support that this did **not** occur and furthermore, no reasonable explanation for why it would be suggested had it not.

Additionally, there were Executive concerns that by leaving her on the unit during this review process, may have exposed her to the suggestion that 'foul play' was a component in the deaths on NNU and that this had been linked to her. Given the subsequent rumours highlighted by the witnesses, this seems a likely possibility. I conclude that Lucy Letby was redeployed from the NNU on a temporary basis to ensure patient safety and to protect her from the alleged comments of the Consultants.

The evidence supports that this was not an inappropriate action as it was taken with the view that the External Review and the subsequent 'deep-dive' forensic report would provide information as to what might have contributed to the increase in deaths. However, I do conclude that Lucy should have been informed of the full scope of the concerns raised as there is no evidence to suggest this would pose a risk to the undertaking of the Review and no other investigations were being commissioned that this disclosure would have impacted or influenced. This failure to inform Lucy of the full rationale behind the decision resulted in a situation where information came to her in an uncoordinated manner, leading to a

breakdown in trust and contributing to a profound negative impact on her health and wellbeing.

I conclude that the Trust Executive team, and Trust Board made a decision that they believed was the best possible solution given their overall assessment of the situation. I feel confident that the Trust explored other options as described above, and that 3rd party advice was sought to inform their decision. I have found that the Trust executive team and nurse management team have showed significant empathy for LL's situation and that they have all been deeply affected by the circumstances in which Lucy was redeployed. I also believe that the Executive Team have reflected on their initial handling of the situation and taken action to address this in their fortnightly meetings with Lucy.

6. RECOMMENDATIONS:

Returning LL to the Neonatal Unit.

My recommendation is that Lucy Letby be given the opportunity to return to NNU to her substantive role. In that context, I also recommend that Lucy's return to the unit should be managed in tandem with the final reports commissioned by the Trust. I surmise that given the nature of what it is believed has been suggested by the consultants in relation to LL, that having these to refer to should alleviate any outstanding concerns that Lucy caused harm to any of the babies on NNU, unintentionally or otherwise.

I would also recommend that the Neonatal Unit Consultant team are clear in their intentions regards Lucy's return to the unit and this needs to be explicitly clarified in advance of the return.

Inevitably, after a period of 4-5 months away from the unit, LL will require the opportunity to reacquire her competencies and will therefore require clinical support from her colleagues.

Due to the nature of the unit and its patients, it is unfortunately probable that a further death will occur on the unit and that LL may be associated with that event. I consider that it would be prudent to acknowledge this prior to Lucy's return to the unit, and to agree an outline plan as to how this might be managed.

Trust Management Team.

The evidence supports that decisions made by the Executive Team and Trust Board relating to Lucy's redeployment were made in a robust and considered manner but that they were nevertheless difficult to reconcile. In retrospect, the Executive Team should have done more to communicate with LL and could have been more open and honest about why LL had been redeployed, however, their intentions around this appear positively directed.

Lucy Letby

In her Grievance investigation meeting, LL raised that she wished her grievance to be considered in line with the Trust Bullying and Harassment Policy. I advised LL at this time that I acknowledged this and LL was sent a copy of the Bullying and Harassment Policy following this meeting. I found that SB and RJ were reluctant to provide information beyond the specific scope of the formal grievance as it had been submitted. I have also found, through interviewing the witnesses, that other employees of the Trust may have made comments that require further investigation. Having established the facts above, it is my recommendation that if LL wishes more detail to be explored with regard to the specifics around SB and RJ and the concerns they raised about her, that she should submit a separate Bullying and Harassment complaint in line with the Trust policy and an investigation undertaken within the scope of said complaint.

The evidence gathered has raised significant concerns around the behaviours reported to have been exhibited by SB and RJ. Further exploration of details surrounding their suggested accusations regarding Lucy and comments that are reported to have been said was not undertaken as it was beyond the scope of this investigation. However, I recommend that the Trust takes action to explore this in more detail and to investigate if required, in line with the Trust Disciplinary Policy.

7. APPENDICES