Witness Name: Jane Tomkinson
Statement No: 2
Exhibits: JT/33 – JT/272
Dated: 27 March 2024

THIRLWALL INQUIRY

WITNESS STATEMENT 2 OF JANE TOMKINSON

I, Jane Tomkinson, of the Countess of Chester Hospital NHS Foundation Trust, Countess of Chester Health Park, Liverpool Road, Chester CH2 1UL, will say as follows:

1. My full name is Jane Tomkinson. I was appointed as Acting Chief Executive Officer of the Countess of Chester Hospital NHS Foundation Trust ("the Trust") in December 2022. At that time, I held the post concurrently with my role as Chief Executive Officer of the Liverpool Heart and Chest Hospital NHS Foundation Trust, which is a post I held between 2013 and 31 January 2024. I have been appointed as the substantive Chief Executive Officer of the Trust from 1 February 2024. Full details of my professional qualifications and experience are set out in my first witness statement.

2. I provide this statement on behalf of the Trust in response to section 2 of a request dated 27 October 2023 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request"). This statement is based on information available to the Trust at the current time and the knowledge and recollections of a number of current members of staff.

3. To assist the Inquiry to the best of my ability, I have addressed each question set out in sections 2 of the Rule 9 Request insofar as I am able to do so at this stage of the process.

Communication with parents

Complaints and concerns

4. The Trust has been asked about complaints or concerns raised by the parents of babies on the indictment ("the parents") about the care of their babies at the neonatal unit at the

Trust. The Trust received two complaints/concerns by parents of babies on the indictment about the care of their babies on the neonatal unit at the Trust.

5. Firstly, the Trust received concerns from Mother A&B, regarding the care Child A received within the neonatal unit at the Trust. These concerns were outlined in an email from Mother A&B to Yvonne Williams at 09.35hrs on 29 January 2016, which I attach as **Exhibit JT/33 [INQ0014407]**. The concerns were listed as follows:
   5.1. *"As we were told* **Child A** *was so well why was his long line not put in straight away?*
   5.2. *While myself and my partner were on the unit we noticed the sats monitors are not checked straight away by a nurse or doctor when they beep so how many times was* **Child A** *monitor allowed to beep without being checked? How long was it beeping before the medical staff attended to him?*
   5.3. *Why when we were told the doctors were struggling to put his long line in was a more senior doctor not called to assist?*
   5.4. *Why were we allowed to believe* **Child A's** *initial postmortem showed nothing when in actual fact he had a condition?*
   5.5. *Why were we not informed straight away that his long line had bin put through his liver? We were told it was taken out straight away is this the case? And if not why not and why were we not informed of this?"*

6. In replying to these concerns, Dr Ravi Jayaram drafted a response dated 10 February 2016, which I attach as **Exhibit JT/34 [INQ0014408]**. In responding to each question in turn, he wrote:
   6.1. *"Preterm babies of [Child A's] gestation can't feed normally and need nutrition intravenously. This can only be given via a long line or UVC and is usually started within the first 24 hours of life. Long lines and UVCs take longer to put in and are not usually inserted immediately. A peripheral IV cannula is usually inserted first so that babies receive fluid, dextrose and antibiotics, if indicated, as soon as possible after birth. Once the medical and nursing staff are confident that the baby is stable, a UVC or peripheral long line is inserted electively to allow total intravenous nutrition to be started in the first 24 hours. The first attempt at umbilical venous access was when he was around 18 hours old ."*
   6.2. *"When monitors alarm, it is a signal to the staff to look at them. They often alarm due to movement or poor contact. If an alarm goes off, a member of staff may look up at the monitor and if it is clear it is a false reading or just a minor change then no action is necessarily needed. Usually the first move would be to check the baby the monitor was attached to. For example an oxygen monitor may read low but if a baby is pink*

or there is a poor trace on the monitor then no action would be needed. However I am unable to comment specifically on how many times the monitors beeped without anyone checking nor on how long they beeped before staff attended to him. I can confirm that at the time of his collapse staff were in attendance as soon as the alarms sounded."

6.3. *"The UVC was inserted by one of the junior doctors training in paediatrics and supervised by a doctor with 3 years of paediatric experience who was experienced in inserting UVCs. Line insertion itself was not problematic but it is a recognised complication that UVCs can enter the liver veins. This is not due to technical issues with insertion but simply due to the anatomy of the veins. The likelihood of the UVC entering the liver veins is not dependent upon the experience of the person inserting it. Had there been difficulties in insertion itself, more senior help would have been asked for."*

6.4. *"I am not sure who fed back the PM results to you but having read the report, the only abnormality described by the pathologist was a crossed pulmonary artery. This is a rare variant where the left pulmonary artery, that carries blood form the heart to the left lung, starts to the right hand side of the right pulmonary artery. However this should not cause any problems with the function of the heart and lungs and the PM report suggests that there was no issue with the heart and lungs as a result of crossed pulmonary arteries."*

6.5. *"The UVC entered one of the liver veins but did not puncture the vein or enter the liver itself. The PM showed a tiny clot on the end of the line which would be expected but the liver itself was normal, suggesting that the UVC did not cause any damage to the liver. As above, this is a not uncommon event in UVC insertion. It was removed but the replacement UVC also entered the liver veins. This UVC was not removed immediately because it could still be used for IV dextrose infusion, but not parenteral nutrition, whilst the peripheral long line was being inserted. Once the position of the peripheral long line is confirmed and starts to be used, the team would normally remove the UVC. Insertion of UVCs and peripheral long lines are a very technical and skilled procedure with many stages including aseptic technique, insertion, imaging after insertion, adjusting to correct position after imaging and adequate fixation. I would not normally expect paediatricians to keep parents informed at every stage of this procedure."*

7. Secondly, the Trust received a complaint by the parents of Child D, regarding Child D's care whilst at the neonatal unit at the Trust. This complaint can be located within the parent's witness statement signed 27 January 2016, which I attach as **Exhibit JT/35**

[INQ0014409], and forms part of the overall proceedings brought by Child D's parents against the Trust. Within this witness statement, Child D's parents state that they believe Child D may have been taken off C-PAP (a form of ventilation or breathing support) too early with notes showing that every time she was taken off the machine, she crashed. The statement further records Child D's parents disputing the APGAR score given to Child D at her birth. (An APGAR score is a scoring system used to assess the condition of a newborn in 5 key areas: Activity/muscle tone, Pulse/heart rate, Grimace, Appearance and Respiration. A score of 7 to 10 is considered 'reassuring', with a lower score considered abnormal and concerning.) Child D was given an APGAR score of 8 at one minute of life and a score of 9 at 5 minutes of life. Within their witness statement, Child D's parents disagree with the score given, stating *"[Child D] seemed limp, of dusky colour and lifeless."* Child D's parents also raised concern in their statement over the actions of staff in the immediate aftermath of Child D's collapse, claiming to hear someone on the phone saying "[Child D], no it's [Child D]," whilst "massaging" her. They continue to state that "*It's not clear who he was talking to or why he was doing that."* The family also queried why the mother was not provided with antibiotics before being sent home when her waters had broken.

8. Elizabeth Newby discussed some of these concerns with the parents in a meeting and further clarified her views in an email from Elizabeth Newby to Heidi Douglas sent at 0949hrs on 17 March 2016, which I attach as **Exhibit JT/36 [INQ0014410]**. On the topic of Child D's potentially premature removal from the C-PAP machine, Dr Newby wrote:

   "In hindsight, it may have been better to leave [Child D] on CPAP but it is extremely doubtful that this would have altered the course of events. When [Child D] collapsed she suddenly stopped breathing and then lost her output. CPAP offers some respiratory support to a baby who is breathing for themselves but it is not ventilation. Therefore CPAP would not have been enough to prevent her collapse or help during the collapse.

   It feels, in hindsight, the wrong thing to have taken her off CPAP but we couldn't predict at the time that she would suddenly collapse & therefore when she was in air, with a normal set of observations, the registrar on call felt it was reasonable to try her off, knowing that it takes seconds to re-start if coming off is not tolerated."

9. In relation to the actions of staff in the aftermath of Child D's collapse, Dr Newby went on to state:

   "I was not involved in this incident but the registrar on call told me afterwards what had happened. I really don't know if mum and dad were there at the time.

When [Child D] collapsed Dr Brunton attended & took over the resuscitation from the SHO Dr Thomas. He asked the nursing staff to ring switchboard & request they call me & ask me to attend urgently. When I received the call from switchboard I immediately came into the hospital and was there in about 7 minutes.

In the meantime, someone else phoned the unit & the staff picking up the phone mistakenly thought it was me ringing back after talking to switchboard. They held the phone to Dr Brunton's ear & he asked the person to come in thinking it was me. He quickly realised the error & the phone was put down. I don't think this is relevant to [Child D]'s care. The resuscitation was not interrupted. It did not delay my attendance as I was already on route."

10. Finally, regarding concerns over an incorrect APGAR score being given to Child D, Dr Newby wrote:

    "A paediatrician was not at the delivery, therefore the midwife documented the Apgar scores and the fact that no resuscitation was need at birth.

    The paediatric notes record 5 & 10 min Apgar scores but I also found 1 minute Apgar scores in Mum's obstetric notes. This issue of baby details being recorded in Mum's notes has been discussed, highlighted as a risk & action taken."

11. The Trust also received further complaints from parents regarding the lack of communication surrounding the subsequent investigations and the lack of counselling and support in the aftermath of their babies' deaths. One of these complaints was made by Father O&P&R. In an email sent by Christine Hurst to Stephen Cross at 1703hrs on 8 February 2017, Christine states that she received a telephone call from Father O&P&R who was "*extremely distraught and very very angry*" about not being informed of the publication of the RCP review, instead having "*now only found out about [it] via the babies' grandparents who saw it on the news*". I attach the following document as **Exhibit JT/37 [INQ0014411]**.

12. Father O&P&R also complained in a telephone call made by him to the Trust to him at 1730hrs on 8 February 2017. Within a handwritten note of this call, which I attach as **Exhibit JT/38 [INQ0014412]**, it is said that "[Father O&P&R is] *not happy with the follow up provided by the Countess – no contact since death of his boys [and] no bereavement support."*

13. The Trust responded to Father O&P&R in a call with him at 1730hrs on 8 February 2017. Within the notes of this call, it is stated that the Trust had been advised of Father O&P&R's

complaint from the coroner's office and that an explanation was provided regarding the lack of communication over the review publication. From the notes, Father O&P&R was told that the address held for him on hospital records was incorrect as the parents had moved. Although the parents' contact number remained the same, it was explained to Father O&P&R that an effort to reach him via phone call was made the previous Friday, but that it "*didn't feel appropriate to leave a message."*

14. It was within this phone call that Father O&P&R also complained about the follow up provided by the Trust, which is outlined above. Within the notes made of this call, it is said that the staff member "*apologised for this lack of support'* and acknowledged that "*this had obviously added to their distress*." Father O&P&R was then told that the Trust 'were keen to meet with families to discuss the report and care of their boys'. He was also advised to contact the Trust back once he had reviewed the report.

15. A complaint was also made by the mother of Child C, through a letter addressed to Ian Harvey and which was received on 13 February 2017, which I attach as **Exhibit JT/39 [INQ0014413]**. Within this letter, she stated that "*at no point had anyone contacted myself or my husband to inform us of this investigation into our son's death – the only way we knew about it was to read it in the newspaper."* She ultimately felt that "*the trust did not respect our grief enough to go to every possible length to inform us about this investigation,"* and that "*the handling of this investigation, and lack of communication has added to the distress of my family."* The letter sought a meeting with Ian Harvey to review her baby's case. In response, a message was left by Sian Williams on 13 February 2017 explaining that Ian was away on leave and that she would pass on his request to him. The meeting did not ultimately take place in view of the subsequent reporting of the cases to the police.

<u>Updates on concerns about the neonatal unit and Letby</u>

16. The Trust has been asked what information the parents were given by the Trust regarding concerns about the neonatal unit and/or Letby's conduct. Paediatric consultants are usually expected to speak to parents following death (in line with the duty of candour) and would offer to meet parents at a convenient time. Following Letby being removed from clinical duties, Ian Harvey led on all communication with families.

17. From a Trust perspective, the Trust shared information regarding concerns over the neonatal unit in different formats to external and internal audiences and with parents.

18. On 7 July 2016, an external statement was published by the Trust regarding the downgrading of the neonatal services to Level 1. Within this statement it was explained that the Trust's neonatal services admissions arrangements were being temporarily changed to focus "*predominantly on lower risk babies, who are born after 32 weeks*", which I attach as **Exhibit JT/40 [INQ0014414]**. The statement confirmed that the Trust had seen "an increase in neonatal mortality rates for 2015 and 2016," and consequently an independent review from the Royal College of Paediatrics and Child Health and the Royal College of Nursing had been requested. While these reviews were taking place, the Trust confirmed that they would be *"closing three intensive care costs at the Chester neonatal unit."* With regard to the baby deaths at the hospital, the statement read "*Our bereavement service will continue to support those families … We will be keeping in regular contact with them during our review."*

19. "Handling lines", attached as **Exhibit JT/41** **INQ0002820** were put into place internally by the Trust through email to certain Trust individuals regarding potential queries following the external statement. In response to the anticipated query of "What does a medical review involve?" the prepared response stated *"This review will provide some helpful objective and independent analysis. It looks at all aspects of our neonatal care including performance data, the patient experience and our staffing."* Regarding the length of the review and what it may involve, the prepared response stated "*We having ongoing case note reviews for all hospital deaths, including neonatal deaths. All cases are reviewed individually at that point in time. Based on the increasing number we now want to review them collectively (as a group) with the help of independent external assessors*."

20. As to direct communication with the affected parents, individual letters were sent on 3 March 2017, 21 April 2017 and 28 April 2017 by Ian Harvey regarding the RCPCH review, and further independent external reviews as follows:
    20.1. Within the 3 March 2017 letter which I attach as **Exhibit JT/42** **INQ0003065** it was stated that although the separate independent review into the care of each baby has been carried out, it has *"indicated that a small number of areas of investigation are required and I aim to undertake this as quickly as possible,"* before suggesting that he aims for further meetings to discuss the RCPCH review, and subsequent independent review "*within the next 6 weeks."*
    20.2. Within the 21 April 2017 letter which I attach as **Exhibit JT/43 [INQ0014417]**, Mr Harvey writes that "*further investigation work has been undertaken, however, we have been advised by the independent external case reviewer to consult with the Pan*

Chesire Child Death Overview Panel (CDOP) which has been arranged for next week." He further states that "*Once this consultation has taken place, I will make arrangements as soon as possible to meet you to discuss all the review findings."*

20.3. Within the 28 April 2017 letter which I attach as **Exhibit JT/44 [INQ0014418]**, Mr Harvey enclosed the independent external report for each parent's child or children. Each report described the events surrounding the child's death and detailed potential areas of 'suboptimal care' and the relevance of this care on the child's death. The level of suboptimal care, and the relevance were graded on a scale of zero to three, with zero indicating that there was no suboptimal care or that the suboptimal care was not relevant, and three indicating that there was major suboptimal care or that the suboptimal care was 'almost certainly relevant.' Within the letter, Mr Harvey also invited the parents to contact him to if they wished to *"discuss these documents and any other issues you might have in greater detail. We will then also be in a position to explain any of the terminology that might be unclear."*

21. The manner in which information was delivered to the parents personally was considered within a wider communications planning document dated January 2017 which I attach as **Exhibit JT/45 [INQ0014419]**. This document included communication considerations and requirements within a table of all stakeholders in neonatal services. Requirements varied depending on whether the parents have previously been contacted regarding the matter. For parents who had previously been in contact regarding neonatal services, the considerations and requirements were as follows:

    21.1.1. Telephone discussion to inform them of recommendations of review due to be published within next week;

    21.1.2. When ready, offer to meet with them, and to understand how they would like to receive it (post, email, in person);

    21.1.3. Opportunity for face to face meeting / process if they have questions;

    21.1.4. Explanation that when published, it may prompt media interest;

    21.1.5. Those requesting to be sent letter, to receive recorded delivery ;

    21.1.6. For parents the Trust had previously tried to re-contact but had not been able to get a hold of, a letter based on the telephone script of the discussion with previously contacted parents, was to be sent instead.

22. I understand that once the matter was referred to Cheshire Police, the Trust had no further contact with the families and the police led on all communications with the families.

<u>Medical records</u>

23. The Trust has been asked when the parents on the indictment were provided with the medical records of their children. One subject access request was made by the parents of Child D for their child's medical records. The request was received on 23 July 2015 and the records were disclosed on 4 August 2015. I attach as my **Exhibit JT/46 [INQ0014420]** the request received from the parents, dated 21 July 2015.

24. Some medical records of babies named on the indictment were requested through their solicitors as part of a claims process. These were managed as follows:

	Disclosure request received	**Records disclosed**
Child A	15 February 2016	29 March 2016
Child B	9 October 2018	October 2018
Child C	29 June 2017 (in respect of obstetric and paediatric records)	8 August 2017
Child D	20 October 2015 (in respect of the Root Cause Analysis report)	Root Cause Analysis report disclosed 11 December 2015
Child D	23 June 2016 (in respect of counselling records for mother and father)	Counselling records disclosed 12 July 2016
Child E	25 July 2017 (in respect of obstetric and paediatric records)	27 February 2018 (note there was a delay in this response as the Trust awaited the fee for the records – invoice sent on 2 August 2017 and paid on 24 January 2018)
Child F	12 February 2021 (in respect of obstetric and paediatric records)	16 March 2021
Child G	2 August 2018	11 September 2018
Child H	30 January 2024 (in respect of obstetric and paediatric records)	Due to be disclosed 29 February 2024
Child I	7 August 2018 (in respect of obstetric and paediatric records)	September 2018
Child J	5 September 2023 (in respect of obstetric and paediatric records)	11 September 2023 (paediatric) 29 September 2023 (obstetric)

Child K	30 October 2023 (in respect of obstetric and paediatric records)	1 December 2023
Child L	16 February 2021 (in respect of obstetric and paediatric records)	30 March 2021
Child M	16 February 2021	30 March 2021
Child N	20 July 2018	14 August 2018
Child O	15 January 2019 (in respect of obstetric and paediatric records)	31 January 2019
Child P	15 January 2019	31 January 2019
Child Q	30 July 2018	September 2018

Support for bereaved families

25. The Trust has been asked about support and counselling available to families who suffered the death of a baby on the neonatal unit. Where families suffered a death of a baby on the neonatal unit, they were offered a meeting with their named obstetrician and if requested with the paediatrician.

26. I attach as my **Exhibit JT/47 [INQ0014421], [INQ0014422] and [INQ0014423]** the Procedure for Listening and Responding to Concerns and Complaints version 3 which was approved on 22 July 2014 and as my **Exhibit JT/48 [INQ0014424], [INQ0014425] and [INQ0014426]** version 4 of the same document, which was approved on 4 January 2016. Although there is nothing specific within these documents directly relating to support for a family suffering the death of a baby on a neonatal unit, the Patient Advice and Liaison Service ("PALS") at the Trust was available to be utilised if there were any concerns. The policies have been amended since 2016 but the same position as to support for a family suffering the death of a baby on a neonatal unit remains.

27. I also attach as my **Exhibit JT/49 [INQ0014427], Exhibit JT/50 [INQ0014428], Exhibit JT/51 [INQ0014429]** and as my **Exhibit JT/52 [INQ0014430]** respectively versions 33, 34, 35 and 36 of the (now archived) "Support for Parents of Babies with Suspected or Actual Poor Outcome" document for 2015 and 2016 (which covered neonatal palliative care). This document was aimed at the situation where there was a poor or uncertain outcome of pregnancy, or concern that the newborn may suffer from developmental delay, and the whole family may be distressed and sought to ensure those families were provided with accurate information and access to other support services which may be able to help.

28. In July 2016, the Trust conducted a Neonatal Standards Review which I attach as **Exhibit JT/53 [INQ0014431] and [INQ0014432]**, which records that families are offered psychological and emotional support after receiving sensitive news, although it was acknowledged a further discussion could take place to further improve this offering. The review further records that counselling services were on offer, with leaflets and a contact number outside the neonatal unit door, information in the parents' accommodation and in the SANDS bag. This bag would contain information cards, a teddy and information on where to go and seek support on return home.

29. The review found that families (including the baby's siblings) should be able to easily access psychological and social support and parents were given written information (in languages and formats appropriate to the local community) about relevant services covering at least, but not limited to: local and national support groups; palliative care services; bereavement support; social services; spiritual support; benefits advice and counselling.

30. The Trust's Guidelines for Perinatal Loss which I attach as **Exhibit JT/54 [INQ0014433], [INQ0014434], [INQ0014435], [INQ0014436], [INQ0014437] and [INQ0014438]** outline that all relevant discussions relating to support following stillbirth should be documented on the Pregnancy Loss and Infant Death Checklist, which is appended to the guidelines. The checklist includes the emotional support that should be included, comprising of religious support, initial communication, photographs of the baby, mementoes, counselling and a bereavement pack.

31. The counselling section within the checklist requires informing the mother that a follow up appointment in the Pregnancy Risk Clinic will be offered in approximately 12 weeks (following a stillbirth). The intention for this appointment would be to discuss the results of any investigations taken and care for any future pregnancy.

32. A Pregnancy Risk Clinic discussion following death of a baby on the neonatal unit involved plans for future pregnancies in respect of the location of care, advice on the ideal time for a future pregnancy and the mode of delivery. Future meetings are then offered for pre-conceptional counselling as a preparation for pregnancy. I attach as **Exhibit JT/55 INQ0008656** an example letter which relates to Child D and Mother D.

33. As set out within the CQC's report in February 2016, the Head of Midwifery at the time stated that 100% of bereaved parents attended the Pregnancy Risk Clinic which was consultant led. The foetal medicine midwife also reviewed each case and counselled women and their partner about their experience.

34. The CQC also noted in their report that assessments for anxiety and depression were completed and women were referred to an external mental health team if perinatal mental health care was required. The report further records that there was no specialist bereavement midwife; however, there were two link bereavement midwives.

35. The bereavement office would refer families to bereavement counselling if requested. On occasions when the Coroner was involved in a death, Coroners' Officers may offer support to families instead of bereavement officers. The Trust now has a bereavement midwife who visits families offering support and signposting families to counselling or to hospices.

36. As the neonatal unit sat within the Trust's unplanned care division and the maternity unit sat within the planned care division, there were some difficulties. The Trust's Women and Children's Governance Board was the overarching governance structure but it could take a while for issues to come to light, such as improvements to PALs access and bereavement counselling which only became apparent as an issue later.

37. There has been an improvement in perinatal mental health support/provision within the neonatal unit network. I attach a document dated November 2019 as my **Exhibit JT/56 [INQ0014440]**, explaining the sources of support available and the role of the perinatal mental health midwife who was available to give advice as well as liaising with health visitors and GPs. Psychiatric support was available if a crisis situation arose. Online training was provided and clear pathways, checklists and other resources/guidance was kept at nurses' stations.

38. The Trust has been asked whether there were any policies and processes in place in the neonatal services between June 2015 and June 2016 whereby medical records, including those accessed in hospital and by GPs, are marked to show that a mother has suffered a neonatal death and/or that parents have suffered a neonatal death so they do not need to give their full patient history each time they access NHS services.

39. The hospital maternity notes in respect of a family who had suffered a neonatal death would be marked with a green SANDs sticker. This was the practice as far as the Trust can recall in 2015/16, but it is thought that this applied predominantly to cases of pregnancy loss rather than neonatal loss.

40. Where a neonatal death occurred in 2015-2016, the consultant paediatrician would write to the GP to inform them of the death. Paediatric secretaries would contact the Cheshire West and Chester Child Health Department to notify them of the death, which would also ensure no child health communication would be sent to the bereaved family. The child's medical record would be updated by the Trust records department to show the patient as deceased so that inappropriate correspondence (e.g. requests to attend for appointments) was not sent out. The mother would also be allocated high risk maternity care, which is shared with paediatricians, and given access to counselling.

41. The Trust now uses the Cerner electronic patient records system which was not available during the relevant period. Cerner is connected to the central data spine for the NHS. When a patient's GP is informed of a death, the GP updates the central database. When a member of staff accesses Cerner and opens a patient record, they are able to click "Update" to update the record with the National Portal (central database) information. The Trust now has a system whereby a report is run every week, which highlights all the deceased patients on the National Portal which are still showing as "alive" in Cerner. The Trust Health Records Data Quality Team actions this report every week and makes sure that all the Cerner records are aligned with the National Portal. The report will normally come through on a Tuesday and it is actioned by the Friday.

42. I also attach as my **Exhibit JT/57 [INQ0014441]** the Trust's draft Child Death Guidelines which are currently out for consultation. These guidelines set out a clear process including checklists of actions upon the death of any under 18 year old, including a list of key workers which can be shared with families prior to leaving hospital.

Recruitment of Letby

43. The Trust has been asked about the recruitment of Letby and her qualifications.

44. In 2011, nurses were not recruited through corporate recruitment, e.g. recruited and then allocated to a ward. Nurses were recruited to specific wards by the ward managers. The individual ward manager would contact the recruitment team and ask them to advertise for

the nursing position. This process was email and paper based as it preceded Trac Jobs which came into effect in September 2018. The recruitment team would then send the applicants' details to the ward manager, who would put together a shortlist of candidates for interview. The ward manager would email the recruitment team with a list of candidate names to send an invitation for an interview, which recruitment would then arrange. The ward manager would then interview the candidates and send an email to the recruitment team to provide the name and details of the successful candidate to be appointed. Recruitment would then send out an offer letter and invite the candidate in for pre-employment checks and seek references. Reference requests would be approved by the hiring manager.

45. In Letby's case, a vacancy for a neonatal practitioner was advertised in 2011. She had recently qualified as a Children's Nurse in September 2011 and applied for the vacancy at the end of 2011. Letby was in possession of her NMC pin and was willing to undertake pre planned neonatal training. The application (which is undated) which I attach as **Exhibit JT/58 [INQ0014442]** provides a list of her qualification and training completed as follows:

Qualifications

Subject/Qualification	**Place of study**	**Grade/Result**	**Year obtained**
Children's Nursing BSc (Hons)	University of Chester	2:2	September 2011
A Level English Literature	Hereford Sixth Form College	C	2008
A Level Psychology	Hereford Sixth Form College	C	2008
A Level Health and Social Care	Hereford Sixth Form College	C	2008
GCSE English Literature	Aylestone High School	B	2006
GCSE English Language	Aylestone High School	B	2006
GCSE Science	Aylestone High School	C	2006
GCSE Mathematics	Aylestone High School	C	2006

GCSE Health and Social Care (Double Award)	Aylestone High School	C	2006
4 other GCSE's	Aylestone High School	B-C	2006

Training

Course title	Training provider	Duration	Year obtained
Duke of Edinburgh Bronze Award	Aylestone High School	1 Year	2005
National Open College Network – Peer Support Programme	CLD Youth Counselling Trust	1 Year	2005
Level 2 Food Safety in Catering	Chartered Institute of Environmental Health	2 days	2008
Infection Control Workshop	Practice Education Facilitators, Countess of Chester Hospital	1 day	2009

46. Letby was interviewed on 5 December 2011 by Eirian Powell, Neonatal Unit Manager at the Trust, for a temporary Band 5 post. Eirian Powell emailed Human Resources on 6 December 2011 to confirm she had allocated Letby the temporary Band 5 12-month contract. A handwritten note states, "cancelled now B4". A pre-employment package was sent on 6 December 2011, which I attach as **Exhibit JT/59 [INQ0014443]**.

47. A letter from Eirian Powell was sent to **Nurse T**, Neonatal Practitioner at the Trust, on 6 December 2011 informing that Letby had applied for the temporary 12-month Children's Nurse post and had provided her name as a referee.

48. Letby received a letter on 12 December 2011 offering her employment on the neonatal unit on a 12-month temporary contract, which I attach as **Exhibit JT/60 [INQ0014444]**.

49. Nurse T completed the Reference Form on 14 December 2011 confirming that Letby was a student nurse and responded "no" to any concerns regarding Letby's conduct, performance and suitability to work with children, young people or vulnerable adults. Nurse T responded "yes" to re-employing Letby. I attach this form as **Exhibit JT/61 INQ0006241**

50. Ruth Sadik, a Senior Lecturer and Child Health Nurse, also provided a reference for Letby on behalf of the University of Chester. The reference referred to Letby as "competent", "committed", "amiable", "motivated" and "enthusiastic." The reference also referred to Letby as being "painfully shy" and "introverted when anxious". Ruth Sadik noted that during the university course, Letby had undertaken the following placements: four placements on general children's wards with a minimum of six weeks per placement, two neonatal placements at the Trust, health visitor/school nurse, adult nursing, an elective and ambulatory care experience and a twelve-week consolidation of practice experience. During her time at university, Letby worked as a student nurse at the Trust. Ruth Sadik highlighted that Letby's passion was in the field of neonatal nursing where clinical reports showed that she excelled and stated that she would be *"a real asset to any team, especially one working in the neonatal environment when she truly comes into her own"*. Ruth Sadik confirmed that Letby had successfully completed her management of care delivery OSCE.

51. Letby completed several pre-employment checks which I attach as **Exhibit JT/62 [INQ0014446]** which included the following:

Requirement	**Date received**
Occupational Health clearance	December 2011
Two satisfactory references	December 2011
Passport or Right to work	12 December 2011
Qualifications required for the role	12 December 2011
Disclosure and Barring Service (DBS) (the new CRB) check	Enhanced DBS issued on 19 December 2011

52. In October 2011, Letby received a letter from the Royal College of Nursing with confirmation that her Membership Card had been renewed, providing a copy of the card (**Exhibit JT/63**) **[INQ0014447]**. A scanned copy of Letby's passport, driving licence and NMC information was provided to the Trust on 12 December 2011. I attach the copy of the driving licence as **Exhibit JT/64 [INQ0014448]**.

53. A criminal record check was undertaken on Letby prior to starting with the Trust. A letter dated 19 December 2011 (**Exhibit JT/65**) **[INQ0014449]** was sent to Linda Cunningham, HR Support Team Leader at the Trust, confirming that Letby did not have a criminal record, together with an enhanced DBS check (**Exhibit JT/66**) **[INQ0014450]**.

54. A letter from K.A Goodwin dated 30 December 2011 (**Exhibit JT/67**) **[INQ0014451]** was sent to Eirian Powell confirming that Letby had been assessed by Occupational Health prior to commencing employment and no adjustments were identified as required.

55. Letby's employment with the Trust started on 2 January 2012. Letby completed her induction checklist between 3 January 2012 and 29 January 2012 **(Exhibit JT/68) [INQ0014452]** together with her learning contract **(Exhibit JT/69) [INQ0014453]**, which was signed off by Yvonne Farmer, neonatal nurse at the Trust. Between January 2012 and June 2012, Letby completed a preceptorship portfolio for a Band 5 Registered Nurse at the Trust. The portfolio required Letby to self-assess various competencies at three intervals: January 2012, April 2012 and June 2012. The assessment ranged from 0-5. Letby initially scored herself between 2-4 on the competencies with the final assessment ranging from 4-5 **(Exhibit JT/70) [INQ0014454].**

56. On 4 January 2012, Letby underwent a competency assessment for recording clinical observations and escalating abnormal recordings utilising early warning scoring system. She was assessed by Yvonne Farmer and attained a pass **(Exhibit JT/71) [INQ0014455]**.

57. On 6 January 2012, Alena Lomax, Financial Management Assistant at the Trust, informed Susan Bates, HR Senior Assistant for the Trust, and Eirian Powell that there was a budgeted 1 WTE post for Letby on the neonatal unit. On the same day, Eirian Powell offered Letby a permanent Band 5 position due to another Band 4 Nurse at the Trust taking a career break **(Exhibit JT/72) [INQ0014456]**.

58. A letter was sent to Letby from Human Resources on 6 January 2012 confirming that she had been booked onto a number of training courses for new staff at the Trust. The courses included:

Course	**Date to attend training**
Welcome Event	9 January 2012

Manual Handling/Infection Control Training	10 January 2012
Inpatients Induction	11 January 2012
Patient Care System & Ordering	12 January 2012
Basic Life Support Training	26 February 2012

59. Letby completed a Supplementary Personal Information form which was to be submitted to her manager on the first day of employment. The form includes information such as NI number, emergency contact details, registration details, qualifications, bank account details and her employment status prior to joining the Trust which reiterates that she was a student. A handwritten note on the form confirms that a copy was passed to payroll on 6 January 2012, together with a request to payroll following the move from a temporary to permanent contract **(Exhibit JT/73) [INQ0014457] and [INQ0014458]**.

60. 15. On 9 January 2012, Megan Cropper, HR Advisor at the Trust, emailed Eirian Powell to request confirmation as to whether two references for Letby had been received to allow her to issue a contract and confirmation letter. Yvonne Griffiths, Deputy Manager at the Trust, picked up the request and subsequently confirmed that she would provide a photocopy of the two references via internal mail.

61. On 12 January 2012, Susan Bates emailed Eirian Powell with a chain of emails between 6 January 2012 to 12 January 2012 regarding Letby not attending induction courses. Letby stated in earlier correspondence with Susan Bates that Eirian Powell had, via verbal and written communication, informed her that she was booked onto an induction day on 16 January 2012 and the computer and training sessions were on 11 and 12 January. Susan Bates responded to request that Letby attend the sessions as set out on the list from 6 January 2012 as outlined above. Letby responded to confirm there was some confusion and that she had not attended the welcome day but had attended another training day. Susan Bates requested that Letby liaise with Eirian Powell as the course may be an additional course as opposed to the mandatory training courses required as a new starter by the Trust. Susan Bates emailed Eirian Powell and Letby on 12 January 2012 with a list of new dates to attend the mandatory training sessions in February 2012. Following Susan Bates' response on 16 January 2012, it appears Yvonne Griffiths requested the new dates to be in January. The list of new dates was as follows:

Course	**Date to attend**

Welcome Event	20 February 2012
Manual Handling/Infection Control Training	24 January 2012
Inpatients Induction	25 January 2012
Patient Care System & Ordering	26 January 2012
Basic Life Support Training	26 January 2012

62. A letter from Linda Walker, Head of Employment Services at the Trust, was sent to Letby confirming her appointment into the position of Registered Children's Nurse at the Trust with effect from 2 January 2012. The letter attached a Written Statement of Employment to be completed which outlined the Terms and Conditions of Service. The statement highlighted that the employment was temporary and expected to continue for a maximum of 12 months, noting the contract would be reviewed not less than one month prior to the anticipated end date **(Exhibit JT/74) [INQ0014459].** A subsequent Written Statement of Employment was sent to Letby on 26 January 2012 with an amendment to reflect that the position was now permanent **(Exhibit JT/75) [INQ0014460].**

63. On 28 August 2012, Letby completed a progress evaluation self-assessment together with Yvonne Farmer. The assessment highlights areas for development and agreement for Letby to attend a neonatal induction course to consolidate her learning.

64. Letby completed a reflection piece on 28 August 2012 **(Exhibit JT/76) [INQ0014461].** The reflection noted that she had attended an IV study day at a regional hospital. The study day provided insight into the importance of infection control measures when drawing up and administering intravenous medications and the possible implications failure to do so could have on the patient. She reflected on how she had met staff from hospitals within the Neonatal Network and how different ways to administer IV medications and the clinical reasons were discussed. During the day, Letby noted that she had the opportunity to draw up antibiotics in a group and then share the procedure each unit followed which made her think about the way in which she had previously drawn up medications and practice to adopt moving forward. Letby stated that the day also included a discussion around how drugs were absorbed and used by the body together with the best route of administration to aid the process. She identified that this helped her to recognise the importance of checking a prescription chart thoroughly prior to giving medication to ensure it was prescribed in a way that would provide the most benefit to the patient. Letby stated that having this knowledge allowed her to be able to monitor a patient appropriately for any

potential side effects of giving a medication, particularly when giving IV medications to an infant who was already in receipt of a number of infusions, recognising what drugs and fluids are compatible and which line is most appropriate for use. Letby continued the reflection noting that IV medications are generally absorbed more quickly and successfully but highlighted that it is important to understand that they often carry a greater risk of side effects and make the infant more susceptible to infection. She stated that the study day encouraged her to think about the possible effects, taking into account all of the factors, IV medications could have on the infants, particularly ones who are already compromised, especially from an infection control perspective.

65. Letby stated that upon returning to the NNU, she was supported with the process of calculating, drawing up and administering medications more independently and indirectly supervised. The process included observing colleagues' methods and obstacles. Since attending the study day, Letby noted that she had given several different antibiotics via peripheral lines as well as setting up an infusion. She had developed skills such as setting up pumps with the correct rate and volumes resulting in gained confidence. She provided an example where whilst administering a flush prior to giving antibiotics, she found the cannula to be leaking resulting in the baby having to be decannulated and antibiotics being discarded as they had been out of the vial for over an hour. Letby concluded the reflection by stating that she was due to begin the Neonatal Induction Programme.

66. Letby had an appraisal with Yvonne Farmer on 29 August 2012 **(Exhibit JT/77) [INQ0014462].** Letby was considered "excellent" in her overall performance in role. The form provides a list of training, both mandatory and additional, attended or to be attended by Letby during the year as follows:

Course	**Date attended**
Induction – Trust and Local	3 January 2012
Fire	3 January 2012
Resus	3 January 2012
BFI	9 & 10 January 2012
Bereavement	19 January 2012
Safeguarding	21 March 2012
Conflict Resolution	15 May 2012
Annual Neonatal Update	18 May 2012
Developmental Care Day	29 June 2012

IV Administration	July 2012
Father's Day SD	10 October 2012

67. Actions from the appraisal included:

Objective	**Actions to be taken**	**Target date**
Completed Neonatal Induction Programme	To attend programme study days and complete 10-week placement	March 13
Maintain mandatory training status	Attend study days	N/A
Consolidate skills and knowledge developed during IV study course	To draw up and administer a variety of IV medications until fully confident and competent	N/A

68. On 30 August 2012, Letby completed a competency assessment to administer IV additives via bolus through a peripheral line. Caroline Oakley was the assessor. Letby completed the competencies and achieved a pass **(Exhibit JT/78) [INQ0014463].**

69. A letter from Sonya Devine, Clinical Educator at Liverpool Women's NHS Foundation Trust ("LWH"), was sent to the Trust on 11 December 2012 **(Exhibit JT/79) [INQ0014464].** The letter outlined that Letby had undertaken a 10-week Regional Induction Programme placement at LWH. The letter informed that Letby had worked "exceptionally" well throughout the placement in the intensive care setting. During the placement, Letby built her knowledge around caring for sick ventilated neonates and was noted to have provided care at a "very high standard". The letter highlights that she had been involved in the emergency resuscitation and subsequent withdrawal of intensive care on a baby and showed sympathy and professionalism during the difficult situation. It was suggested that Letby consolidate her learning via a placement on ITU at the Trust.

70. A training Band 5, 6 and 7 Equipment List on the Neonatal Unit was completed by Letby in January 2013. She was assessed on using the following equipment:

Equipment	**Training completed/further training required**	**Date completed**
Ventilator 4000	Further training required	January 2013

Infant Flow Driver Sipap (M675)	Further training required	Not provided
Infant Flow Drive M672P	Completed	January 2013
Humidifier MR850	Completed	January 2013
Infant Resuscitator Neopuff RD 900	Completed	January 2013
Infant warmer (resuscitaire)	Further training required	Not provided
Nursing Incubator Caleo	Completed	January 2013
Transport Incubator 5400	N/A	N/A
Ventilator BabyLog 2000	Further training required	Not provided
Volumetric Infusion Pump Arsena	Completed	January 2013
Syringe Driver Arsena CCMK 111	Completed	January 2013
Blood Gas Analyser	N/A	N/A
Patient Monitor M3002A (MP30)	Completed	January 2013
ECG/Resp/SpO2/NIBP/temp/IBP M3001A (MP30)	Completed	January 2013
Monitor (Portable) M8002A (MP30)	Completed	January 2013
Cerebal Function Monitor Olympic CFM 6000	Further training required	Not provided
Pulse Oximeter Display	Completed	January 2013
Pulse Oximeter Docking Base	Completed	January 2013
Oxygen Mon OXYDIG	N/A	N/A
Respiratory Mon MR10	Completed	January 2013
ECG/NBP/SpO2/temp Monitor PROPAQ 202EL	Completed	January 2013
Transport Incubator Trolley ITUSIX	N/A	N/A
Suction Controller International (High/Low)	Completed	January 2013
Suction Controller Thoracic	Completed	Not provided
Electronic Thermometer Sure Temp 692	Completed	January 2013
Jaundice Meter JM 103	Further training required	Not provided
Phototherapy Unit 4000	Completed	January 2013

Phototherapy Unit Neoblue MK 11&111	Completed	January 2013
Phototherapy BilliBlanket	Completed	January 2013
Phototherapy Unit Neoblue cozy	Completed	January 2013
Prospect Diagnostics Haemocue	N/A	N/A
Baby Warmer Cosytherm	Completed	January 2013
Infant care system Cosy crib	Completed	January 2013
Suction unit (portable) Disposable Serres 780030	Completed	January 2013
Docking Station Asena	Completed	January 2013
Single air Flowmeter International	Completed	January 2013
Twin oxygen Flowmeter International	Completed	January 2013
Low Flow meter Micro range	Completed	January 2013
Micro Flowmeter Micro range	Completed	January 2013
Blender Low flow 20031 Low Flow	Completed	January 2013
Twin adaptor T1000	Completed	January 2013
CRP training manikin Rescsci-Baby	N/A	N/A
Breast Pump Lactina Select	Completed	January 2013
Breast Pump Symphony	Completed	January 2013
Baby Scales 376 Class 111	Completed	January 2013

71. On 6 January 2013, Letby completed a competency assessment for preparing and administering a transfusion of blood/blood components. She was assessed by Yvonne Farmer. Having undertaken the assessment, she achieved a pass with Yvonne Farmer noting she observed three transfusions **(Exhibit JT/80) [INQ0014465]**.

72. On 20 March 2013, Letby completed a Staffing Solutions Internal Application Form to register with the Temporary Staffing Bank. Letby noted that she had attended clinical mandatory training on 6 March 2013. Eirian Powell completed part of the form ticking "good" for Letby's punctuality, performance and reliability **(Exhibit JT/81) [INQ0014466]**.

73. On 23 April 2013, a letter was sent to Letby from Sue Davies, Staffing Solutions Team Manager at the Trust, acknowledging her application to join the Temporary Staffing Bank **(Exhibit JT/82) [INQ0014467].** The letter outlined the registration process which included a CRB Form, Model Declaration Form, HR1a, birth certificate/passport/driving licence and proof of address (dated within 3 months) and evidence of professional registration e.g. PIN number. The registering with temporary staffing form states that Letby's start date was 3 May 2013.

74. On 5 May 2013, Letby completed an Individual User Assessment/Competency Tool, Fisher and Paykel Optiflow. Letby was assessed by **Nurse Y**, Neonatal Practitioner. Letby was assessed on the following:

Competency **Individual has an understanding of the following:**	**Discussed/demonstrated**	**Date achieved**
Able to recognise said medical advice	Discussed	5 May 2013
Able to recognise accessories and relevant disposable items applicable to the device	Discussed	5 May 2013
Where to find user manual	Discussed	5 May 2013
Reason for the equipment and when to use	Discussed	5 May 2013
The safety checks & precautions to take prior to use	Discussed and demonstrated	5 May 2013

Competency **Individual able to identify, discuss and demonstrate the following parts,**	**Discussed/demonstrated**	**Date achieved**

functions and patient care:		
Knows how to choose correct circuit, and interfaces for Optiflow system	Discussed and demonstrated	5 May 2013
Knows how to assemble circuit and interface to Optiflow	Discussed and demonstrated	5 May 2013
Knows how to attach chamber and humidification water	Discussed and demonstrated	5 May 2013
Knows how to attach temperature probe and heater wire adaptor	Discussed and demonstrated	5 May 2013
Knows how to switch humidifier on	Discussed and demonstrated	5 May 2013
Understands all symbols and displays, and their significance on humidifier	Discussed and demonstrated	5 May 2013
Knows what humidifier mode should be set to for Optiflow	Discussed and demonstrated	5 May 2013
Knows how to set flow and suggest starting rate in l/min	Discussed and demonstrated	5 May 2013
Knows how to set Oxygen %	Discussed and demonstrated	5 May 2013
Dates and labels all consumables to comply with infection control guidelines	Discussed and demonstrated	5 May 2013
Knows how to connect to power & gas supplies	Discussed and demonstrated	5 May 2013
Knows how to attach circuit to the patient	Discussed and demonstrated	5 May 2013

Recognises and understands all alarms, and action to take should they sound	Discussed and demonstrated	5 May 2013

Competency **Individual to have an understanding and explain the procedure for the following:**	**Discussed/Demonstrated**	**Date achieved**
Procedure for cleaning and decontamination	Discussed and demonstrated	5 May 2013
Procedure for reporting faults, defects and failures	Discussed and demonstrated	5 May 2013
Procedure for reporting adverse incidents and near miss	Discussed and demonstrated	5 May 2013
Safe and correct storage of device	Discussed and demonstrated	5 May 2013

75. Letby was placed on the bank/temporary staffing register on 5 May 2013. On 9 May 2013, information was provided to payroll in relation to Letby registering with the Temporary Staffing Bank. I attach this as **Exhibit JT/83 [INQ0014468].** A bank new starter check list was completed by HR on 17 June 2013. The check list included salary and personal information.

76. A Datix incident form was completed by Shelley Tomlins, Neonatal Nurse at the Trust, on 22 July 2013 following a medication error **(Exhibit JT/84) [INQ0014469]**. Letby was named on the form. On carrying out fluid/medication checks at the start of the morning shift; it was noted that the Morphine infusion was running at 1.32 ml/hour as opposed to the correct amount of 0.13 ml/hour. The dose was prescribed at 5 micrograms/kilogram/hour and was therefore infusing at 10 times the prescribed amount.

77. Letby subsequently had a one to one on 23 July 2013 with Yvonne Griffiths in relation to the medication error **(Exhibit JT/85) [INQ0014470].** It was noted that Letby had

commenced a continuous infusion of Morphine at the end of her shift at 7am for a reintubated infant. At 8am on handover the infusion was noted to be infusing at the incorrect rate. The error was rectified quickly with no detrimental effect on the infant. Letby was to abstain from checking any intravenous infusions requiring additives and controlled drugs until the incident was reviewed. In addition, she was required to complete intravenous competencies/drug calculations with Yvonne Farmer.

78. On 30 July 2013 a letter from Sue Davies and Terms and Conditions for as and when required worker were sent to Letby **(Exhibit JT/86) [INQ0014471].** The letter confirmed that she had been placed on the Temporary Staffing Register and could make herself available for work. She signed the Terms and Conditions on 19 August 2013 **(Exhibit JT/87) [INQ0014472].**

79. Letby completed a further one to one on 30 July 2013 following the incident on 22 July 2013 **(Exhibit JT/88) [INQ0014473].** It is noted that the drug calculation was correct; however, the infusion pump rate was incorrect. Actions were for Letby to continue to care for infants' infusions, check controlled drugs and to go over intravenous competencies with Yvonne Farmer in relation to alaris pump settings (calculations).

80. On 26 August 2013 Letby completed a further Individual User Assessment/Competency Tool, Fisher and Paykel Optiflow. The competencies listed were assessed and achieved by Letby.

81. On 2 September 2013, Letby was awarded a certificate for achieving a score of 100% for the e-Learning course, Information Governance: The Refresher Module.

82. Letby had her annual appraisal on 5 September 2013. The appraisal was conducted by Yvonne Griffiths. The form notes that Letby was having additional study days, and her Neonatal Induction Programme was completed along with NLS (newborn life support). Objectives were as follows:

Objective	**Actions to be taken**	**Target date**
Attend high risk deliveries and utilise knowledge from foundation and NLS course	1. Attend deliveries when possible 2. Support by senior staff	Six months

	3. When allocation allows, for shift leader to attend high risk deliveries and support Letby in management of infants	
Complete mentorship programme	1. Attend study days 2. Supported study leave and assistance with studies 3. Adhere to NMC guidelines	Five week course followed by three months for mentoring students
Co-ordinate and develop 'developmental care' on the unit and facilitate staff groups	1. Attend network benchmark days for developmental care 2. Three monthly group sessions 3. Relay new knowledge and educate staff	Six months

83. 40. Objectives 1 and 2 are marked as "completed" and objective 3 is marked as "ongoing" **(Exhibit JT/89) [INQ0014474].**

84. 41. The appraisal form provides the following information on training attended or due to be attended by Letby during the year:

Course	**Date completed**
Developmental care meeting	26 February 2013
Neonatal induction programme	28 March 2013
Face to face safeguarding children	12 March 2013
NLS	2 June 2013
Annual Neonatal Nurse update	17 June 2013
Information Governance	2 September 2013
Focus on father's study day	10 October 2013

Palliative care study day	27 November 2013

85. On 6 September 2013, practice calculations were completed with Letby by Yvonne Farmer as intended from her one to one on 30 July 2013. She was observed inputting doses required into the alaris pump and the pump settings and safety features were discussed. Letby was deemed "competent" to use this equipment and calculate various drug doses by intermittent and continuous infusion.

86. In 2014 Letby completed a question and answer form in relation to the care of the neonate with a central line **(Exhibit JT/90) [INQ0014475].** The questions included reasons as why a neonate may require a central line, complications with a central line in-situ, observations to undertake and what to do if central line is difficult to flush.

87. Letby was re-assessed in relation to Band 5, 6 and 7 Equipment List Neonatal Unit (as set out above in relation to January 2013). She completed all training between January to September 2014.

88. Letby completed her annual appraisal with Yvonne Farmer on 2 October 2014 **(Exhibit JT/91) [INQ0014476].** She completed a number of training sessions during the year which was as follows:

Course	**Date completed**
Mentorship	7 April 2014
Equality and Diversity	14 May 2014
Information Governance	14 May 2014
Safeguarding Children	14 May 2014
Resuscitation	19 May 2014
Annual NNU Update	17 July 2914
Fire	23 July 2014

89. A number of objectives were set for Letby as listed below:

Objective	**Action to be taken**	**Outcome**
To attend and complete the ITU course	To attend all study sessions and complete all course requirements	Completed and passed

To complete ITU placement at LWH to gain further ITU experience	TO work at the LWH to gain experience of ITU	Completed
To complete Information Governance re-fresher e-learning	To completed e-learning online	Completed
To attend Chaps course	To book onto the course and attend course	Completed

90. On 16 October 2014, Letby completed a self-verification of competencies in relation to Tecotherm Neo medical device. Letby ticked 'yes' to all the competencies required. **(Exhibit JT/92) [INQ0014477].**

91. Letby became a Neonatal Practitioner in March 2015 following completion of a 'Development of Special and Intensive Care of the Newborn' course at Liverpool John Moore's University/Liverpool Womens NHS Foundation Trust.

92. On 31 May 2015, Letby completed a competency assessment for the Safe Administration of Medication by bolus/intermittent administration via a Long Line, Broviac Line or umbilical venous catheter **(Exhibit JT/93) [INQ0014478]**. The assessor was **Nurse T**. Letby passed the assessment. On the same day, Letby also completed a supervised drug administration to a central IV Bolus assessment. She was assessed on preparing and administering caffeine, ben pen, TPN and lipid, sodium chloride, lipid and 10% glucose. The assessors' ticked 'yes' to Letby adhering to correct procedure and action/side effects being discussed **(Exhibit JT/94) [INQ0014479].**

93. On 2 June 2015, Letby completed a competency assessment for collecting blood using Bloodhound **(Exhibit JT/95) [INQ0014480]**. The assessor was Trish Brown. All of the competencies were achieved by Letby and as such, she achieved a pass.

94. In April 2016, Letby produced a reflective piece following a drug error. The mistake related to Letby and a colleague giving a baby Gentamicin when it was not due and had not been prescribed. Letby noted that she was "*disappointed in her clinical practice and role as a nurse*" and the impact this had had on a baby and the team. Letby stated that, upon reflection, due to administering multiple antibiotics all due at a similar time, caring for her own patients and supporting junior members of the team when the Unit was not fully staffed, the situation was "unavoidable," and care was given to the best of ability. Letby

concluded by stating that she did not feel anything could be added or changed to prevent a recurrence but that she needed to develop her own professional role to ensure she adhered to protocol at all times to make sure a mistake like this did not happen again. **(Exhibit JT/96) [INQ0014481]**.

95. Letby completed a blood transfusion workbook on 11 May 2016. This included answering questions in relation to when to put in a UVC/UAC and potential complications of having a UVC/UAC in-situ, for example, and completing a transfusion competency assessment and observational assessment. The workbook is signed off by C Barnard **(Exhibit JT/97) [INQ0014482]**.

Management response to concerns about the neonatal unit and/or Letby

96. The Trust has been asked to set out from January 2012 (when Letby was first employed) each and every concern and/or complaint that was raised with the Countess Hospital management concerning either the neonatal unit and/or Letby.

97. Concerns and complaints raised by parents of babies on the neonatal unit during the relevant period are referred to elsewhere in my statement. The below paragraphs list those concerns and complaints raised about the neonatal unit and/or Letby which are deemed most relevant (relevant to the Inquiry's terms of reference) and that the Trust is aware of from a review of available documentation. Some of those concerns were logged as Datix incidents and some are concerns raised by those working within the neonatal unit. Please note that I have not at this stage listed each and every email or meeting which might have taken place in relation to the concerns raised by those working within the NNU and instead focussed on providing a summary of the chronology with regards to the concerns raised and subsequent action taken.

July 2013

98. A Datix incident was reported in relation to I&S for an incident on 22 July 2013. I exhibit this document as **Exhibit JT/98 [INQ0014483]**. Within the description it is noted that "*the Morphine Infusion was running at 1.32 ml/hour rather than the correct amount of 0.13 ml/hour. The dose was prescribed at 5 micrograms/kilogram/hour and was therefore infusing at 10 times the prescribed amount – (to micrograms/kilogram/hour)".* The staff nurse who handed over the baby's care was informed and the "*dose was re-checked and changed to the correct infusion rate. The nurse in charge of the shift was also informed,*

as well as the registrar and consultant on ward round". Shelley Tomlins (Neonatal Nurse) is detailed as reporting the incident and Angela Andrews and Letby are noted in the details of employee section.

99. On 23 July 2013, Letby had a one to one with Yvonne Griffiths (Deputy Neonatal Unit Manager) and it was noted that "*Letby had commenced a continuous infusion of Morphine at the end of her night shift*" and *"at 8am on handover infusion noted to be infusing at incorrect rate*." As part of the actions listed, Letby was to "*complete intravenous competencies/ drug calculation with practice development nurse (Yvonne Farmer)"*. I exhibit this document as **Exhibit JT/99 [INQ0014484]**. It is understood that a one to one meeting with Letby was held on 30 July 2013 with a subsequent note from Yvonne Farmer stating "*practice calculations completed with Letby*" and "*I am happy that Letby is competent to use this equipment and calculate various drug doses by intermittent and continuous infusion*". I exhibit this as **Exhibit JT/100 [INQ0014188]**. It was noted to review in 6 months.

March 2014

100. A Level 2 Root Cause Analysis report was completed in relation to the unexpected neonatal death of **I&S** on 24 March 2014. I exhibit this report as **Exhibit JT/101 [INQ0009291]**, which contains a detailed description of the incident. The investigation team included Dr Barnard (Consultant Paediatrician based at Glan Clywd Hospital, Chair), Dr Jayaram (Consultant Paediatrician), Doctor V, Dr Eyton-Chong (ST3 Registrar), E Powell (Neonatal Manager), L Eagles (Senior Neonatal Practitioner), C Jackson (Cheshire and Merseyside Neonatal Network Transport Service (CMNNTS) Nurse Consultant) and D Peacock (Risk & Patient Safety Lead for Women's & Children's Care). It was noted that "*medical and nursing rotas for this period were compliant with national standards and recommendations. The event did occur over a weekend*."

101. The root causes were listed as human error ("*failure in intubating the baby on two occasions*" and "*failure to realise that the tube was not correctly sited*"), "*lack of clarity over who had responsibility for the management of the baby once the transport team arrived*" and "*delay in receiving advice from the surgical team in Alder Hey.*" It was recommended that there be revision of the current intubation guidelines, use of adhesive documentation for the review of x-rays to highlight importance of reporting x-ray findings, further education session on the use of flow loops in the ventilators in the neonatal unit, disseminate information regarding who has clinical responsibility for the baby at each stage of the care,

when the transport team is involved and identify and address any training issues for middle and junior grade doctors in intubation skills.

April 2015

102. Within the Executive Directors Group (EDG) on 8 April 2015, with Tony Chambers, Mark Brandreth, Debbie O'Neill, Alison Kelly, Ian Harvey, Stephen Cross and Sue Hodkinson in attendance, it was noted that "*SW reported baby death over weekend. Review to be undertaken*". I exhibit the note of this meeting as **Exhibit JT/102 [INQ0003923]**

103. On 22 April 2015, there was an EDG meeting with Alison Kelly, Stephen Cross, Tony Chambers, Sue Hodkinson, Mark Brandreth and Ian Harvey in attendance. I exhibit the note of this meeting as **Exhibit JT/103 [INQ0003924]** It was noted that there was a "*neonatal case – coroner informed, no further action being taken by Coroner, SUI investigation continues, family briefed*."

June 2015

104. A Datix incident was reported in relation to Child A on 9 June 2015 following an incident on 8 June 2015. I exhibit this document as **Exhibit JT/104 [INQ0014192]**. It was reported that there was a "*sudden and unexpected deterioration and death of a patient on the Neonatal Unit after full resuscitation"* and that a post mortem was required. The employees involved were listed as Dr David Harkness, Dr Chris Wood, Melanie Taylor, Caroline Bennion, Letby, Jian Hor and Dr Racheal Lambie. It was noted that Minna-Maria Lappalainen was the reporter. The SBAR was completed on 12 June 2015 by Ruth Millward and it was noted that "*at present, there is no explanation for sudden cardio respiratory arrest."* The recommendation noted that the SBAR was "*to be forwarded to SI panel for review and to determine the level of investigation required*."

105. Another Datix incident was received in relation to Child A on 29 August 2015 for an incident on 8 June 2015. I exhibit this document as **Exhibit JT/105 [INQ0014193]**. It was noted that on reviewing the notes "*the maintenance dose of caffeine was prescribed 12 hours after loading dose rather than 24 hours after the loading dose (which is the usual case)*" and that Baby A "*passed away 12 hours later*." It was also noted that "*it was not clear from the notes if the medication was given early in error or because the baby was still having apnoeas for which this medication is the treatment*." Within the description it

was detailed "*I do not think this incident is responsible for the apnoea and subsequent death which happened 12 hours later as Caffeine is in fact the treatment for that.*" It was noted that there needed to be a review of the incident in the neonatal review meeting and to disseminate information about documentation for reasons.

106. The reporter was listed as Murthy Saladi and the employee involved as Melanie Taylor.

107. On 14 June 2015 a Datix incident in relation to Child C was reported by Yvonne Griffiths following "*sudden deterioration of an infant following full resuscitation*". I exhibit this document as **Exhibit JT/106 [INQ0014194]**. The employees involved were listed as Amy Usher, Rosalind Harris, Mr Semple, Lauren Witham, Dr Victoria Finney, Dr Lorraine Dinardo and Mr McCormack.

108. The incident was discussed at a SI Panel Meeting on 2 July 2015 with Alison Kelly, Sian Williams, Ruth Millward, Stephen Brearey, Julie Fogarty and Debbie Peacock noted to be in attendance. I exhibit this document as **Exhibit JT/107** **[INQ0003229]**

109. A Datix incident in relation to Child C was reported on 16 June 2015 as "*no notification of the death was passed to the Newborn Hearing Screening Team*". I exhibit this document as **Exhibit JT/108 [INQ0014196]**. The incident was reported by Nicola Evans.

110. On 22 June 2015, Stephen Brearey sent an email to Ravi Jayaram copying in Eirian Powell, Elizabeth Newby, Murthy Saladi, Debbie Peacock and Joanne Davis in which he confirmed that he had met with Eirian and reviewed the case notes of Child D. I exhibit this email chain as **Exhibit JT/109** **[INQ0003110]**. It was noted "*we have also discussed whether there are any other issues to address in view of the two other recent sudden deaths on NNU.*" Stephen set out in his email in regard to the three deaths that:

- *"All deaths occurred in room 1, our intensive care room, but in different cot spaces.*
- *All microbiology results have been negative to date.*
- *Initial post mortem results for"* Child A *"did not identify any definite cause of death, although* **I&S** *were detected in his blood, presumably following placental transfer. The other two PMs are in process."*
- Child D *"was not on TPN and died less than* PD *days of age, so nosocomial infection is very unlikely.*
- *There does not seem to be any staff (medical or nursing) members present at all three episodes other than one nurse, who was not the nurse responsible for"* Child D *"on that shift.*"

111. An action plan was agreed that Stephen will review Child A and Child C's case notes in detail, review Child A's preliminary post-mortem report, discuss with microbiology and ask them to review all the results and Eirian Lloyd Powell was to check that all the "*thermometers used, the incubators used and that the antibiotics prescribed and signed f or were actually given*."

112. Eirian Powell replied to Stephen's above email on 25 June 2015 to advise that "*the 3 babies were nursed in different incubators*", that the thermometers were checked and were in good working order and that "*the antibiotics that were prescribed were given as per Emar*."

113. On 23 June 2015, a Datix incident was reported for Child D in relation to an incident on 22 June 2015. I exhibit this document as **Exhibit JT/110 [INQ0014198]**. Child D was admitted to the neonatal unit "*with poor respiratory effort*." It was noted that her condition later "*deteriorated and baby's skin became extremely mottled. At 03:45hrs baby's condition deteriorated and full resuscitation was required – baby did not recover and died at 04.25hrs*." It was noted that the Head of Urgent Care and the clinical risk facilitator were contacted with a review completed by the Neonatal Lead Consultant and Manager to "*ascertain if there were any commonalities or poor standards of care. There were none found.*" Caroline Oakley reported the incident and the employee involved was listed as Dr Elisabeth Newby. Debbie Peacock noted that she met with Eirian Lloyd Powell to review the case notes and to discuss whether "*there are any other issues to address in view of the two other recent sudden deaths on NNU*." The incident was also discussed at the SI Panel meeting on 2 July 2015.

114. On 26 June 2015, an email was sent from Ruth Millward to Alison Kelly, Ian Harvey, Sian Williams and Sarah Harper-Lea copying in Mary Crocombe, Debbie Dodds and Dean Bennett providing SBARs for review and noted "*we have 3 neonatal deaths under review via speciality M&M. The plan is to arrange a speciality specific SI Panel for next Friday 3rd July to go through all 3 cases*."

115. A Datix incident was reported in relation to Child D on 29 June 2015 following an incident on 20 June 2015 when it was noticed that Child D "*was dusky and blue in colour*." I exhibit this document as **Exhibit JT/111 [INQ0014199].** It was noted that Child D was taken into nursery 1 and was then placed on sp O2 monitoring and "*placed in an incubator and observed to be apnoeic*." The shift leader and ward manager were noted to be

informed. The reporter was Lisa Walker (Nursery Nurse) and the employee involved was Dr Ahmed Chowdhury.

July 2015

116. There was a SI Panel Meeting on 2 July 2015 in which the death of Child A was discussed. Alison Kelly (Director of Nursing & Quality), Sian Williams (Deputy Director of Nursing & Quality), Ruth Millward (Head of Risk & Patient Safety), Stephen Brearey, Julie Fogarty and Debbie Peacock were noted as being present. It was noted that Child B *"had similar difficulties, now recovered and ready for home"* and that it was a "*complex case*" and "*may be related to maternal disease*."

117. It is understood that around this time Eirian Powell had undertaken a staffing analysis and had identified that Letby was present for all 3 recent child deaths.

118. On 13 July 2015, a Datix incident for Child B was reported in relation to an incident on 16 June 2015 when the day PDbloodspot was missed. I exhibit this document as **Exhibit JT/112 [INQ0014200]**. The incident reporter was Carla Malpeli.

119. There was an Urgent Care Division meeting on 20 July 2015 with Mrs Cooper, Mr Ornsby, Ms Brown, Mrs Guatella, Mrs Scowcroft, Mrs Burnett, Dr Sedgwick, Dr Webster, Mr Newman, Dr Benton, Dr Rath, Dr Shandilya, Dr Chakraborty, Mrs Townsend, Mr Braimo and Dr Jayaram in attendance. Mrs Burnett went through the report and it was raised in the risk register section that the neonatal unit environment was "*not big enough - pseudomonas – Sr E Powell is concerned to drop this below maximum risk. Mrs Burnett asked the Board if we would agree to this being high and escalated higher. Dr Jayaram will speak to Sr. Powell and Dr Brearey for further information and feedback to Mrs Burnett and Mrs Brown*." I exhibit this document as **Exhibit JT/113 [INQ0003936]**

August 2015

120. On 4 August 2015, a Datix incident was reported in relation to the "*unexpected death following GI bleed*" of Child E on the same day. I exhibit this document as **Exhibit JT/114 [INQ0014202].** The incident reporter was noted as Letby. A SBAR Incident Overview was completed by Debbie Peacock (Risk & Patient Safety Lead) on 4 August 2015. I exhibit this document as **Exhibit JT/115 [INQ0002660]** The review noted that Child E "*had a sudden deterioration at 23.40 hours with bradycardia down to 80-90 bpm*" and "*there was*

a noted colour change over the abdomen, purple discoloured patches." Child E later had a cardiac arrest and a decision was made to stop resuscitation. It was discussed with the coroner and "*no PM/inquest required.*"

121. A SI Panel meeting in relation to Child E took place on 13 August 2015 with Ian Harvey, Alison Kelly, Ruth Millward (Head of Risk & Patient Safety), Dean Bennett (Compliance Manager) and Sarah Harper-Lea (Head of Legal & Complaints) marked as being in attendance. It was noted that the "*likely cause of death was NEC*" and it would be discussed in neonatal review.

122. On 28 August 2015, a Level 2 Root Cause Analysis Investigation Report was completed in relation to Child D. I exhibit this document as **Exhibit JT/116 [INQ0014204]**. The investigation team included an Obstetric Secondary Review team and a Neonatal Review Team which consisted of Stephen Brearey, Eirian Lloyd Powell, Yvonne Griffiths and Debbie Peacock. It was noted that "*the incident was escalated to the Medical Director and Director of Nursing & Quality and was subsequently discussed at an extraordinary Executive Serious Incident Panel.*" It was flagged that "*there had been three neonatal deaths in a short period of time and circumstances were discussed to identify if there was any commonality which linked the deaths. Two of the babies had medical conditions which could be clearly seen to have contributed to their deaths. The third baby appeared to be an unexplained death and, at this time, this baby's cause of death was unknown. It was agreed that no further investigation was warranted at this stage as there were no concerns highlighted in the obstetric or neonatal reviews; however the SI Panel were of the opinion that the Obstetric Secondary Review findings and the Neonatal Review findings should be consolidated into one report on a Level 2 template.*"

123. Within the Level 2 report it was identified that "*The Paediatrician did not identify that the baby had two risk factors for sepsis when he initially reviewed the baby and therefore did not admit the baby to the NNU as the baby appeared to be clinically well at that point. However, as soon as the observations were noted to be outside normal limits, the baby was transferred to the NNU, investigations were undertaken and IV antibiotics were administered.*" There was also no root cause identified and it was noted that the post mortem results were awaited. The report was to be discussed at the morbidity and mortality meeting (joint meeting with Obstetric medical and midwifery staff and neonatal medical and nursing staff), the neonatal morbidity and mortality meeting, to be shared with Neonatal Network via Quarterly Report, to be presented to junior neonatal medical staff and the lessons learnt to be shared with Urgent and Planned Care Divisional Board

meetings. The report notes the incident was reported to the CCG and CQC and the distribution list includes Trust Executives, QSPEC, Urgent Care Divisional Board, Planned Care Divisional Board, Women's & Children's Care Governance Board and CCG.

September 2015

124. On 6 September 2015, a Datix incident was reported in relation to the "*respiratory/ cardiac arrest*" resulting in the death of I&S. I exhibit this document as **Exhibit JT/117 [INQ0014205].** It was noted that they had "*3 episodes of desaturation requiring facial oxygen*" and "*at 02.55 baby desaturated*." They had "*final bradycardiac arrest from 04.22" and "resus stopped at 0450*." Nurse X was detailed as the incident reporter and Deborah Worrall as the employee involved.

125. Within a EDG meeting on 9 September 2015, with Tony Chambers, Mark Brandreth, Sue Hodkinson, Stephen Cross, Ian Harvey, Lorraine Burnett, Sian Williams and Sue Phillipson in attendance, it was noted that "*SW reported that a baby death had been reported to STEISS and an investigation was taking place*." I exhibit this document as **Exhibit JT/118 [INQ0003200]**

126. An Executive Summary of perinatal mortality surveillance report (UK perinatal deaths from births January to December 2013) dated 7 September 2015 was noted to have been received by the Clinical Improvement & Assurance Group. I exhibit this document as **Exhibit JT/119** [INQ0003576]. The report was by Dr J Davies (Consultant Obstetrics & Gynaecology) and Dr S Brearey (Consultant Paediatrics). There were noted to be 18 deaths including late fetal loss, still birth, early neonatal deaths, late neonatal deaths and post neonatal deaths. The adjusted neonatal mortality rate was noted to be "*up to 10% higher than UK average*" but that "*this discrepancy may be due to classifying babies born 22-24/40 as neonatal deaths rather than stillbirths*." It was noted that "*all neonatal deaths are subject to multidisciplinary local and network review and at this time we do not feel any further review is necessary*." An addendum was added on 19 June 2016 by J Davies and the figures were updated with "*Trust specific data for all perinatal data*" as the data previously used were "*patients from West Cheshire. However we do care for patients from other areas and this reflects the change in data*." The neonatal death rate was then said to be "*up to 10% lower*" on comparison to the average for similar Trusts and Health Boards.

127. On 27 September 2015, a Datix incident was reported in relation to the death of I&S I&S after full resuscitation. I exhibit this document as **Exhibit JT/120 [INQ0014208]**. The incident reporter was noted as Laura Eagles.

October 2015

128. On 1 October 2015, a Datix incident was reported in relation to Child I for an incident on 30 September 2015 when an antibiotic infusion was administered over 10 minutes instead of 30 minutes and the "*correct dose was given*" but "*delivered at a faster rate*". I exhibit this document as **Exhibit JT/121 [INQ0014209]**. The infusion was adjusted when they were aware of the mistake and the registrar, shift leader and unit manager were to be informed. The incident reporter was noted as Miss Bernadette Butterworth.

129. A Datix incident in relation to Child I was reported on 13 October 2015 when they required blood and bloodhound scanned ID but did not accept the pin number and they utilised the switch at the back of the fridge. I exhibit this document as **Exhibit JT/122 [INQ0014210]**. It was noted that medical staff and haematology were aware and the unit manager was emailed. The incident reporter was Ms Caroline Oakley (Senior Neonatal Practitioner).

130. On 23 October 2015, a Datix incident was reported in relation to when Child I "*arrested and was intubated and received full resuscitation*" and then "*collapsed again an hour later and did not respond to resuscitation.*" I exhibit this document as **Exhibit JT/123 [INQ0014211]**. The incident reporter was Ms Caroline Oakley.

131. Around this time it is understood that Eirian Lloyd Powell undertook a further staffing analysis which showed that Letby was on shift for seven of the recent deaths.

132. Eirian Lloyd Powell sent an email to Stephen Brearey on 23 October 2015, copying in Debbie Peacock, Anne Murphy and Yvonne Griffiths with the subject "*mortality 2015.*" I attach this as **Exhibit JT/124 [INQ0014212]**. She advised that she had "*discussed the above with Anne Murphy and on reflection it was decided to leave this until Monday. Alison Kelly was not in the hospital and Sian had left as was not well.*" Eirian stated that she had "*devised a document to reflect this information clearly and it is unfortunate that she was on – however each cause of death were different, some were poorly prior to their arrival on the unit and the other were ?NEC or gastric bleeding/congenital abnormalities."* It was

noted that she would see Stephen on Monday and would discuss further with Debbie on Monday.

133. On 27 October 2015 Eirian Lloyd Powell sent an email to Stephen Brearey, copying in Yvonne Griffiths and Debbie Peacock. I exhibit this as **Exhibit JT/125 [INQ0014213]**. Eirian advised that she had "*spoken at length with Debbie this morning in relation to the mortality rate for this year. It was decided that it was necessary to create a table that includes all doctors that was involved with the deceased patients on the unit. This would then ensure that all avenues have been addressed. Debbie was of the same opinion that we did not think there was a connection – however we would be highlighting the issues once the report has been completed.*"

Review of neonatal deaths and stillbirths

134. In November 2015 there was a review of neonatal deaths and stillbirths between January 2015 and November 2015 "*in response to a perceived increase in number of Stillbirths and Neonatal deaths at the Countess of Chester Hospital (COCH) in 2015.*" I exhibit this document as **Exhibit JT/126 [INQ0003589] [INQ0003590] and [INQ0003591]**. A panel was set up "*to independently review all of these cases again on an individual basis to identify any common themes or trends and lessons to be learnt.*" The review team consisted of Dr S Brigham (Consultant Obstetrician & Gynaecologist, Lead for Obstetric Risk – Chair), Dr J Davies (Consultant Obstetrician and Gynaecologist, Clinical Lead for Obstetrics and Gynaecology), Mr J McCormack (Consultant Obstetrician and Gynaecologist, Lead for Obstetrics and Gynaecology), Julie Fogarty (Head of Midwifery), Gwenda Jones (Supervisor of Midwives), Lesley Tomes (Retired Head of Midwifery and External Supervisor of Midwives), Debbie Peacock (Patient Safety Lead) and Lorraine Milward (Practice Development Midwife).

135. The stillbirth and neonatal deaths "*were identified utilising Neonatal Badger system and DATIX reporting systems.*" 18 cases were identified of either stillbirth or neonatal death with three not included in the review due to their diagnoses. It was noted that "*no new issues were identified from the review.*" It was concluded that they would "*continue to review each case of still birth or neonatal death on an individual basis within the multidisciplinary review processes in place - Obstetric Primary review, Obstetric Secondary review, Perinatal Mortality and Morbidity and Neonatal reviews. Some additional actions have been identified from the review and will be completed as per action plan*".

December 2015

136. A Datix incident was reported on 14 December 2015 in relation to I&S when she required resuscitation on 12 December 2015. I exhibit this document as **Exhibit JT/127 [INQ0014217]**. When the emergency drug box was opened the adrenaline "*had expired 05/2015*" and the "*sodium bicarbonate 4.2% had expiry date of Dec 2015.*" The "*drug box was removed from the Unit and returned to the Pharmacy who were informed of the problem.*" The incident reporter was noted to be Letby.

137. A Datix incident was reported in relation to an incident with I&S on 13 December 2015 which was reported on 1 February 2016. I exhibit this document as **Exhibit JT/128 [INQ0014218]**. During the "*ongoing resuscitation*" of the baby, the "*Neonatal Consultant on call requested Ambisone (anti-viral drug) to be given. Drug should be available on ward 30- contacted but drug expired.*" The on-call pharmacist was called and came to the neonatal unit with the drug and helped prepare the drug. There was a "*delay in treatment*" because the pharmacist was off site. The incident reporter was Nurse W.

138. On 15 December 2015, a Datix incident was reported in relation to I&S following her "*neonatal death*" on 13 December 2015 as "*Cheshire & Mersey Neonatal Transport team unable to collect baby for 12 hours*". It was noted that "*baby had arrested several times, and arrested again within minutes of them arriving. Resuscitation on this occasion unsuccessful.*" I exhibit this document as **Exhibit JT/129** [INQ0002661]. The incident reporter was Yvonne Griffiths.

139. A SBAR was completed in relation to I&S and the "*Consultant Neonatologist prescribed the second dose of Gentamicin to be given at 24 hrs instead of 36hrs in line with the policy for a very sick baby.*" The pharmacist reviewed the medication and advised if the "*gentamicin level above 2mg/l please withhold the dose and wait 12 hours – once level <2mg/l give dose. The second dose due at 16:30 hrs (24 hrs after the first dose, initially prescribed the previous day by the Consultant) had been crossed out on the chart and was not given as per pharmacists advice.*" The baby "*suffered 3 cardiac arrests requiring resuscitation during that night. A second dose of Gentamicin was prescribed and administered at 09:30 12/12/2016 41 hours after the 1st dose.*" The transport team were going to be delayed due to attending another case and the infant suffered "*2 further episodes of desaturation and bradycardia before the transport team*

arrived" and "*at this point the infant was too unstable to transfer*" and died at 03:50 on 13 December 2015. It was noted that "*once the decision was made to transfer the baby to LWH there was a 12 hour delay due to their capacity*" and that the network issue had already been added to the risk register and "*this needs to be flagged to the network as possibly contributing to the death of this patient.*"

140. The incident in relation to I&S was discussed at a SI Panel Meeting on 25 January 2016 with Alison Kelly, Sian Williams, Dean Bennet and Sarah Harper-Lea in attendance. It was noted that "*there is a Neonatal Thematic Mortality review being undertaken and that they are bringing in a Consultant from Liverpool Women's to help.*" Two issues were raised by Sian, one was "*Neonate staffing levels as a result of a paper that has been published, it shows we are understaffed, the second around concerns regarding a Locum that NNU are not happy to have working there.*" It was agreed that the issues needed "*wider Exec escalation and everyone to sit around a table and discuss.*"

141. A note was added on 20 April 2016 that a meeting was held between the "*Consultant Neonatologist, the Director of Pharmacy, NNU manager and R&PSL (SB, CG, EP, JMcM)*" in relation to I&S and "*an error the pharmacist made in advising about gentamicin administration".* They discussed that the pharmacist was covering maternity leave but "*NNU was not her usual field of expertise however she is an experienced and competent professional.*" The pharmacist advised that she "*discussed her query with the registrar and experienced neonatal nurse who did not challenge her advice. The pharmacist and neonatal nurse have both reflected that in future they would extend this query to the Consultant.*" It was noted that "*the unconfirmed diagnosis of sepsis was also discussed in that all microbiology investigations came back negative, despite an obvious clinical picture of sepsis and a number of infection markers. Further investigation into this was not now possible due to the time frame.*"

<u>January 2016</u>

142. On 11 January 2016 a Datix incident in relation to I&S was submitted in relation to her death. I exhibit this document as **Exhibit JT/130 [INQ0014220]**. It was noted that she had a "*bradycardia secondary to desaturation while ventilated on the neonatal unit*" with "*successful CPR, with return of spontaneous circulation after 25 minutes.*" She had a further episode of desaturation 45 minutes later leading to bradycardia and then asystole with CPR commenced which was later withdrawn due to poor chance of survival.

The neonatal manager was aware and the coroner informed. The incident reporter was Nurse X.

143. It is understood that around this time further staffing analysis showed that Letby was present for all the recent baby deaths since the last analysis.

144. In January 2016 Stephen Brearey sent an email to Debbie Peacock, Eirian Lloyd Powell, Ravi Jayaram, Anne Murphy and Yvonne Griffiths, copying in Joanne Davies. I exhibit this email as **Exhibit JT/131 [INQ0003113]** Stephen advised that he had discussed the "*increased mortality with Nim after the network meeting yesterday. He would be happy to be an external panel member for a mortality review.*" Nim [Dr Nim Subhedar, lead neonatologist of the Cheshire and Merseyside Neonatal Network] suggested just reviewing the cases they are uncertain about the diagnosis for and Stephen advised they had reviewed three in detail and was "*not sure of the benefit of going over them again at this time*" which would leave six babies to review. He asked if Debbie would arrange a meeting date and place to discuss the cases, if everyone agreed, and then he would liaise with Nim about an external reviewer.

February 2016

145. A thematic review was undertaken in February 2016 which is detailed later in this statement.

146. On 9 February 2016, a Datix incident was reported in relation to **I&S** for an incident on 7 February 2016. I exhibit this document as **Exhibit JT/132 [INQ0014222]**. He required emergency blood "*during a resuscitation on the Unit*" but access was denied to the fridge for two staff members who were advised to "*press the 'Emergency' button displayed on the screen – when doing so screen stated that log in had failed and screen then went blank. Unable to press anything.*" The blood was issued by the lab and obtained by a porter, arriving at the neonatal unit approximately 15 minutes later. It was noted that Letby was the incident reporter.

147. A further Datix incident was reported on 9 February 2016 in relation to **I&S** following an incident on 7 February 2016. I exhibit this document as **Exhibit JT/133 [INQ0014223]**. It was noted that **I&S** "*deteriorated on Unit, 2 episodes of resuscitation required*" and he "*was transferred to Liverpool Women's Hospital where he later passed away*" Letby was noted as the incident reporter.

148. On 23 February 2016, a Datix incident was reported in relation to I&S being "*identified as RSV positive, nursed in Nursery 2.*" I exhibit this document as **Exhibit JT/134 [INQ0014224]**. It was noted that the bay was closed to limit patient movement and "*standard and contact precautions to be maintained.*" The action taken section included that "*all relevant staff informed of bay closure – monitored via the Infection Prevention and Control Team to ensure that any closed beds return to service at the earliest opportunity.*" The incident reporter was Alison Jenkins.

149. The CQC sent a letter to Mr Chambers dated 25 February 2016 advising that "*analysis of maternity indicators undertaken by the Care Quality Commission has indicated significantly higher rates of puerperal sepsis and other puerperal infections within 42 days of delivery at your trust.*". I exhibit this letter as **Exhibit JT/135** **[INQ0004936]** They advised that they had previously written on "*19 May 2015 to inform you that this outlier alert had been passed to your local CQC inspection team who would follow up on your progress with implementing the one outstanding action, along with the outcomes of your monthly audit.. Your local inspector has now confirmed that they are satisfied that sufficient action has been taken to reduce the risks to patients in relation to issues identified by your review of the alert. As a result, this outlier case has now been closed".*

March 2016

150. On 2 March 2016, Stephen Brearey sent an email to Ravi Jayaram, John Gibbs, Doctor V, Doctor ZA, Susie Holt, Murthy Saladi, Eirian Lloyd Powell, Yvonne Farmer, Yvonne Griffiths, Anne Murphy, Nim Subhedar and Chris Green, copying in Janet McMahon, Joanne Davies and Ruth Millward. Stephen advised that he had "*brought together all the summaries of the reviews of care into this thematic review report*" and noted that the report included "*themes identified and an action plan.*" He flagged that "*Ian Harvey had asked if this can be joined up with the obstetric review.*" Stephen Brearey forwarded this email to Eirian Lloyd Powell and copied in Ravi Jayaram stating "*I think we still need to talk about Letby, maybe when you are back and free the three of us can meet and talk about it?*" I exhibit this document as **Exhibit JT/136** **INQ0003114**

151. On 7 March 2016, a Datix incident for I&S was reported in relation to her death on the neonatal unit following resus. I exhibit this document as **Exhibit JT/137 [INQ0014227]**. The incident reporter was Nurse T.

152. On 8 March 2016, a Datix incident was reported in relation to I&S on 3 March 2016 and it was noted that "*infant had a septic screen carried out for temperature instability and low blood sugars approx. 11:00*" and "*Cefotaxime prescribed and given via Broviac line. Glucagon and 20% glucose infusions were running via Broviac*." A telephone call with the pharmacist *"informed that Teicoplanin is not compatible with a Glucose concentration of 20% and NO drugs are compatible with Glucagon. Advised that due to incompatibilities of the infusions they could not guarantee what/if any benefit the Cefotaxime given earlier in the day had had*." It was noted that the doctors and shift leader were informed. The incident reporter was detailed as Letby. The action taken noted that "*IM Cefotaxime given as difficulty obtaining peripheral access. Peripheral line sited and Teicoplanin given*." I exhibit this document as **Exhibit JT/138 [INQ0014228]**.

153. Another Datix incident was reported on 8 March 2016 in relation to an incident on 3 March 2016 in relation to I&S. I exhibit this document as **Exhibit JT/139 [INQ0014229]**. It was noted at 20:00 that "*Teicoplanin had not been given as per sepsis guideline – infant had a Broviac line in situ*." The doctors were informed and Teicoplanin was prescribed with a "*further delay in administering due to lack of access*." The incident reporter was Letby.

154. Eirian Lloyd Powell sent an email to Stephen Brearey, copying in Yvonne Griffiths and Anne Murphy, on 15 March 2016 setting out:

"*Just out of interest these are our following numbers:*

2010 2

2011 2

2012 3

2013 2

2014 3

2015 8

2016 2 (to date)

Letby commenced working on the NNU in January 2012." I exhibit this email as **Exhibit JT/140 [** [INQ0005697] **]**

155. On 17 March 2016, Eirian Lloyd Powell sent an email to Alison Kelly copying in Stephen Brearey, Ravi Jayaram, Yvonne Farmer, Yvonne Griffiths and Mary Crocombe. I exhibit this email as **Exhibit JT/141 [INQ0014231]**. Eirian stated that she "*was hoping that we could arrange a meeting with you how to move forward with regards to our findings.*

1. *High mortality – 8 as opposed to our normal 2 to 3 per year*

2. *A commonality was that a particular nurse was on duty either leading up to or during. (this particular nurse commenced working on the unit in January 2012 without incident).*
3. *A doctor was also identified as a common theme however not as many as the nurse*".

156. Eirian advised that "*despite reviewing these cases there was nothing obvious that we were able to identify – therefore your input would be valued. I have been informed that Ian Harvey is aware that we have had an external thematic review.*"

157. Alison Kelly replied to the above email on 21 March 2016 asking that Eirian "*send Ian and I the report in the first instance, then once we have reviewed this, I think it would be good for me, you, Ian and Steve/Ravi to meet to discuss.*" I exhibit this as **Exhibit JT/142 [INQ0014231]** Eirian Lloyd Powell sent an email on 14 April 2016 to Alison Kelly copying in Yvonne Griffiths, Stephen Brearey and Anne Murphy to ask "*what your thoughts were going through the thematic review? I noticed that the thematic review did not include the medical team that were involved. I have therefore attached the document that includes this.*" I attach this as **Exhibit JT/143 [INQ0005702]**

April 2016

158. On 13 April 2016, a Datix incident was submitted in relation to an incident with Child M on 12 April 2016. I exhibit this document as **Exhibit JT/144 [INQ0014234]**. A long line "*was inserted into left ante-cubital fossa for a premature baby*" on the neonatal unit. It was noted that the line snapped into two and that the "*whole length of the guide wire and long line both accounted for and both measured to confirm no residual parts left behind in baby*" and there was a repeat chest x-ray which was normal. One action was "*feedback to manufacturers arranged.*" The incident reporter was Dr Anthony Ukoh.

159. On 18 April 2016, Alison Kelly emailed Ian Harvey advising that since their last one to one "*there are a few things other things that require consideration.*" I attach this as **Exhibit JT/145 [INQ0003121]**. She flagged that there was an outstanding Datix which Stephen Brearey had not provided an initial review on which was highlighted at SI panel and asked him to chase Stephen Brearey. Alison stated that the "*NNU review doc that was sent to us was indeed the review with the Consultant from Liverpool Women's (attached). Eirian (NNU Manager) has also sent through a separate doc with the clinical details and the teams involved.*" She also set out "*the above is not going to QSPEC today but thought it*

will need to go to Mays meeting, however, before then, I suggest we meet with the Steve and Eirian early May to check on actions as a few are due to be completed in April - would welcome your comments."

160. In April 2016, Letby documented a reflection on drug error when an "*error occurred when Gentamicin was given when it was not due and had not been prescribed.*" I exhibit this as **Exhibit JT/146 [INQ0014236]**.

May 2016

161. A review of the neonatal unit 2015-16 was undertaken. I exhibit a document of this review as **Exhibit JT/147 [INQ0014237]**. Within the document it is noted:

- "*there is no evidence whatsoever against LL other than coincidence. LL works full time and has the Qualification in Speciality (QIS). She is therefore more likely to be looking after the sickest infant on the unit. LL also avails herself to work overtime when the acuity or unit is over capacity.*"
- "*there are no performance issues, and there are no members of staff that have complained to me or others regarding her performance.*"
- "*I have found LL to be diligent and have excellent standards within the clinical area.*"
- "*whilst our mortality rate has risen in January 2016- January 2016 we have had x3 mortalities from January 2016 to date (May 2016) x2 died due to congenital abnormalities.*"
- "*Dr. H and Dr. G (Consultant) appears to be involved in many of the mortalities.*"
- "*The Cheshire and Mersey transport service have been involved in a few of these mortalities and they may have survived in the service was running adequately.*"
- "*Alderhey's children's hospital's failure in facilitating a cot also added to the complexities of these mortalities. If there had been a bed sooner the infant may not have died.*"
- "*Some of the issues were related to midwifery problems*"
- "*Two of the babies PM's diagnosed Congenital Pneumonia – transport team issue*"
- "*4 babies had congenital abnormalities*"
- "*1 maternal syndrome*"
- "*2 with ? necrotising enterocolitis*"
- "*1 Overwhelming sepsis – transport team issue*"
- "*AHCH cot availability – 6 admissions between LWH/AHP and COCH*"
- "*Of all the post mortem results there was no evidence of foul play*"

162. Within the actions of the review document, it was noted that a debrief had been held, a thematic review was held and led by an external neonatologist, the mortalities had been highlighted to the ODN and discussed at the meetings. It was noted that "*Debbie Peacock was aware of the commonalities of both the nursing and medical staff. In order to ensure that we support this particular practitioner I have brought her onto days to ensure that she is well supported.*" It was also noted that "*any profound event is monitored closely irrespective of members of staff involved.*"

163. The review document sets out that there was a discussion between Dr Brearey, Anne Murphy and Eirian Lloyd Powell and that "*Karen Rees requested that we discussed exactly what issues (if any) where other than coincidence that was evidence. Despite highlighting the usual factors there was not real evidence or statement that could confirm whether there was an issue here.*" It was stated that "*the only consensus was that we needed advice as to what (if any) do we do next? We felt that we had highlighted any commonalities or themes and have escalated as necessary to the relevant health professionals to ensure transparency.*"

164. On 4 May 2016, Stephen Brearey emailed Alison Kelly copying in Eirian Lloyd Powell in response to an email chain about an alternative time for a meeting. I exhibit this email chain as **Exhibit JT/148** **[INQ0003087]** He set out that "*there is a nurse on the unit who has been present for quite a few of the deaths and other arrests. Eirian has sensibly put her on day shifts only at the moment, but can't do this indefinitely. It would be very helpful to meet before she is due to go back on night shifts. There is some pressure regarding staffing numbers with this at the moment.*"

165. Alison forwarded Stephen's email to Ian Harvey flagging Stephen's comments which "*alarmed*" her. I attach this as **Exhibit JT/149** **[INQ0003087]** She advised that "*since receiving this, I have asked Karen Rees to liaise with Eirian regarding this particular nurse" and that she was "currently reassured that there are no issues but I think this is worthy of a wider review hence our planned meeting.*" She advised a meeting had been arranged to review all the issues and that it was perhaps something to discuss in their one to one.

166. On 4 May 2016, Alison Kelly forwarded Stephen Brearey's above email to Karen Rees copying in Sian Williams asking them to "*look into this with Anne M/Eirian – if there is a staff trend here and we have already changed her shift patterns because of this, then this is potentially very serious.*" She also stated "*I will check the report they sent through – I did not notice there was a staff trend.*" I attach this as **Exhibit JT/150** **[INQ0003138]**

167. On 5 May 2016, Eirian Lloyd Powell sent an email to Karen Rees copying in Yvonne Griffiths, Stephen Brearey and Yvonne Griffiths thanking Karen for meeting with them that lunchtime. I attach this as **Exhibit JT/151 [INQ0014241]**. Eirian advised that they would like to have a meeting with Alison Kelly and Ian Harvey as a matter of urgency, "*primarily for reassurance and to ensure that we have covered all the relevant actions*."

168. On 16 May 2016, Stephen Brearey emailed Ravi Jayaram, Doctor V, John Gibbs, Murthy Saladi, Susie Holt, Selma Al-Wahab, Doctor ZA, Eirian Lloyd Powell and Anne Murphy. I exhibit this email as **Exhibit JT/152 [INQ0014242]**. He advised that he, Eirian and Anne had met with Ian Harvey and Alison Kelly the previous "*week to discuss the rise in neonatal mortality the previous year.*" Stephen advised they would be keeping a "*close eye on things in the immediate future"* and "*if you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on the NNU, please could you let me and Eirian know. We will keep a record of these cases and review them as soon as practicable*."

June 2016

169. On 9 June 2016, a Datix incident was reported as a patient had been prescribed IM cefotaxime but had a peripheral cannula in situ. I exhibit this document as **Exhibit JT/153 [INQ0014243]**. The peripheral cannula was flushed and patent and the prescription rewritten as IV and the dose given. The incident reporter was Nurse X.

170. On 26 June 2016, Stephen Brearey emailed Alison Kelly copying in Ravi Jayaram, Anne Murphy and Eirian Lloyd Powell stating that he hoped Karen had "*already spoken to you about our 2 mortalities last week*." He advised they were going to discuss them at the senior paediatricians' meeting and wondered "*if it might save time and meetings if you and Ian could join us at the meeting to discuss ongoing concerns*?" I attach this as **Exhibit JT/154 [INQ0014244]**.

171. Eirian Lloyd Powell made a note of her meeting with Anne Murphy and Alison Kelly on 27 June 2016 "*for an update regarding the mortality review meetings and the outcomes/ commonality.*" It was noted that "*this meeting was to ascertain how we felt with regard the accusations against LL. Apparently the Paediatric consultants had stated that we (as a collective) all felt the same i.e. agreed with them. We agreed to the external review as we did not wish to not consider ALL the possibilities but we did not or never had believed for*

an instant that LL was guilty of ANY wrong doing." I exhibit this as **Exhibit JT/155 [INQ0004855]**

172. On 27 June 2016, Alison Kelly sent an email to Eirian Lloyd Powell, Anne Murphy and Karen Rees, copying in Ian Harvey and Karen Townsend. I exhibit this as **Exhibit JT/156 [INQ0014246]**. She thanked them for "*meeting with Ian and I at short notice that afternoon to further discuss concerns raised by consultants colleagues at their lunchtime meeting*." She set out the agreed action points following the meeting which included:

- a "*microbiology/infection control review to be undertake within the NNU" and* that Alison and Ian would "*meet with the Consultant group re their concerns*"
- Eirian Lloyd Powell was "*to be mindful of staff allocation during shifts re LL to provide support, supervision etc.*"
- Ian was "*to identify Royal College Lead to facilitate External NNU review (multi disciplinary)*"
- Eirian was to "*check Datix submitted from the unit*," Alison was to "*request the Datix report from Ruth Millward about recent NNU submissions to identify any trends*"
- Alison was "*to contact NMC Professional support line to gain any further professional advice re current situation*"
- "*LL to remain on days for support, on Annual leave next week. EP, IH, AK, KR & AM to undertake a review of actions on Friday 1st July*"
- Eirian was "*arranging de-brief for unit staff this week following recent deaths x2, usual practice for the unit in these circumstances*"
- "*Mortality reviews to be undertaken next week*"
- Eirian was asked to *"review staff competences re skills and knowledge to support sick babies of varying levels of dependency*."

173. On 27 June 2016, Ian Harvey sent an email to Alison Kelly stating "*Steve claiming that all in the meeting, including Eirian and Anne Murphy, agreed nurse be excluded from patient contact! 180 deg about fact from them if that's the case – do you want to check*?"

174. Karen Rees emailed Stephen Brearey, Linda Guatella and Alison Kelly on 27 June 2016 to update that she had "*asked the Clinical Site Coordinators to support the Neonatal Unit over the weekend, by regular visiting (1 hourly) to pick up any issues and ensure that staff had breaks*." I exhibit this as **Exhibit JT/157 [INQ0014247]**. They confirmed there were no concerns escalated to them. She advised that "*there were twins delivered*" and that she was told "*both are doing well. No issues/concerns reported.*" Karen advised she had met with Alison in the morning and she was going to speak to Ian Harvey and arrange

to meet with Stephen and Ravi "*to discuss the concerns you have in relation to this staff member*." Karen noted that she had spoken to Eirian and updated her in relation to the events of the end of last week and that "*Eirian assures me that she has no concerns regarding the staff member's ability or competence*."

175. It is understood that on 27 June 2016, a meeting of a number of paediatricians and neonatal nurses took place at which concerns were discussed and it was agreed that Stephen Brearey would ask Ian Harvey to remove Letby from clinical duties. The consultants were subsequently notified that Letby would remain on day shifts that week before going on planned leave for two weeks.

176. On 28 June 2016, Karen Townsend emailed Ravi Jayaram to request his and his colleagues' availability for a meeting with Ian Harvey and Alison Kelly to discuss their concerns. Stephen replied to advise he would "*like to have this meeting before Thursday when there is a neonatal network meeting. This needs to be discussed with the network lead and I would like clarity regarding the Trust's position beforehand*." Karen provided time slots providing availability for Wednesday and Friday but Stephen advised he had arranged a meeting to discuss the care of one of the previous babies who had died on Wednesday. Stephen advised "*if Ian and Alison feel it is safe to wait til Friday, I will come in especially then*." I exhibit this document as **Exhibit JT/158 [INQ0014248]**.

177. On 28 June 2016, Stephen Brearey emailed Karen Townsend (Divisional Director, Division of Urgent Care) copying in Ravi Jayaram, John Gibbs, Ian Harvey, Alison Kelly, Eirian Lloyd Powell and Anne Murphy. I exhibit this email chain as **Exhibit JT/159 [INQ0014249]**. He advised he "*thought it might be helpful to put down in an email what was discussed at the senior paediatricians meeting yesterday lunchtime*." He set out that:

- "*We have significant concerns about the increased mortality on NNU, the sudden deterioration of apparently well babies with no cause identified and the presence of one member of nursing staff at these episodes*."
- "*There has been a watchful waiting approach since the last meeting with Ian and Alison in March. However, since the episodes and deaths last week there was a consensus at the senior paediatricians meeting that we felt that on the basis of ensuring patient safety on NNU this member of staff should not have any further patient contact on NNU*."
- "*We entirely agreed with Ian's suggestion for an external peer review and the RCPCH have undertaken these in other units recently. However, it does not address our immediate concerns regarding patient safety*."

- "*Other measures I think would be helpful would include a deep clean and reducing the number of allocated cots on NNU at least temporarily. 2 ICU cots and 3 HDU cots (rather than 3 and 4) would improve nursing staffing ratios and reduce the risk of nosocomial infection by making the space around the cots closer to BAPM standards*"

178. Stephen flagged that he understood that Ian and Alison had met with Eirian and Anne the previous day and that "*the outcomes from that meeting don't entirely fit with what was suggested at our senior paediatricians' meeting yesterday. Hence, it would be helpful to meet sooner rather than later, with nursing and medical colleagues together*."

179. Karen Townsend replied to the above email from Stephen Brearey advising that she was "*aware of the issue as raised by Ravi to me at out 1:1*." She set out what she understood the actions to be. Stephen Brearey replied with "*just to confirm them, Ian and Alison are happy for LL to work on NNU in the same capacity as last week despite the paediatric consultant body expressing concerns that this may not be safe and that we would prefer her to have further patient contact?*" He asked whether "*they are happy to wait til Friday before we can discuss this in person?*".

180. Karen Townsend emailed Stephen Brearey on 29 June 2016 to confirm the meeting date of 1 July with Ian and Alison and advised "*if you feel there is sufficient concern/evidence and your discussion should be brought forward can I suggest you speak directly with Ian as Medical Director*."

181. On 29 June 2016, Stephen emailed Karen Townsend to advise that he was "*unhappy with the way it has been managed this week. To make decisions against the wishes and concerns of the clinicians involved without discussing it with any of us first for a week seems a little odd and disrespectful*." I exhibit this email as **Exhibit JT/160 [INQ0014250]**.

182. Karen Townsend emailed Ian Harvey and Alison Kelly on 29 June 2016 making them aware of a series of emails she had received from Stephen and that "*there appears to be some anxiety as to whether Friday is soon enough for you to meet with the clinicians*." Ian Harvey replied to the email on the same day stating "*there is now email silence on this, I have spoken to Ravi, we are taking action and will keep you updated*." I attach this as **Exhibit JT/161 [INQ0014249]**

183. On 29 June 2016, a Datix incident was reported in relation to Child O's "*sudden collapse*" and "*full resuscitation*" on 23 June 2016. I exhibit this document as **Exhibit JT/162 [INQ0014252]**. It was detailed that Child O had died, "*cause as yet unknown.*" Letby was noted to be the employee involved and Eirian Lloyd Powell was the incident reporter.

184. A Datix incident in relation to Child O was reported on 30 June 2016 in relation to an incident on 23 June 2016 when he "*had a sudden acute collapse requiring resuscitation"* and *"Intraosseous access required - resources not available on Unit*". I exhibit this document as **Exhibit JT/163** **[INQ0008586]** The staff obtained the equipment from the Children's Ward with *a "delay in this happening due to staff being needed for infant care needs*." The incident reporter was noted to be Letby. On 25 July 2016, it was noted that the incident was reviewed at NNIRG with Stephen Brearey, Eirian Lloyd Powell, Annemarie Lawrence, Ailsa Simpson and Gemma Webster. It was noted that "*resources for intraosseous access are not routinely kept on NNU. However, there has been a recent increase in usage therefore ward manager EP has ordered one from the resus council and is awaiting delivery*."

185. Ravi Jayaram responded to an email from Murthy Saladi on 29 June 2016 copying in Ian Harvey, Alison Kelly, Anne Murphy, Eirian Lloyd Powell, John Gibbs, Susie Holt, Doctor V and Doctor ZA. I exhibit this email chain as **Exhibit JT/164** **[INQ0003411]**. Murthy raised in his initial email that they "*believe we need help from outside agencies, who can deal with suspicion. At the moment we are all under suspicion and the only agency who can investigate all of us I believe is the police. That is the only agency who can know our past history and our life outside the hospital, which might shed more light. I think we should pro-actively seek their help before we are forced because of further deaths. We will need to understand that those of us who are permanent staff and work on the neonatal unit of the trust will particularly be under investigation. I think this is better than acting ourselves on unreliable information, which opens ourselves to criticism in the future*." They also set out "*once we have reason to be suspicious we need to take appropriate action which in this case is submitting ourselves as a department for external investigation by an independent agency who can do these type of investigations. I am not sure who that is, but I don't think it will not be another clinical department who can only look at what is happening inside this hospital*."

186. Ravi Jayaram responded to Murthy's email advising that "*Steve and I are trying to meet with senior execs ASAP to discuss exactly this issue. However they do not seem to see*

the same degree of urgency as we do. Until we have met with them I am reluctant to go to an external non-medical agency ie police off my own back. I am going to speak to the MDU today to find out where I stand as lead for the service with regards to these concerns and I will share their thoughts with you all." I attach this as **Exhibit JT/165 [INQ0003411]**

187. On 28 June 2016, Ian Harvey responded to Ravi's above email to advise that "*this is absolutely being treated with the same degree of urgency - it has already been discussed and action is being taken. All emails cease forthwith*" and that they will share what action they are taking.

188. A Datix incident was reported in relation to Child P on 29 June 2016 in relation to his collapse and death on 24 June 2016. I exhibit this document as **Exhibit JT/166 [INQ0014256]**. It was noted that Letby was the employee involved and that Eirian Lloyd Powell was the incident reporter.

189. On 30 June 2016, a Datix incident was reported in relation to Child P when he had a "*sudden acute collapse requiring resuscitation*". I exhibit this document as **Exhibit JT/167 [INQ0008625]** It was noted that "*Sodium Bicarbonate infusion was required - nil Sodium Bicarbonate (other than resuscitation drug boxes which were already in use) available*." The bottle was obtained from the Children's Unit. The incident reporter was Letby. The incident was reviewed at NNIRG with Stephen Brearey, Eirian Powell, Annemarie Lawrence, Alisa Simpson and Gemma Webster and the "*group discussed storage and stock facilities on NNU*" with "*GW to chase stores to ensure adequate stock levels in future*" and Eirian to do "*weekly stock check to reduce the risk of incident reoccurrence*."

190. On 30 June 2016, a meeting took place between Tony Chambers, the paediatricians and various other staff. I exhibit a handwritten note of this meeting as **Exhibit JT/168 [INQ0014258]**. Tony Chambers explained that there had been an "*unexplained increase in deaths*" and in-depth medical reviews had failed to highlight a theme. Stephen Brearey raised the common theme of a nurse and it "*doesn't take away concern re this individual*." The note next to Ravi says "*concern potentially member of staff causing harm. Recurring theme*." An action plan is listed in the handwritten note.

<u>Position Paper – Neonatal Unit Mortality</u>

191. A position paper, dated July 2016, was compiled in relation to the neonatal unit "*to provide the Executive Team with key mortality data and supplementary narrative to enable*

an assessment of patient safety concerns identified by the neonatal clinicians relating to a perceived increase in the number of neonatal deaths during the financial years 2015/16 and 2016/17." I exhibit this document as **Exhibit JT/169 [INQ0004593] and [INQ0004594]**

192. Within the background section it was noted that "*in June 2015, the Neonatal Unit identified 3 deaths during a 2 week window.*" It was noted that a comprehensive review had taken place in February 2016 with a consultant from Liverpool Women's Hospital present and that a further 'deep dive' review was undertaken by the Neonatal Unit Manager. Within the report it is stated "*this nursing review led to further discussions regarding other possible, contributory factors including the medical devices used, infection control practices and staffing establishment and skill-mix. This review was discussed with the Medical Director and Director of Nursing & Quality in May 2016. Having reviewed the information presented, there were no obvious causes for concern and therefore a further meeting was agreed to take place in July 2016.*"

193. It was noted that the "*speciality highlighted their concerns regarding an apparent increased mortality rate*" following the death of two triplets in June 2016. A review was undertaken including reviews of babies who had died in 2015/16 plus cases since 2013 "*whereby baby's had deteriorated and were transferred to another hospital who subsequently died – in total 32 cases were reviewed*," staffing levels, actual staff on duty before and when babies deteriorated and died, levels of acuity, activity and external factors, security of NNU, equipment review, infection control review and NNU staff training, appraisal, competency and potential HR issues. Data from the Badgernet database was used with the aim of the analysis to "*review the significance of any increase in mortality levels*", "*evaluate activity levels*" as a "*possible contributory factor*" and "*to evaluate certain measures of acuity in NNU during 2015/16.*"

194. The findings of the review noted that:

- "*there has been a step change in mortality levels in the Neonatal Unit since June 2015. The monthly average numbers and the frequency of mortality over time have increased. Fluctuation due to common cause variation cannot account for the increased mortality seen in the Neonatal Unit.*"
- "*The number of admissions to the Neonatal Unit is recorded as higher than average for some months during 2015/16; the monthly 'total care days' also shows a sustained period of above average during this period. Similar periods of increased activity recorded in previous years have not been associated with an increased*

mortality. Therefore activity levels alone cannot account for the increase but may be a contributory factor."

- "*an increased and sustained acuity level may be a contributory factor. There does not appear to be an escalation process in place between obstetrics and the neonatal unit to highlight when the unit is struggling to cope. The unit is 'closed' on numerous occasions each month due to capacity and acuity levels being high*."
- "*There is evidence that the Neonatal Unit does not consistently meet the BAPM recommended nurse staffing levels or the recommended provision of 'Qualified in Specialty' nurses*."

195. The Executive Team were "*asked to note the challenges to the analysis and the findings of the mortality review*." An action plan was included in the report with the action plan lead listed as Eirian Lloyd Powell.

July 2016

196. On 4 July 2016, Alison Kelly emailed Tony Newman at the NMC to arrange a call to discuss a situation she was "*dealing with re allegations again a nurse (no referral made to the NMC at present) and to also provide some professional advice*." I exhibit this and subsequent emails as **Exhibit JT/170** **INQ0002964**

197. Tony Newman provided an email summary of their discussion setting out that the "*trust has seen a rise in the mortality of babies on the neonatal unit", that "each death has been subject to a clinical team case review*", "*the reviews have produced no evidence as to a lack of competence by individuals or the team*", that "*further analysis has identified one registrant that has been present at nearly all these incidents*", that "*some clinicians were concerned that the registrant may present a serious risk to public safety although no evidence is available at this time*" and that "*the executive team were to meet today (6/7/16) to decide if this registrant will be reported to the Police to investigate*". Tony advised that the NMC would need to be advised of "*both the trust board decision to report to the Police and any subsequent action taken by the Police in relation to this matter*."

198. On 31 August 2016, Alison provided an update to Tony Newman to advise that an internal review had taken place, that Letby was placed on non-clinical duties and that there had been "*no indication to discuss this matter with the Police at this time, but our Medical Director has commissioned an external review*" and "*LL will remain undertaking her non clinical duties until we are in receipt of the final report*."

199. On 5 July 2016, Joanne Davies sent an email to Lorraine Burnett and Stephen Brearey copying in Ravi Jayaram, Eirian Lloyd Powell, Ian Harvey, Alison Kelly, Nim Subhedar and Gill Galt to flag that last minute concerns had been flagged by obstetric colleagues as they had been under the impression that the neonatal unit would be closed to all below 34 weeks. I exhibit this email as **Exhibit JT/171** **[INQ0004886]** She noted that she had confirmed with Steve and Eirian that of the 14 babies that died, 3 were 32-34 weeks and one had an identifiable cause, that Nim and Julie Maddocks *"know all the facts and reasons for concerns and feel that 32/40 is appropriate*", "*ITU ventilation is rarely required in gestation 32-34*" and "*the main outcome for level 1 will be the acuity of care and loss of ITU will allow the nursing staff to concentrate more on less sick babies*." She noted that the obstetric consultants were in agreement with the proposal but stated that "*we will assess every patient in the group 32-34 weeks individually, and any we think have a higher chance of requiring ITU care because of serious fetal concerns we will transfer out*."

200. I understand that around this time meetings took place with the CCG, NHS England and the Coroner's office.

201. On 8 July 2016, Tony Chambers sent an all staff email providing an update on the neonatal services stating that they had "*identified a change in what the internal mortality data and information is telling them*", that "*we are acting responsibly in requesting an independent review to help us understand this change*" and were "*responding to the advice of our senior clinicians in how most importantly we support the needs of expectant or new Mums and their babies*."

202. On 14 July 2016, there was an extraordinary board of directors meeting. I exhibit the minutes of this meeting as **Exhibit JT/172 [INQ0014263]**. Tony Chambers gave "*an overview of the paper and stated that the COCH team had highlighted an issue which was an increased mortality rate over a period of time. They had been unable to come to a view despite reviews, however there seemed to be a common link to a member of staff*." It was noted that "Mrs Hopwood said that she was hearing that the issues were due to staffing pressures. Mr Harvey replied that this was one factor in what was a multi factional case. Mr Chambers added that the Trust saw an increase in mortality but not a change in other data."

203. On 14 July 2016, it is understood that a meeting took place between Sian Williams, Sue Hodkinson and Eirian Lloyd Powell. I exhibit an email chain referring to this meeting

as **Exhibit JT/173 [INQ0014264]**. It was noted "*we all agreed that LL is to be supervised in practice on all of her shift time initially until the 31st August 2016. To be clear- she must not be allowed to care for a baby unsupervised- I outlined my expectations that she works solely with the PDN or equivalent. The time scale will be determined by the external review findings and any other information that is obtained in due course*." It was also stated "*we agreed that all staff who appear on a regular basis in the reviews would also be supported in the same way that this has been done*." It was stated that "*you raised concerns with regarding Dr Harkness who also you believe features in a number of the case of babies who collapse. Sue agreed to take this concern to Ian Harvey*."

204. It was also noted "*You informed us of a number of incidents this week that you feel relate to the understanding that clinicians have with regards to the babies and some delays in the response times from the medical staff when being called to the unit. I emphasised the need to ensure that all of these are reported via Datix- this will allow the patient safety team to pick up trends and also enable you to feedback the issues your staff are having in clear and concise way that will support the need for change. Please reinforce the need to do this with the staff*."

September 2016

205. On 7 September 2016, Lorraine Burnett (Director of Operations) emailed Eirian Lloyd Powell, Stephen Brearey, Jim McCormack, Julie Fogarty, Kathleen Grimes and Rebecca Fryer and copied in Yvonne Griffiths, Anne Murphy, all paediatric consultants, all "*Obs and Gynae*" consultants, Alison Kelly and Ian Harvey. I exhibit this email chain as **Exhibit JT/174 [INQ0005256]** She flagged that "*following our weekly review of maternity/neonatal dashboard at executives this morning I raised my concerns regarding the over occupancy of the unit over the weekend and into Monday. I was also concerned that admissions from COCH were still occurring despite lack of NNU capacity*." She advised that Alison and Ian were supportive of Eirian's initiative "*to commence daily meetings whereby the activities of both areas can be understood and a plan agreed*."

206. Lorraine stated "*please could you set up a daily early morning meeting to begin tomorrow. I suggest a lead midwife and the team leader or yourself from NNU with expected delivery numbers for the day, any anticipated admissions to NNU plus the NNU occupancy and any planned admissions/discharges*." Any discrepancy should be escalated to "*lead clinicians for a resolution that maintains the safety of both units and complies with the agreed model*." She reminded that "*any over occupancy should be*

escalated to the Head of Nursing and executive team." She advised Mr Harvey was happy to be contacted to discuss further if there were any concerns. Alison Kelly responded to Lorraine Burnett, Ian Harvey and Sue Hodkinson to advise she had "given Karen R the heads up" as once the meetings are established the exec on call would attend during the week and once established the meetings need to be articulated in more detail in the daily bed management report so they are clear on the status and staffing.

207. On 9 September 2016, Ravi Jayaram sent an email to Gillian Mort, Doctor ZA, Stephen Brearey, John Gibbs, Susie Hold, Doctor V and Murthy Saladi following a meeting with Ian Harvey the afternoon before. I exhibit this document as **Exhibit JT/175 [INQ0014266]**. He provided a summary of the meeting and set out "*there was (predictably) no smoking gun to explain the increase in death rate identified. They did not feel that there was any major issue that needed urgent attention and noted our plans to expand consultant numbers to allow a named consultant to cover NNU in the week.*" Ravi also set out that "*They did acknowledge the concerns we raised over foul play and recommended a forensic detailed independent review of all the cases. This would be far more detailed than the thematic review and would be conducted by 2 teams independently of each other including neonatologist and a pathologist who would have access to all records and pathology specimens and reports (with air embolus specifically being considered in the pathology).*" He also detailed that "*the board are still fully aware that this may end up with the police being involved but will now await the more detailed case reviews (which is what we wanted back in June).*"

208. On 21 September 2016, Dee Appleton-Cairns (Deputy Director of HR) sent an email to Alison Kelly and Sue Hodkinson in relation to the grievance submitted by Letby which stated "*as part of this we were going to ask Ian to speak to SB and ask him to formally voice his concerns under Speak Out Safely. I think we need to do this in parallel – any thoughts?"* I exhibit this as **Exhibit JT/176 [INQ0014267]**.

December 2016

209. On 21 December 2016, Ian Harvey sent an email to Dr Jo McPartland, Consultant Paediatric Pathologist at Alder Hey Children's NHS Foundation Trust. The email requested a review of the pathology/histopathology relating to four cases, following a recommendation from the Jane Hawdon review referenced in paragraph 363 of this statement. I provide further information about the review conducted by Dr McPartland at paragraph 367 of this statement.

January 2017

210. A paper on the neonatal services at the Trust was completed by Ian Harvey dated 10 January 2017 for the extra-ordinary board meeting on 10 January 2017. It was noted that:

- "*as a result of concerns raised by the clinical team regarding a higher than usual number of neonatal deaths from January 2015, together with inconclusive results from internal reviews, a number of actions were taken.*"
- "*after discussion with, and with the agreement of, the Cheshire and Merseyside Neonatal Network the designation of the service was reduced to a Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation."*
- "*an invited review was requested from the Royal College of Child Health and Paediatrics. A team consisting of two paediatricians with special interest in neonatology, plus a senior neonatal nurse manager and a lay reviewer visited and conducted interviews on 1st and 2nd September 2016 which led to the issuing of a final review with recommendations.*"

211. It was noted that "*following the review recommendations the secondary external case review has been commissioned and completed. As part of this case review a secondary pathology review of a small number of cases was advised and is in process with completion likely mid-January 2017.*"

212. In the recommendations the Board is asked to accept the report of the invited review, support the Executive in implementing the review recommendations and issues described in the review, "*support the Executive in assisting the staff member's return to work on the Neonatal Unit – the reviews having found no evidence of a single person's culpability – and in implementing the recommendations of the "grievance*" investigation." The Board were also asked to maintain the current admission criteria and "*reserve its decision regarding the future service designation of the Neonatal Unit, this to be guided by the recommendations of the College review and Cheshire and Merseyside Women's and Children's Review.*"

February 2017

213. On 24 February 2017, John Gibbs emailed Ravi Jayaram a summary of a meeting with Ian Harvey on 23 February 2017. I exhibit this email chain as **Exhibit JT/177 [INQ0014268]**. He stated that they discussed the "*review Anne Martyn and I undertook*"

and that "*Ian didn't tell me how many patients had been identified but said there were quite a few*" and that "*apparently, Letby did not feature prominently in the staff correlation analysis of those collapses*." He stated that "*Ian felt that him and Stephen had made our concerns clear to the Coroner*" and that "*Ian and Stephen Cross discussed our concern that one particular nurse featured more often than any other nurse in the resuscitations/immediate care of the deaths and collapses*".

214. Ian advised that they "*can look at the issues surrounding the deaths that Jane Hawdon/Nim had identified as unexplained when they meet next week*." Ian asked "*what I thought would be the end point of these reviews and further discussions and whether we'd be able to draw things to a close and move on with implementing the recommendations from the College review in order to enhance the neonatal service*." John explained to Ian "*a problem 'we' have (and I said I thought this applied to all the consultant Paediatricians), was that we remain somewhat suspicious of Letby's involvement but we don't know what she did (if anything), nor how she did it and, obviously, we don't know that she actually did anything untoward. Even so, I made it clear that unlike the impression given in the full version of the College review that it was only after Steve's first review (at the end of 2015) happened to highlight an association between Letby and many of the sudden, unexpected collapses that our suspicions over Letby then became aroused, each of us had already started to become worried about this association from our own personal involvement in various episodes. Initially, we felt Letby was just unlucky in happening to be involved in more of these infants than other nurses but this association become steadily more worrying especially with recurrent sudden collapses at night that stopped when Letby was moved off nights and then, on one occasion (only that I'm aware of), when Letby covered a stable infant during a colleague's coffee break during which that infant unexpectedly collapsed*."

215. John also raised "*although we didn't know that Letby had been the cause of unnatural collapses or deaths, we were still worried that this might be the case and that this problem could resurface at any stage in the future - either here or, if Letby moved, in another Trust. So, whilst we don't know if anything unnatural had happened, we felt we had to do everything reasonable to try to find out*."

216. I understand that a meeting of the paediatric consultants, Medical Director and Neonatal Network Lead took place on 28 February 2017, and that on 1 March 2017 Tony Chambers received a letter from the paediatric consultants expressing concern with regards to the outcome of the reviews of care that had taken place (which I refer to later

in this statement); essentially that there had been no common theme identified and that they were no closer to understanding the reasons for the increased mortality. Prior to this, there had been correspondence between Ravi Jayaram and Tony Chambers about the concerns.

March 2017

217. On 6 March 2017, Stephen Brearey emailed Ian Harvey and copied in Nim Subhedar, Ravi Jayaram, John Gibbs, Doctor V, Murthy Saladi, Susie Holt and Doctor ZA providing a summary of the meeting on 28 February 2017. I exhibit this document as **Exhibit JT/178 [INQ0003395]**. The meeting summary noted *"general dissatisfaction from the consultant body with the way the Trust had handled this difficult situation since it was escalated. All the paediatricians voiced concerns at the time and now feel that their professional opinions have not been given due regard and that we have been excluded from discussions which we would have expected our views to have been required and indeed welcomed. It was agreed that small changes in acuity and staffing could not explain the increase in mortality seen and actually medical and nursing staffing levels at the Countess were better than most other LNUs in the region."*

218. Within his email with the meeting summary, Stephen noted that "*Nim Subhedar stated at our meeting that he too was concerned that the cause of death and/or deterioration remained unexplained in several cases"* and *"emphasised the Network's position that the observed excess in neonatal mortality at COCH could not be explained merely as a consequence of medical or nursing workforce deficits or increased activity and occupancy levels. Other network local neonatal units are working at similar level of occupancy and staffing and COCH is not an outlier in this regard. Since these units are not reporting an excess in neonatal mortality, it suggests that there is a different explanation for our increased number of unexplained deaths."*

219. Ian Harvey responded to Stephen's email on 6 March 2017 to advise that he was "*surprised that there is no reference to the conversation about the Coroner*" and that "*Stephen Cross and I had had a detailed conversation and the Deputy*" and "*not only had we given the Coroner a copy of the recent letter from you and your colleagues which highlighted your concerns but Stephen and I also discussed this at length with them. The Coroner told us we should not necessarily expect a response from him*." Ian stated in his email that "*it might have been stated but it was not agreed either that there were small changes in acuity (I certainly would dispute this) or that, by extrapolation, this couldn't play*

a part. I, for one, would not limit myself to looking for a single cause." He also noted that "*whilst I agree that Nim did say that other units are (were) working at similar levels of occupancy and staffing and COCH is (was) not an outlier – I have seen no evidence to confirm this nor have I seen anything to indicate that there was the same trajectories that we had in the period leading up to 2015/16. I accept, however, that this would not tell the whole story, most incidents are, by their nature, multifactorial in origin and it is relevant here to mention one thing that was agreed by all was that there no "smoking gun", no single cause, has been identified*."

220. I understand that a number of meetings took place In March 2017 about the consultants' concerns and that by the end of March it was concluded that no further work or investigation short of a police investigation could be undertaken that would address the concerns being raised.

April 2017

221. On 6 April 2017, Ian Harvey emailed Ravi Jayaram, Stephen Brearey, John Gibbs, Susie Hold, Doctor V, Murthy Saladi and Doctor ZA copying in Mary Crocombe to arrange a meeting with Simon Medland QC and advised that "*I think it is important that as many as possible meet with him.*" I attach this as **Exhibit JT/179 [INQ0003109]**

222. In response, Stephen advised "*there is a good deal of uncertainty as to why we are having this meeting and why we all need to attend this meeting. Our concerns are quite clearly expressed in the letters that we have written and Tony Chambers had agreed to the actions we discussed on 27th March. I am concerned the meeting with cause further unnecessary delay.*" He asked for clarification on the purpose of the meeting. Ian responded on 7 April 2017 to confirm in relation to Mr Medland "*it was his advice that he meet with you to fully understand, and explore, the basis for your concerns to help frame the approach since letters only convey so much*."

223. On 12 April 2017, a meeting was held between Simon Medland QC, Stephen Brearey, Susie Holt, Ravi Jayaram, Murthy Saladi, John Gibbs and Doctor V with it being noted that "*minutes of the meeting would be shared with the Board*." I attach minutes of the meeting as **Exhibit JT/180 [INQ0014271]**.

224. Simon Medland QC explained that he had '*been instructed by the hospital to bring an independent objective view to present situation and see if formal report to police was presently merited, in other words whether there is presently information giving rise to reasonable grounds for suspecting that a criminal offence has been committed in respect of any one of the neonatal deaths in question*'. After inviting comments from the consultants, the consultants expressed themselves clearly as to '*their concerns which derived from the increase in number of deaths, that certain of the deaths occurred in neonates who would not ordinarily be expected to die and that there were particular unusual features which could be shown to have occurred or been present, some of which were common amongst several of the incidents. Amongst these latter features were the presence of one particular nurse on duty during/around some of the deaths, presence of unusual or unidentifiable rashes on some of the neonates and other features*.'

225. Simon Medland QC remarked that '*officially reporting any matter to the police was a condign step which was effectively a public action and would incur adverse publicity and raise matters for the families of the neonates which might be seriously disturbing*'. The consultants are all said to have '*felt that there had been an unacceptable delay of 9 months when little seemed to have happened*' and that they were '*not blindly pressing for the matter to be reported to the police but wondered who else might conduct such a review'*.

226. In canvassing 'potential routes of investigation´, it is understood that Simon Medland QC '*suggested the possibility of a private discussion with Detective Chief Superintendent Wenham'* as he was '*senior, independent and experienced in this area as he sat on the CDOP'*. In concluding the meeting, Mr Medland '*emphasises that if, in his opinion, there had been clear information leading to reasonable grounds for suspecting that a criminal offence had been committed, he would have no hesitation in advising the hospital that it was their public duty to report the matter to the police and actively assist in the enquiry'*. He indicated his view that '*the hospital trust would agree with this course but was cautious of proceeding along that path in the apparent absence of such material (as things stand), given the serious, public and irrevocable nature of such a step'*.

227. On 13 April 2017, an extra-ordinary board of directors meeting was held with Simon Medland QC in attendance and a copy of the minutes from the meeting between Mr Medland and the paediatricians was provided to the Board. I attach the minutes of the Board meeting as **Exhibit JT/181 [INQ0014272]**. It was stated that "*the consultants take the view that they are not militant or agitating for the matter to go to the police but they*

cannot see anyone else who could investigate it but the Trust view is if go the police this is an irrevocable step and carries potentially enormous risks for reputation and for the families, the question is, does it merit that step?" It is understood that Mr Medland stated '*that in his view there is no evidence of a crime but the consultant view is to go to the police*' and it is said that all around the table agreed '*that if there is clear evidence of a crime that you would want to go to the police straight away'*. It was suggested by Mr Medland that '*an alternative approach would be to approach the police member of the Child Death Overview Panel (CDOP) although it is possible he may say he is unable to help due to his position'*. Sir Duncan Nichol stated that the consultants '*may say we are handicapping ourselves by excluding the police at the moment but let 's see where the next step recommended by Dr Hawdon takes us'*.

228. I understand that on 27 April 2017, Ian Harvey, Medical Director, Stephen Cross, the Director of Corporate and Legal Services, Dr Mittal, Dr Holt and Dr Jayaram met with the Chair of CDOP (Child Death Overview Panel) which included Superintendent Nigel Wenham (police representative on the panel) to discuss the clinician's concerns.

May 2017

229. On 2 May 2017, an extraordinary board of directors meeting took place. I attach the minutes as **Exhibit JT/182 [INQ0014273]**. Ian Harvey reported that he "*had met with the Chair of the Child Death Overview Panel (CDOP), a small number of CDOP members, including Superintendent Nigel Wenham of Cheshire Police, Dr Holt and Dr Jayaram to discuss the circumstances that led to the reviews, where we had got to and to discuss from a CDOP point of view where to get a degree of closure. The feeling was that we had done everything and that the next step was to consider a police investigation*." It was noted that Mr Chambers, Mr Harvey and Mr Cross were to have a meeting with the wider police team on 15 May 2017.

230. From this point a police investigation into the concerns surrounding the neonatal ensued.

Meetings in which concerns were raised

231. The Inquiry has requested a chronological account of all senior management meetings, board meetings and other meetings where concerns regarding the neonatal unit and/or Letby were discussed. There were a significant number of meetings held between

the beginning of 2015 and 2018 in which concerns relating to the events in the neonatal unit and/or Letby were discussed. I attach a list of these meetings in Appendix A, which has been collated from a review of relevant documents currently available to the Trust and disclosed to the Inquiry. I cannot say with certainty that these were the only meetings in which concerns were discussed. The most significant meetings in which concerns about the events in the NNU were discussed and the most significant correspondence relating to those concerns (insofar as the Trust is aware from a review of available documentation) are referred to elsewhere in this statement. Insofar as the Trust's ongoing preparations for the Inquiry may reveal further meetings which fall within the scope of the Rule 9 request, the Trust will disclose any such notes or minutes of those meetings to the Inquiry as they are identified.

Police

232. The Trust has been asked on what date was consideration first given to reporting the neonatal deaths and/or Letby to the police, who was involved in any such discussions and what was the outcome of such consideration.

233. The first recorded consideration of reporting the neonatal deaths to the police from the documents currently available to the Trust appears to be an email from Dr Murphy Saladi, consultant paediatrician at the Trust, sent on 29 June 2016 at 08:16 to Ian Harvey and Alison Kelly. The subject line reads *"Should we refer ourselves to external investigation?"* This email followed a senior paediatricians meeting on 27 June 2016 to discuss their significant concerns regarding the increased mortality on the neonatal unit. I attach this email as my **Exhibit JT/183** **[INQ0003415]**

234. As exhibited, Dr Saladi wrote '*I believe we need help from outside agencies, who can deal with suspicion. At the moment we are all under suspicion and the only agency who can investigate all of us I believe is the police.'* Later in the email thread, Ian Harvey requested that all emails were ceased forthwith as action was being taken.

235. In a further email sent from Dr John Gibbs, dated 29 June 2016 at 10:24am, sent exclusively to Dr Ravi Jayaram and Dr Stephen Brearey, it was suggested that "*if there is an unusual and unexpected incidence of air inside skulls"* arising from the post-mortem skeletal survey, then it would be "*mandatory that the Police are involved ASAP*." Dr Jayaram responded that "*the Trust are contacting the police soon, once some information*

gathering has taken place, which is why Ian has asked for the chit chat to stop now." I attach this email and the response as my **Exhibit JT/184** **[INQ0003411]**

236. I also attach, as my **Exhibit JT/185** **[INQ0003362]** a handwritten note of a meeting on 30 June 2016 between consultants, Ian Harvey, and Tony Chambers in which reporting the matter to the police was considered and discussed.

237. On 1 July 2016, I understand that a meeting of Ian Harvey, Stephen Cross, Ravi Jayaram, Murthy Saladi and Stephen Brearey took place to discuss whether a report should be made to the police. Notes of that meeting cannot currently be located despite searches being made of the Trust's shared electronic drive. The meeting is referred to in a neonatal unit timeline, but no further detail is provided. It is possible that notes of that meeting were not taken.

238. I attach the minutes of an extraordinary Board of Directors meeting on 14 July 2016, which was additionally attended by consultants Dr Ravi Jayaram and Dr Stephen Brearey. The minutes refer to *"considerable disquiet about an individual"* and Mr J Wilkie, non-executive director, wanted to better understand what are the critical issues that mean it is not appropriate to engage the police. Sir Duncan Nichol said that, *in light of the data, if the Trust take the basis that it was proportionate to call the police, we would*. I attach the minutes as my **Exhibit JT/186 [INQ0014277]**.

239. On 18 July 2016, Corinne Slingo, Partner and Head of Healthcare Regulatory at DAC Beachcroft LLP, provided legal advice to Sue Hodkinson, Executive Director of Human Resources & Organisational Development at the Trust. It was advised that 'there does not currently appear to be any reason to formally alert the police to these issues', however, 'this fine balance of decision making be kept under very close review, with a very low threshold for moving this to a decision to notify the police'. I attach this email as my **Exhibit JT/187** **[INQ0002848]**

240. As referred to in paragraphs 196-198 above, on 31 August 2016 an email was sent (following previous emails) from Alison Kelly, Director of Nursing and Quality at the Trust to Tony Newman, Regulation Adviser at the Nursing and Midwifery Council, which states there had been '*no indication to discuss this matter with the Police at this time'*.

241. On 6 February 2017, during a meeting between the Trust, Letby and her parents, the note of which I exhibit as **Exhibit JT/188 [INQ0014279]**, it was noted that Tony Chambers,

Chief Executive, stated that 'the easy thing would have been to phone the police, but that would have been the end of your career' while explaining the actions taken as a Board in response to the allegations made against Letby.

242. On 24 February 2017, following a discussion between Dr Gibbs and Ian Harvey, exhibited above, Dr Gibbs wrote in an email to Dr Jayaram that:

"- I also explained that a problem 'we' have (and I said I thought this applied to all the consultant Paediatricians), was that we remain somewhat suspicious of Letby's involvement but we don't know what she did (if anything), nor how she did it and, obviously, we don't know that she actually did anything untoward. Even so, I made it clear that unlike the impression given in the full version of the College review that it was only after Steve's first review (at the end of 2015) happened to highlight an association between Letby and many of the sudden, unexpected collapses that our suspicions over Letby then became aroused, each of us had already started to become worried about this association from our own personal involvement in various episodes. Initially, we felt Letby was just unlucky in happening to be involved in more of these infants than other nurses but this association become steadily more worrying especially with recurrent sudden collapses at night that stopped when Letby was moved off nights and then, on one occasion (only that I'm aware of), when Letby covered a stable infant during a colleague's coffee break during which that infant unexpectedly collapsed. Ian again mentioned that Letby, being a young, single nurse, undertook more sessions than other nurses on the unit and so would be expected to be associated with more 'events' but I countered that this was true but her involvement still seemed to be unexpectedly frequent. I added that in any mediation with Letby it would be very difficult to know how to answer if Letby (or the mediator with Letby present), asked whether we still had 'suspicions' about her - although I suggested that like a politician we could aim to resolutely refuse to answer the question directly and instead talk about how the rise in mortality, and the unexpected collapses, is worrying and difficult to explain and it's not clear what caused this (despite the reviews).

- I said that although we didn't know that Letby had been the cause of unnatural collapses or deaths, we were still worried that this might be the case and that this problem could resurface at any stage in the future - either here or, if Letby moved, in another Trust. So, whilst we don't know if anything unnatural had happened, we felt we had to do everything reasonable to try to find out. Ian assured me that the issues on our NNU had lead to a great deal of soul searching amongst the Executives and that, for months, our neonatal unit has been given priority at each of the weekly Executive meetings.

- I also reminded Ian that most of the 'failings' highlighted by the College review (lack of consultant, middle grade, nursing staffing) also applied to most other NNUs and so didn't

adequately explain our increased mortality. Ian went back to the observation he'd made when we all met prior to the College review, that the workload intensity had increased significantly on our unit in the past 2 years (prior to the voluntary regrading). Interestingly, without me needing to bring this up again, he said himself that he understood that we were also worried about the sudden, unexpected nature of many of the collapses, but he then added that perhaps when workload is high sometimes early warning indicators aren't spotted and so patients are more likely to then deteriorate, sometimes rapidly.

243. Dr Gibbs went on to conclude "*I feel that we've probably done all we can and that it's not appropriate to consider whistleblowing to the media or Police particularly since it seems that 'the Trust' has informed the coroner (in fact two coroners), about our 'dark' suspicions and that's almost the same as telling the Police"* and *"We may have to accept that we are probably never going to get a clear answer to the cause of our increased neonatal mortality and non-fatal collapses and insisting on 'pushing things further' isn't likely to provide any better answers (although the coroners or parents might decide to 'take things further' but it's not clear what they could do to clarify the situation). Amongst all of us, Steve might find it the most difficult not to press for further forensic-style investigations (i.e. direct Police involvement), because he's put so much effort into trying to resolve this issue and has been even more frustrated, humiliated and angered (by Ian especially), than the rest of us - not that any of us have found this affair to be anything other than highly distressing."*

244. On 16 March, according to the handwritten executive meeting minutes, which I exhibit as **Exhibit JT/189 [INQ0014280]**, Tony Chambers is quoted as saying 'part of me says ring police & GMC'.

245. On 28 March 2017, the handwritten notes of an executive meeting between Tony Chambers, Sir Duncan Nichol, Sue Hodkinson, Alison Kelly and Ian Harvey, which I exhibit as **Exhibit JT/190 [INQ0014281]**, note that the consultants' position was that the 'only independent robust investigation is police investigation', a formal report was to be sent to the police and it was 'not when but how do we manage Police'.

246. On 30 March 2017, Dr Jayaram sent an email to Sue Hodkinson, which I exhibit as **Exhibit JT/191 [INQ0014282]**, that referred to Letby having been led to believe that "Dr Jayaram and a colleague gave an ultimatum to the Trust that if she was not suspended we would call the police". Dr Jayaram maintained in his email that this was not true.

247. On 3 April 2017, Stephen Cross, Director of Corporate and Legal Affairs, authored a rationale for referring to the Police, which I exhibit as **Exhibit JT/192** **[INQ0003226]** This noted that, in the Trust's view, 'there is no evidence to justify a criminal investigation'. However, 'in the spirit of openness and transparency, the matter is being reported to the Police, having regard to the fact that a number of Consultant Paediatricians are not satisfied with the very thorough investigations and reviews undertaken'.

248. On 4 April 2017, legal advice was obtained by the Trust about referring the matter to the police. The advice concerned the question the Trust was considering which was 'whether, and if so how, to liaise with the police in this matter, with particular pressure being brought by a consultant and others, about the desire to continue to investigate the issue in the neonatal unit'. Advice was therefore given on the implications of referring the matter to the police and in what way to do so [INQ0003088].

249. The Trust also sought legal advice at this time from Simon Medland QC who met with the consultants on 12 April 2017. I refer to this meeting and Mr Medland's involvement in advising the Trust at that time at paragraphs 221-227 above. As set out in those paragraphs, in canvassing 'potential routes of investigation', it is understood that Simon Medland QC '*suggested the possibility of a private discussion with Detective Chief Superintendent Wenham'* as he was '*senior, independent and experienced in this area as he sat on the CDOP*'. As is also referenced in paragraphs 221-227 above, subsequently, at the extraordinary Board of Directors meeting on 13 April 2017, which Simon Medland QC attended, it is understood that Mr Medland stated '*that in his view there is no evidence of a crime but the consultant view is to go to the police*' and it is said that all around the table agreed '*that if there is clear evidence of a crime that you would want to go to the police straight away'*. It was suggested by Mr Medland that '*an alternative approach would be to approach the police member of the Child Death Overview Panel (CDOP) although it is possible he may say he is unable to help due to his position'*.

250. Subsequently, Dr Ravi Jayaram and Dr Susie Holt attended a Child Death Overview Panel meeting which took place on 27 April 2017. This meeting was the first contact with the police where the concerns about Letby were raised and the paediatric consultants concerns were explained to them. Also present at the meeting was Ian Harvey and Stephen Cross, as well as CDOP members including Detective Chief Superintendent of Cheshire Police Nigel Wenham. The CDOP chair recommended that Letby did not return to clinical duties, as was imminently planned. On the advice of Detective Chief Superintendent Nigel Wenham, Mr Tony Chambers was to write to Cheshire Police to

conduct a forensic investigation into the circumstances surrounding the neonatal deaths occurring in the period January 2015 to June 2016, therefore formally reporting the matter to the police.

251. Ian Harvey subsequently emailed Nigel Wenham at 08:54 on Friday 28 April 2017. I exhibit a copy of this email as **Exhibit JT/193 [INQ0014284]**.

252. As set out in paragraph 167 of my first statement, on 2 May 2017 a letter was sent from Tony Chambers, Trust CEO, to Chief Constable Byrne, which I exhibit as **Exhibit JT/194 [INQ0003080]** referring to the meeting that took place with members of the Pan Cheshire CDOP on 28 April 2017 and that on the advice of T/Detective Chief Superintendent Nigel Wenham (a member of the CDOP) Mr Chambers was writing to request that Cheshire Police conduct a forensic investigation into the circumstances surrounding the neonatal deaths occurring in the period January 2015 to June 2016.

Child Death Overview Panels

253. The Trust has been asked how many Child Death Overview Panels were held that were linked in some way with Letby and/or neonatal deaths between June 2015 and June 2016. Child Death Overview Panels ("CDOPs"), including the pan-Cheshire CDOP, are covered in my first statement to the Inquiry, starting at paragraph 151. As set out in paragraph 161 of my first statement, according to the draft Pan-Cheshire CDOP annual report for 2015/16, the Pan-Cheshire CDOP met on five occasions between April 2015 and March 2016 and the total number of child deaths reviewed by the panel between April 2015 and March 2016 was 51. The Pan-Cheshire CDOP annual report for 2016/17 confirms that the Pan-Cheshire CDOP met on six occasions between April 2016 and March 2017 and the total number of child deaths reviewed by the panel between April 2016 and March 2017 was 51. At the time, the CDOP did not review neonatal deaths as they did not feel they had enough expertise.

254. All CDOP information, including minutes of meetings, are held by the Cheshire and Merseyside ICB and therefore the ICB will be best placed to advise on matters such as who attended CDOP meetings, what they discussed, conclusions reached and action taken.

Coroner

255. In this section of my statement, I set out the Trust's understanding of information reported and provided to the Coroner in relation to babies on the indictment who died at the Trust. By way of clarification, 7 babies on the indictment died at the Trust (referenced below). One baby on the indictment did not die at the Trust.

Child A

256. Child A was born on PD June 2015 on the neonatal unit at the Trust and died on 8 June 2015. The postmortem report conducted by Dr Rajeev Shuhkla on 18 December 2015 concluded the cause of death to be 'IA Unascertained.' The death was reported to the Coroner on 8 June 2015.

257. On 30 June 2015, Heidi Douglas, Legal Assistant at the Trust sent a letter to the Coroner's Officer, Karen Shaw, and confirmed she was in the process of obtaining a report from the relevant consultant. On 12 January 2016, the Trust disclosed Child A's medical records and the maternity records of Child A's mother to the Coroner.

258. On 17 February 2016, to assist the Coroner, Heidi Douglas sent letters to the relevant consultants requesting a report which included the details of any medication prescribed to Child A and the care provided to Child A which gives consideration to the facts and circumstances that may have led to their death. I attach an example of this letter as my **Exhibit JT/195** **[INQ0008852]** In response, statements were provided by the following individuals:

258.1. Dr Christopher Wood;

258.2. Dr Sally Ogden;

258.3. Dr Teresa McCarrick;

258.4. Dr Jian Hor;

258.5. Dr David Harkness;

258.6. Dr Andrew Brunton;

258.7. Dr Gail Beech;

258.8. Dr Joanne Davies;

258.9. Dr Satyanarayana Saladi;

258.10. Dr Ravi Jayaram.

259. A report was also written by Miss Rachel Lambie dated 06 April 2016 detailing her involvement in Child A's care, also attached as **Exhibit JT/196** **[INQ0008894]**

260. On 20 January 2016, Yvonne Williams from the Coroner's Office spoke to Heidi Douglas at the Trust to request the maternity report covering the pregnancy and birth of Child A. On 19 February 2019, Heidi Douglas from CoCH spoke to the Coroner's office as they were chasing the SUI Report from the Trust.

261. A witness summons letter was sent on 19 August 2016 confirming the inquest into the death of Child A was due to be held at 9.30am on Monday 10 October 2016 at Warrington Coroner's Office, and requesting the attendance of the following individuals:

261.1. Dr Christopher Mark Wood – GPST3;

261.2. Dr David Ian Harkness – Paediatric Registrar;

261.3. Dr Ravi Jayaram – Consultant Paediatrician;

261.4. Dr Teresa Mac Carrick – Paediatric SHO;

261.5. Dr Satyanarayana Saladi – Consultant Paediatrician;

261.6. Dr Sally Rebecca Ogden – Paediatric Registrar.

262. HM Senior Coroner Nicholas Rheinberg sent a letter to Mr Stephen Cross on 11 August 2016 chasing missing statements and a copy of the Serious Untoward Incident Review. HM Senior Coroner confirmed it had been over a year since Child A had died and they had not yet received the documents. The Coroner therefore requested the following documents:

262.1. A statement from Dr David Harkness;

262.2. A statement from Dr Theresa McCormick;

262.3. A copy of the Root Cause Analysis/Serious Untoward Incident report;

262.4. All statement or transcripts of interview produced in relation to the production of the above report with the identities of the individuals making the statements;

262.5. A copy of the full medical notes.

263. HM Senior Coroner Nicholas Rheinberg also confirmed in this letter that he intended to call Dr Gail Beech, Dr Rajeev Shukla, Dr Christpher Wood and Dr David Harkness as witnesses to give evidence at the inquest in October 2016.

264. On 27 September 2016, Joshua Swash from the Trust spoke with the Coroner's Office as they had urgently required the SUI report.

265. The inquest into the death of Child A commenced on 22 June 2015 and resumed on 10 October 2016. Evidence was heard on 10 October 2016 from Dr Murthy Saladi, Dr Sally Ogden, Dr David Harkness, Dr Christopher Wood and Dr Ravi Jayaram. Dr Rajeev Shukla

who conducted the post-mortem report stated that he could not say whether Child A's death was due to natural or unnatural causes.

266. Dr Ravi Jayaram was asked by HM Senior Coroner if he had come across any similar cases like this inquest. Dr Jayaram stated that there had been several similar cases on the neonatal unit at the Trust and as such a review was taking place. However, the preliminary findings suggested no link between the cases.

267. Following evidence of the inquest into the death of Child A, HM Coroner confirmed the cause of death was 'Unascertained' and provided a narrative conclusion on 10 October 2016 as follows:

> *"[Child A] was the second of twins born prematurely at the Countess of Chester Hospital, Chester, in his case at 20:31 on* **PD** *June 2015. After initial concerns relation to the respiration, [Child A] appeared to thrive, albeit subject to support on the neonatal unit of the hospital. During the afternoon of 8th June 2015 there were two attempts to insert an umbilical venous catheter in order to provide a means to achieve parenteral nutrition. Both attempts resulted in the line entering the hepatic vein as opposed to the inferior vena cava, the latter being the intended destination. Therefore, a peripheral long line was inserted, the procedure being completed at approximately 6.45pm. At approximately 8.15pm a glucose infusion was commenced through the long line. At 8.26pm [Child A] suddenly and unexpectedly became apnoeic whilst still maintaining a steady heart rhythm. Attempts were made to revive [Child A] but these proved to be unsuccessful. It cannot be determined what caused [Child A]'s collapse and subsequent death and further it cannot be determined whether this was due to a natural or unnatural event."*

268. Julie Fogarty, Head of Midwifery, completed the lesson learning statement (undated) which I attach as my **Exhibit JT/197 [INQ0014288]** for this inquest. Within this document, she provided the six-month summary report produced by the Head of Midwifery to monitor overall compliance reviewed at Women & Children's Care Governance Board. Ms Fogarty also provided the annual record keeping audit to demonstrate good overall compliance, and a PowerPoint presentation that was emailed to all staff following the initial Obstetric review.

269. Ms Fogarty produced a summary report on 20 March 2017 which I attach as my **Exhibit JT/198 [INQ0014289], [INQ0008103] [INQ0014291], [INQ0014292],**

[INQ0014293], [INQ0014294], [INQ0014295] and [INQ0008716] confirming the lessons learned and actions taken since the incident in June 2015 and the death of Child A.

Child C

270. Child C was born on **PD** June 2015 at the Trust and died on 14 June 2015. The suspected cause of death was "*unknown*" and it was noted that they had an "*acute sudden deterioration leading to cardiorespiratory arrest*." It was noted that an individual telephoned the coroner's office on 14 June 2015 and left a message on the answerphone. On the checklist for staff following a neonatal death, the date entered next to "*Dr to Notify Coroner of Neonatal death*" was 15 June 2015.

Child D

271. Child D was born on **PD** June 2015 at the Trust and died on 22 June 2015. The post-mortem report conducted by Consultant Jo McPartland on 26 August 2015 concluded that Child D's cause of death to be 'pneumonia with acute lung injury.' The death was reported to the Coroner on 22 June 2015.

272. HM Senior Coroner Rheinberg opened an investigation into the death of Child D on 25 June 2015. On 22 September 2015, the Coroner's Officer, Yvonne Williams, wrote to Ms Sarah Harper-Lea at the Trust requesting the consultant to submit a report. This was to include details of any medication prescribed and copies of any relevant correspondence and details of any relevant medical staff witnesses. Ms Douglas sent a letter in response from the Trust on 22 September 2015, confirming the Trust would obtain the report and requesting a copy of the postmortem report.

273. On 7 October 2015, Ms Douglas sent a letter to Dr Elizabeth Newby and Dr Joanna Davies, requesting the report of medications prescribed and care that gives consideration to the facts and circumstances of Child D's death.

274. Dr Elizabeth Newby provided a statement confirming her involvement in Child D's care, which was received by the Legal Department in the Trust on 26 October 2015 **(Exhibit JT/199) [INQ0008734]**

275. The Coroner's Officer called the Trust on 7 January 2016 and spoke with Heidi Douglas to request an urgent copy of medical records of Child D and Child D's mother as HM Senior Coroner Rheinberg was going to obtain an independent medical report.

276. HM Senior Coroner Rheinberg wrote to the Trust on 11 January 2016 to confirm that he was opening an inquest into the death of Child D and confirmed he was making arrangements to instruct an independent obstetrician and paediatrician to act as experts to his inquiry.

277. On 12 January 2016, Heidi Douglas from the Trust sent the records for Child D and Child D's mother to the Coroner's officer, Yvonne Williams. On 26 January 2016, Heidi Douglas spoke to Yvonne Williams at the Coroner's Office to confirm a time scale for expert reports to be obtained.

278. Dr Ian K Mecrow prepared an expert report for the Coroner on 9 June 2016 in which he concluded that it was likely Child D died from bacterial sepsis as a result of pneumonia **(Exhibit JT/200) [INQ0014298]**.

279. On 23 September 2016, the Coroner wrote to Messrs Gamlins Law to inform them that he had engaged Mr Andrew Pickersgill, a Consultant Gynaecologist and Laparoscopic Surgeon, in order to obtain an obstetric report.

280. On 20 November 2016, a medical report was prepared by Mr Andrew Pickersgill for the HM Senior Coroner Rheinberg **(Exhibit JT/201) [INQ0014299]**. Mr Pickersgill stated in his report that the treatment of Child D's mother followed good practice for the management of a term rupture of the membranes, however in line with RCOG recommendations she should have been prescribed oral erythromycin.

281. On 21 February 2017, the Coroner's office wrote to Joshua Swash in the Legal Services Department at the Trust to confirm the inquest into the death of Child D was due to be held on 25 May 2017 at Warrington Coroner's Office. It was also confirmed in the letter that Julie Fogarty, Dr Elizabeth Newby and Dr Joanna Davies would be required to attend the inquest.

282. The inquest was due to take place on 25 May 2017, although this was adjourned.

283. Ms Victoria Finney provided a statement signed on 26 January 2018 in order to assist HM Coroner's investigations, detailing her involvement in the care of Child D's mother **(Exhibit JT/202) [INQ0014300]**.

284. Julie Ann Robson provided a statement to HM Coroner dated 02 May 2017 detailing her involvement in the mother's care **(Exhibit JT/203)** **[INQ0008774]**

Child E

285. Child E was born on **PD** July 2015 and died at the Trust on 4 August 2015. Doctor ZA noted on 4 August 2015 that she had a discussion with the coroner's office and they were to discuss with the coroner and get back to Doctor ZA. In a SBAR Incident Overview, exhibited as my **Exhibit JT/115** **[INQ0002660]** it is noted "*Discussed with Coroner. No PM/Inquest required.*"

Child I

286. Child I died at the Trust on 23 October 2015. It is noted in Child I's records that their death was reported to the coroner's office on 23 October 2015 and it was explained that a clear cause of death could not be ascertained.

Child O and Child P

287. Child O was born on **PD** June 2016 in the neonatal unit at the Trust and died on 23 June 2016. The cause of death for Child O was given as:
"1a) Fresh bleeding into abdominal cavity due to
1b) Rupture of sub-capsular haematoma of liver
1c) To be established by full histology."

288. Child P was born on **PD** June 2016 at the Trust and died on 24 June 2016.

289. In relation to Child O, it was noted that a message was left with contact details on the coroner's answerphone on 23 June 2016. It is noted on the bereavement service referral form that the coroner was notified of Child O's death on 24 June 2016 by Doctor V. Within Child P's records it is noted that there had been a discussion with the senior coroner's officer and it was agreed that both triplets' deaths were unexplained and would require a

coroner's postmortem. Within the bereavement services referral form the date entered next to "Date HM Coroner Notified" is 27 June 2016.

290. On 1 July 2016, the Senior Coroner's Officer, Christine Hurst, emailed Sarah Harper-Lea to request reports touching the deaths of Child O and Child P. In her email to Mrs Harper-Lea, the Coroner's Officer outlined concerns that were raised by the father of the babies in relation to **Doctor V** hygiene practice and the safety of donor breast milk. [Category Q - 2016-07-01 Family Concerns Raised via HM Coroner.]

291. Sarah Harper-Lea responded to the above letter on 1 July 2016 confirming she would start the process of obtaining the reports from the relevant consultants and staff.

292. On 7 July 2016, Josh Swash from the Trust also wrote a letter to the Coroner's Officer, Chris Madra, to confirm receipt of the above letter.

293. On 18 October 2016, Josh Swash from the Trust sent a letter to **Doctor V** requesting reports of their involvement in Child O and Child P's care.

294. **Doctor V** provided a statement detailing their involvement in Baby O's care, and a report detailing their involvement in Baby P's care, both dated 03 November 2016. I attach the statement as my **Exhibit JT/204 [INQ0014302]**.

295. On 15 February 2017, Stephen Cross wrote to HM Senior Coroner Rheinberg enclosing an in-depth review into baby deaths and advisory medical report from Dr J Hawdon dated October 2016. Mr Cross also enclosed a letter from Mr Tony Chambers dated 10 February 2017, and observations additional to the RCPCH Review of Neonatal Services at the Trust. I attach this correspondence as my **Exhibit JT/205 [INQ0008622]**

296. There has not yet been an inquest into the deaths.

Other correspondence with the Coroner

297. On 10 February 2017, the paediatric consultants sent a letter to Tony Chambers [INQ0003117] stating "*We are respectfully requesting you to urgently ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses that occurred on the neonatal until between June 2015 and July 2016.*"

298. Ian Harvey and consultant John Gibbs discussed the matter on 23 February 2017. As set out in a subsequent email sent by Dr Gibbs (attached as my **Exhibit JT/206 [INQ0005825]**

"- Ian felt that he and Stephen Cross had made our concerns clear to the Coroner. As Tony Chambers had said in his letter to each of us, our letter in which we gave our view that the deaths and non-fatal collapses had not been adequately addressed through the two reviews so far, and that we felt some of these were unnatural, was given to the Coroner. Also, Ian and Stephen Cross discussed our concern that one particular nurse featured more often than any other nurse in the resuscitations/immediate care of the deaths and collapses. Also, as we already knew, the Coroner has the 'full' College review (where our concerns are again covered), and also Dr Hawdon's review.

- This discussion was held both with the **I&S** *coroner, Nicholas Rheinberg, and the deputy Cheshire Coroner, Alan Moore, who is to take over from the current Coroner next month (like Rhienberg, Moore's background is as a lawyer). [I feel it was useful for both to be informed together because although Rheinberg will not doubt want to maintain his professional integrity, I would worry that his decision over what action, if any, to take might to an extent be influenced by* **I&S** *whereas the new coroner may have a different perspective at the start of his role as Cheshire Coroner].*

- The coroner told Ian that he would not expect to have to re-open inquests that have already been held but that the forthcoming inquests, of which Ian thinks there are likely to be 3 (although 2 of these are probably **Child O&P***, would provide an opportunity to examine issues associated with the deaths. Ian does not know if the coroner/deputy coroner are considering any other actions.*

- Ian explained that we can look at issues surrounding the deaths that Jane Hawdon/Nim have identified as unexplained when we meet next week."

Employment issues: management of Letby following concerns raised, grievance and dismissal

299. It is understood that concerns were first raised about Letby by the paediatric consultants in or around May 2016 following the death of two triplets.

300. On 28 June 2016, Letby had a one to one following the deaths of Child O and Child P **(Exhibit JT/207) [INQ0014305]**. Letby was noted to be "upset." It was stressed to her that she needed to take a step back from ITU for the time being to focus on her own wellbeing. The Transport Consultant, Oliver Racleham, stated that he was impressed with Letby's

professionalism. **Dr U** also stated that he had been impressed with Letby's competence and professionalism during the difficult time of two neonatal deaths.

301. Letby was moved from night shifts to day shifts in June 2016. I exhibit as my **Exhibit JT/208 [INQ0014306]** an email trail from 28 June 2016 summarising a discussion between Eirian Powell and Letby about this move [2016-06-28 Email from Eirian Powell to Stephen Brearey following speaking with LL].

302. On 14 July 2016 a meeting took place between Letby, Letby's line manager, Eirian Powell, and Sian Williams, Deputy Director of Nursing & Quality, to discuss the recent events in the neonatal unit, namely the high mortality rate identified. Sian Williams advised at that meeting that there had been an increase in mortality rates on the neonatal unit and that the Trust was undertaking an in-depth review of the neonatal unit. Letby was informed that the review undertaken to date had revealed that a small number of staff were regularly involved in the care of the babies concerned and that the review had identified Letby as one of those members of staff. Letby was advised that all such staff would, by way of support and to ensure patient safety, be subject to a period of supervised practice and that due to her being identified as being most regularly involved in the care of the babies concerned, she would be the first nurse to be subject to supervised practice pending the outcome of an external review process to be undertaken by the Royal College of Paediatrics and Child Health. It was agreed that supervision would commence on Monday 18 July 2016 and that Letby would take authorised leave prior to that date. I exhibit the letter sent to Letby following this meeting as my **Exhibit JT/209 [INQ0014307]**.

303. On 18 July 2016 Letby attended a further meeting with Karen Rees, Lead Nurse Urgent Care, and Linda Guatella, HR Business Partner, in which she was told that the NNU was unable to undertake supervised practice due to staffing levels. Letby was therefore redeployed into the Risk Team from that date under the direction of Ruth Millward, Head of Service. This meeting is summarised in a letter to Letby dated 18 July 2016 which I exhibit as my **Exhibit JT/210 [INQ0014308]**. It is believed that the redeployment of Letby took place due to the concerns that had been raised by consultants at this point, as referred to further below, but that Letby was not told of this rationale on 18 July.

304. It is understood that further meetings took place with Letby during August and September 2016 to provide support and updates on the position.

305. Letby submitted a grievance, dated 7 September 2016, in accordance with the Trust's grievance procedure. This followed an email and letter raising similar concerns sent by Letby's RCN representative, Tony Millea, to the Trust on 2 September 2016. The grievance was submitted on the grounds of victimisation and discrimination with regards to her removal from the neonatal unit. The outcome sought was *"I wish to be reinstated into my full time position as a Registered Nurse within the NNU."*

306. Her grievance listed a number of grievances/concerns that she had. I exhibit as my **Exhibit JT/211 [INQ0014309]** the grievance form submitted and also as my **Exhibit JT/212** **[INQ0003171]** the letter of 2 September from the RCN representative.

307. Her grievance referred to an external review into the increased mortality rates in the neonatal unit having taken place and referred to there being no mention of any wrongdoing by Letby. Letby therefore questioned why she had been "redeployed and singled out." She also alleged discrimination due to allegations having been made by consultants regarding her clinical practice.

308. Legal advice was sought by the Trust from DAC Beachcroft on the handling of the grievance.

309. During Letby's redeployment and whilst her grievance was being investigated, weekly support meetings were put in place with Karen Rees, Head of Nursing Urgent Care and occupational health support was available.

310. A meeting took place with Letby, Karen Rees, Sue Hodkinson, Director of People & Organisational Development, Alison Kelly, Director of Nursing & Quality, and Letby's RCN representative, Hayley Cooper, on 5 October 2016 to provide Letby with an update on the external review. It was agreed that weekly updates would be provided to Letby and she confirmed that she was also meeting with the senior team from the neonatal unit to receive clinical updates from the neonatal unit. Letby was advised that Dr Christopher Green, Director of Pharmacy, would be investigating her grievance. A letter was sent following that meeting which I exhibit as my **Exhibit JT/213** **[INQ0003445]**

311. A further meeting was held on 20 October 2016. During this meeting Letby was advised that a draft report of the external review had been received, but that a 'deep dive' clinical review was recommended – a review to be led by Dr Ian Harvey, Medical Director.

312. Letby was also advised that her grievance would be heard on 15 November 2016 by Annette Weatherley, Deputy Chief Nurse at the University Hospital of South Manchester NHS Foundation Trust, with Dee Appleton-Cairnes, Deputy Director of HR, also present. Letby was advised that she had been redeployed from the neonatal unit "*as a supportive measure as it was a vulnerable environment with some of the comments we had been made aware of*". This is reported in a letter to Letby following the meeting, dated 26 October 2016, which I exhibit as my **Exhibit JT/214** **[INQ0003447]** Support continued to be offered to Letby by the Trust during her period of redeployment.

313. Further meetings took place on 2 November 2016 and 15 November 2016, During the meeting on 15 November, Letby was advised that a factual accuracy check process had been completed on the draft external review report and that draft feedback had also been given on the clinical review. It was hoped that both reports would be available in final form soon. Letby was also advised by Alison Kelly that the decision-making process for Letby's reinstatement to the neonatal unit had been delegated from Board level to Alison, as Letby's professional nursing lead, and that Alison had no concerns in relation to Letby's return to the Unit. Letby was advised that a plan for her return would be developed over the coming weeks. I exhibit the letter sent to Letby after this meeting summarising the discussion, dated 6 December 2016 as my **Exhibit JT/215** **[INQ0003453]**

314. Around this time, arrangements were being put in place for Letby to attend Alder Hey NHS Foundation Trust to observe in theatre for a couple of days. On 9 December 2016, Michelle, a Human Resources Assistant at Alder Hey Children's NHS Foundation Trust, emailed the Trust's HR vacancies team to request pre-employment checks for Letby. On the same date, Susan Bates, HR Senior Assistant, completed a pre-employment checks form for Letby listing the substantive information held by the Trust in relation to employment.

315. The hearing of Letby's grievance was rescheduled to 1 December 2016. I exhibit a letter dated 7 November 2016 to Letby advising her of this date as my **Exhibit JT/216** **[INQ0006329]** I exhibit the letter sent to Letby on 1 December 2016 confirming the findings of the grievance hearing as my **Exhibit JT/217** **[INQ0003280]** I also exhibit the transcript of the grievance hearing as my **Exhibit JT/218** **[INQ0003155]** Prior to the hearing of the grievance, Annette Weatherley, who heard the grievance, had been provided with a report, dated 22 November 2016, by the investigating officer, Dr Christopher Green. I exhibit a copy of this report as my **Exhibit JT/219 [INQ0014317]**.

316. The findings included that the Trust had not been as open and honest with Letby as it could have been in relation to her redeployment from the NNU, and that the concerns raised about Letby by consultants in the Trust to the Executive Team were not "*clear, honest and objective.*" The concerns raised by consultants were that there was a direct link between Letby's presence on the neonatal unit and the increased mortality and suggestions were made that this link was due to knowingly deliberate action by Letby.

317. The grievance hearing concluded that the Trust had considered the concerns in line with the Trust's 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. It concluded that the action of removing Letby from the neonatal unit while the external review and 'deep dive' clinical review was being undertaken was within a range of reasonable responses, "*as it was believed that these reports would provide further information that would clarify any concerns regarding any deliberate action resulting in patient harm".* However, it was found that a further option available to the Trust was to provide support to Letby to remain on the neonatal unit with supervision.

318. It was suggested that immediate steps needed to be taken to address the consultants' behaviours and that it was hoped that such measures would support Letby's return to the neonatal unit.

319. Meetings with Letby took place to discuss the outcomes of the grievance process on 7 and 13 December 2016. I exhibit a letter to Letby dated 4 January 2017 summarising those meetings as my **Exhibit JT/220** **[INQ0003465]** One of those outcomes was for a meeting to be arranged with Letby, her parents, Tony Chambers, the Chief Executive, and other members of the Executive team to discuss the concerns raised by the grievance. The meeting was arranged for Thursday 22 December 2016 and a further meeting took place on 6 February 2017. Plans for Letby's transition back to the neonatal unit were also discussed including plans for her continuing professional development. I exhibit a letter from Tony Chambers to Letby following the meeting on 22 December 2016, together with notes of the 22 December 2016 meeting as my **Exhibit JT/221 [INQ0014319]**. I also exhibit a letter to Letby's parents on 20 February 2017 including notes of the meeting with her parents on 6 February 2017 as my **Exhibit JT/222 [INQ0014320]**.

320. At a meeting on 10 January 2017 Mr Chambers reported to Letby that at the Board meeting earlier that day, Alison Kelly had read out a personal statement provided by Letby, and the Royal College report had been shared with the Board in addition to the outcome of Letby's grievance hearing. Letby was advised that the Board was supportive of her

return to the neonatal unit and of the recommendations arising from the grievance, including that the consultants be required to make an apology to Letby and engage in mediation. I attach the notes of that meeting as my **Exhibit JT/223 [INQ0014321]**.

321. Further meetings took place between Letby, Alison Kelly, Sue Hodkinson and others from January to April 2017 to provide continuing support to Letby, implement the recommendations from the grievance process and plan for Letby's transition back to the neonatal unit. I further exhibit a letter to Letby of 3 April 2017 with meeting notes from the meetings from January to March 2017 as my **Exhibit JT/224 [INQ0003475]**

322. During this period, discussions took place relating to the publication of aspects of the external review report and communication management and plans regarding the sharing of the 'deep dive' clinical reviews with the parents of each of the babies. The planned mediation with medical colleagues was also discussed. Initial mediation meetings took place in March 2017. I exhibit the letter of apology provided to Letby by the consultants, dated 28 February 2017 as my **Exhibit JT/225 [INQ0003187]**. The consultants continued to have concerns about the mortality levels in the neonatal unit and the reviews undertaken and about the mediation process being undertaken in light of these concerns. By way of example, I exhibit an email from Dr Brearey to Ian Harvey dated 6 March 2017 summarising discussions during a meeting on 28 February 2017 as my **Exhibit JT/226 [INQ0006427]** There is concern amongst the consultants that the complaint in the grievance was never made clear to the consultants and it was an adversarial process where the report and outcome was never shared with the consultants.

323. At a meeting on 5 April 2017 Letby was advised that her return to the neonatal unit would be paused because, on reflection following the meetings with Letby and her parents, it was important that "*we got everything right, both in terms of timing and process, to ensure that your transition back to the unit was successful and supported you,*" as a number of actions were ongoing arising from the clinical reviews. I exhibit a letter to Letby of 5 April 2017 which summarises this discussion as my **Exhibit JT/227 [INQ0014325]** and a letter sent to Letby following a further meeting on 18 April 2017 as my **Exhibit JT/228 [INQ0002790]**

324. At a meeting with Letby on 27 April 2017 Letby was advised that there remained ongoing clinical concerns arising from the clinical review that had been conducted by Dr Hawdon. Dr Hawdon had suggested the Trust link in with CDOP, which it had done. I exhibit notes of this meeting as my **Exhibit JT/229 [INQ0014327]**.

325. I exhibit notes of further meetings with Letby on 4 May 2017 as my **Exhibit JT/230 [INQ0014328]**, 9 May 2017 as my **Exhibit JT/231 [INQ0014329]** and 22 May 2017 as my **Exhibit JT/232 [INQ0014330]**. At the meeting on 22 May 2017 Letby was advised that the matter was now the subject of a police investigation following an action identified by CDOP. At a further meeting with Letby on 3 June 2017, Letby was advised that her shadowing at Alder Hey Children's Hospital (as part of professional development support) should also be paused. I exhibit the notes of that meeting as my **Exhibit JT/233 [INQ0014331]**.

326. These notes were sent to Letby under cover of a letter of 5 June 2017 which I exhibit as my **Exhibit JT/234 [INQ0014332]**.

327. I exhibit an email to the Police of 17 May 2017 confirming the welfare support in place for Letby as my **Exhibit JT/235** **[INQ0006437]**

328. On 5 July 2018, Alison Kelly wrote to Letby to advise her that she had made the decision to exclude her from work on full pay whilst the police continue with their investigation. Letby had been arrested by the police on 3 July 2018. I exhibit this letter as my **Exhibit JT/236** **[INQ0006444]** The letter also advised Letby that in instances of alleged professional misconduct the Trust is required to report ongoing investigations to the NMC and that this report had been done. A further letter was sent on 21 December 2018 to ensure continuing support was provided to Letby to protect her welfare – at this point Letby had moved out of the Trust's area. I exhibit this letter as my **Exhibit JT/237** **[INQ0006445]** A referral was made by Alison Kelly to the OH team at Hereford Hospital in January 2019.

Dismissal of Letby

329. Letby continued to be excluded from work on full pay during the course of the police investigation. On 26 November 2020, Alyson Hall, Director of Human Resources and Organisation Development, wrote to Letby to advise that with effect from 12 November 2020 her salary payments would cease "*in response to the Courts judgement to remand you in custody*." I exhibit this letter as my **Exhibit JT/238 [INQ0014336]**.

330. On 11 December 2020, Alyson Hall wrote to Letby to advise that the Trust had decided to commence a disciplinary hearing following Letby being charged by Cheshire Police on 11 November 2020 with the murder of 8 babies and attempted murder of a further 10

babies and being remanded in custody on 12 November 2020 pending committal to the Crown Court for trial. The Trust had also been advised by the NMC at this point that an 18-month interim suspension order had been placed on Letby on 20 November 2020. The letter advised that a "*disciplinary hearing is to be convened to establish whether, by reason of the above circumstances, there is evidence to form a reasonable conclusion that you have committed such serious breach or breaches of the Trust's disciplinary policy such that your employment should be terminated for gross misconduct or, in the alternative, your employment should be terminated for some other substantial reason."* I exhibit this letter as my **Exhibit JT/239 [INQ0014337]**.

331. The disciplinary hearing took place on Monday 4 January 2021. The hearing was chaired by Darren Kilroy, Medical Director. Letby had been provided with the option of attending using an online video link, being represented by another individual such as a union representative or submitting a written response to the allegations. Letby did not take up any of these options. Following the hearing, Darren Kilroy sent a letter to Letby, dated 4 January 2021, advising her that the outcome of the hearing was that her employment with the Trust was terminated with immediate effect. The letter reported the reasoning for the decision:

"I do not consider it appropriate or necessary within this internal disciplinary hearing to determine whether or not I find the allegations of murder/attempted murder brought against you to be proven. That is for the criminal court to decide.

However, in reaching my decision, I have taken into consideration that the burden of proof in a criminal case is far higher than in the case of an internal disciplinary hearing and that, even were you to be acquitted of these criminal charges, there would remain for the foreseeable future such a significant loss of trust and confidence in you as a neonatal nurse both from the perception of the public, the Trust and colleagues that would make your position with the Trust, untenable.

In addition, since being charged with these offences, I am also of the opinion that your continued employment represents a serious risk to the reputation of the Trust as a responsible health care provider.

I gave consideration to the possibility of retaining you in the employment of the Trust until such time as your case is heard. However, I do not believe that is an appropriate use of public funds in light of the above findings including the fact that I believe trust in you is irretrievably broken down. "

332. I exhibit the letter of 4 January 2021 as my **Exhibit JT/240 [INQ0014338]**.

Professional regulators

333. The Trust advised the NMC of the Police investigation in July 2018 and of Letby's arrest. I exhibit the email and attachments sent to the NMC by Alison Kelly on 5 July 2018 as my **Exhibit JT/241 [INQ0014339] and [INQ0014340]**. The NMC was provided with a brief chronology of events and with a copy of the RCPCH review report dated October 2016. It seems that this followed a conversation between Alison Kelly and Kristian Garsed, Regulation Adviser, Employer Link Service, NMC. I exhibit an email from Kristian to Cheshire Police on 4 July 2018 which explains this timeline of events and the NMC's involvement as my **Exhibit JT/242 [INQ0014341]**.

334. Previously, Alison had spoken with Tony Newman, Regulation Adviser, Employer Link Service, NMC, in July 2016 about the concerns about Letby to seek advice as to referring the matter to the NMC, as referred to in paragraphs 196-198 and 240 above.

335. It is understood that no other nurse from the NNU was reported to the NMC during the period in question by the Trust as there was no basis on which to make any such report. However, I am aware that Alison Kelly, Director of Nursing & Quality, was reported to the NMC by Drs Brearey, Jayaram, Doctor ZA and Holt on 20 May 2020, and that this NMC investigation is ongoing. I attach as my **Exhibit JT/243 [INQ0014342]** the NMC referral form in relation to that referral.

336. A report was made to the GMC about Dr Ian Harvey by Drs Brearey, Jayaram, Doctor ZA and Holt, four consultants, as a result of concerns about how Ian Harvey had handled the concerns raised about Letby. I attach as my **Exhibit JT/244 [INQ0014343]** an email dated 20 July 2018 containing that referral. After an initial interview with Dr Brearey, the consultants were notified the investigation would be paused until after the police investigation had been completed. On 5 May 2022, the GMC wrote to Dr Brearey to say that the GMC had finished their investigation of Mr Harvey and he had subsequently erased himself from the GMC register. Drs Jayaram, Doctor ZA and Holt were never interviewed or had an opportunity to share their concerns with the GMC.

337. Contact was made with West Cheshire CCG and NHS England at an early stage (thought to be in or around July 2016) to notify them of the concerns and engagement with both bodies took place from that date.

338. The CQC inspected the Trust in February 2016 (rated overall "Good"). I understand that Trust consultants may have raised a number of concerns with the CQC at that time about the events in the NNU but the Trust currently does not have any documentation to evidence any such discussions.

339. The paediatricians' concerns were raised with the RCPCH invited reviews team. Letby was also interviewed by the RCPCH team, outside of their terms of reference.

340. It is understood that no other reports were made to other professional regulators in relation to any matters arising from the actions of Letby, save as set out above.

Thematic reviews

341. On 8 February 2016, a thematic review of neonatal mortality in the neonatal unit (NNU) from June 2015 to January 2016 was undertaken due to the higher-than-expected mortality rate. Dr Stephen Brearey discussed the planned review with Dr Nim Subhedar, lead neonatologist of the Cheshire and Merseyside Neonatal Network, and Dr Subhedar was asked to be part of the review. The review covered the deaths of babies between June 2015 and January 2016. An obstetric review had already been completed at this point.

342. Present at the review meeting were consultants Dr Brearey and **Doctor V**, Dr Nim Subhedar, NNU manager Eirian Lloyd-Powell, lead nurse of children's services Ann Murphy, NNU nurse Ms Eagles, and quality improvement facilitator Debbie Peacock.

343. The aim of the review was to review the cases as a multidisciplinary team with an external reviewer and tertiary level neonatologist to assess if all action points were completed, were there any new areas of care improvement, any possible common themes and whether any further action was required. Patient electronic records, written notes, radiology and Meditech entries, in addition to previous reviews, were available as part of the thematic review.

344. The outcome of the review was that there was no common clinical theme or diagnosis identified in all the cases. However, some themes were identified across more than one case and a number of actions were produced to seek to improve practice. The review found that a majority of the babies suffered a sudden and unexpected collapse and that 6 of the 9 babies reviewed had arrests between 00:00 and 04:00. Some areas for practice

improvement were identified e.g. delayed cord clamping in preterm babies and umbilical line placement, but these were not considered contributory to the deaths. Actions from the meeting included a further detailed review of the care of all the babies received in the 4 hours prior to collapse and for Dr Brearey to forward the thematic report to Ian Harvey and Alison Kelly requesting an urgent meeting. I exhibit the minutes of the review and action plan, dated 8 February 2016 as **Exhibit JT/245 [INQ0014344]**, **INQ0003552**, **INQ0003295**, **INQ0003297**, **INQ0006833**, **INQ0003299**, **INQ0003296**, **INQ0003551**, **[INQ0003550]**, **INQ0003545**, **INQ0003543**, **INQ0003286**, **INQ0003288**, **INQ0003549**, **INQ0003548** and **INQ0003547**.

Royal College of Paediatricians and Child Health review

345. Following the thematic review, a number of concerns remained about the increased mortality and these were heightened on the death of two triplets on the Unit in May 2016. The Trust therefore requested an invited service review by the Royal College of Paediatricians and Child Heath ("RCPCH") on 28 June 2016.

346. The intention was to assess the unit against national standards, using the standard terms of reference for invited reviews. However, at the request of the Trust, an additional question was added to the terms of reference which was "*4.6 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*?"

347. The terms of reference were agreed with the RCPCH and the RCPCH was ultimately commissioned to conduct the review in early August 2016, with a plan for the review to commence at the beginning of September 2016.

348. On 1 and 2 September 2016, the RCPCH carried out a review visit. Neonatal nursing staff and medical staff were interviewed, including all the paediatric consultants who discussed their concerns regarding Letby. Letby was also interviewed by the reviewers.

349. It is understood that a draft report was sent to the Trust on or around 18 October 2016 with a request to check for factual accuracy. It is understood that Dr Stephen Brearey, Dr Ravi Jayaram, Dr John Gibbs and Anne Murphy did not have sight of the report for some time and were given only a very short period of time (one hour) to read the draft report and make comments regarding its factual accuracy to Ian Harvey. The copy of the report that

was shared is said to have been heavily redacted. A final version of the report was received on 28 November 2016. I attach this as **Exhibit JT/246 [INQ0002457**

350. It is understood that the report was shared with the Trust board in the second week of January 2017. Subsequently, all the paediatric consultants were asked to attend a meeting with Executives on 26 January 2017. I exhibit the minutes as my **Exhibit JT/247 INQ0003523**. I understand the consultants attended on the understanding that the RCPCH report and Dr Hawdon report would be discussed. However, whilst Ian Harvey gave a verbal summary of the findings of the two reports and the grievance procedure report of the outcome of Letby's grievance, the consultants were then asked by Chief Executive Tony Chambers to apologise to Letby and a written statement from Letby was read out by Karen Rees. The consultants were asked to accept the findings of the reports and the decisions of the board, apologise to Letby and were told that there was a 'need to draw a line under the 'Letby issue''.

351. I exhibit a letter from the consultants to Tony Chambers on 30 January 2017 as my **Exhibit JT/248 INQ0003095** asking for clarification of the plan they had been asked to agree to and a request to see the RCPCH and Dr Hawdon reports. On 31 January 2017, the paediatric consultants were informed by Sue Eardley, head of invited reviews at RCPCH, that there were 2 copies of the report, one for the Trust and one intended for release to the public.

352. It is understood that the recommendations arising from the RCPCH report were completed by late 2017.

Dr Gibbs and Ms Martyn review

353. Following the decision to request a review by the Royal College of Paediatrics and Child Health in July 2016, Ian Harvey was asked by the Chief Executive Officer, Tony Chambers, to undertake a detailed forensic internal review of the increase in neonatal mortality. I understand this was completed during the two weeks that Letby was on annual leave in July 2016.

354. Dr John Gibbs and Ms Anne Martyn were requested to undertake a health record review of all infants who collapsed or deteriorated in the neonatal unit and needed to be transferred out of the hospital during the period June 2015 to June 2016. Dr Gibbs & Ms Martyn commenced their review on 8 July 2016 and finished it on 11 July 2016. Initially, a

larger group of patients who required a transfer out of the neonatal unit were considered to form part of the review. Any patients who had a problem that would automatically require a transfer (e.g. significant bowel malformation, severe congenital heart disease) were excluded and the remainder were subject to Dr Gibbs and Ms Martyn's review.

355. It was assumed by Dr Gibbs that amongst those remaining on the list would be patients who had deteriorated significantly, or in some other way were considered to be particularly unwell, such that the Countess of Chester Hospital could no longer meet their needs and instead they required support from a level 3 NNU (or other specialised service such as Alder Hey). Whilst this list of transferred patients may have included some patients whose collapses had been unexpected or unusual in some other way, it did not cover any patients who had died or who had collapsed but recovered and remained in the Countess of Chester Hospital between June 2015 and July 2016.

356. It is understood that Dr Gibbs looked through the health records and Ms Martyn took notes (which included recording the ID of each infant). I understand that there was a deliberate effort on Dr Gibbs's part to not know which staff had been looking after the infant and Dr Gibbs was said to be intentionally ignorant of which nurses were involved. Whilst Ms Martyn could see the nursing notes on Meditech and reported what these said to supplement the health records, she did not inform Dr Gibbs of which nurse made the entry. Ms Martyn did not include any information about the named nurses in the notes she made regarding each patient.

357. After their review, Ms Martyn gave the handwritten notes she had made to one of the senior nurses, believed to be Deputy Nursing Director Sian Williams. It was understood that this would form part of a wider Trust 'investigation' of the cases and analysis of all the nurses and doctors on duty when each patient deteriorated or collapsed.

358. Dr Gibbs and Ms Martyn estimated there were around 6 cases of those reviewed for which there was not a reasonable explanation for their deterioration or collapse, noting a high threshold set in their review.

359. In respect of the outcome of the review and any steps taken by the Trust, I exhibit as **Exhibit JT/249 [INQ0014363]** a typed copy of the neonatal review document that Dr Gibbs and Ms Martyn completed, which I understand was subsequently edited by Ian Harvey in blue text. It is believed that the red text is the notes that Ms Martyn made relating to those features that she or Dr Gibbs felt were in some way unusual. It is understood that the

review document was not initially shared with Dr Gibbs and Ms Martyn, nor with the consultant paediatricians.

Director of Nursing review

360. I understand that Alison Kelly, Director of Nursing at the Trust, conducted two reviews into activity, acuity, and staffing levels on the neonatal unit during the period 2015 to 2016: a Bi-annual Safe Nurse Staffing Established Review dated 6 July 2015 and a Position Paper on the NNU Mortality dated July 2016. I attach the 2015 review as **Exhibit JT/250 [INQ0014364]**. The 2016 Position Paper is referred to in paragraphs 191-195 of my statement above.

361. The 6 July 2015 review was conducted following the 'Hard Truths' publication and in line with the National Quality Board recommendations 'How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability'. An expectation of the recommendations was that a nurse staffing review would take place twice a year as a minimum to ensure the Board receives assurance that patient safety is being maintained with regard to staffing numbers and skills. The report was also produced to provide assurance both internally and externally that wards were appropriately staffed, and that staff could provide appropriate levels of care to patients.

362. The review highlighted that the NNU had an action plan to replace staff at Band 4 who left the NNU, with a Band 5. The aim of this was to support further compliance with national guidance and standards. The review noted that the nursing staff were committed and supported short notice changes to their off duty to enable the NNU to function effectively. However, this was not sustainable and as a result the Head of Nursing was supporting further reviews and was asked to undertake benchmarking with other Units based on occupancy and further recommendations would be made dependent on the outcome. There was an emphasis on ensuring staffing levels were sufficient to meet the needs of the service, especially following the Kirkup Report.

Dr Jane Hawdon review and Dr Jo McPartland review

363. A recommendation from the RCPCH review referred to above was that the death of each baby was independently reviewed by way of a detailed case note review. It is understood that Dr Jane Hawdon (Consultant Neonatologist, Royal Free Hospital, London)

was commissioned to undertake this independent review in September/October 2016. I exhibit email correspondence between Dr Hawdon and Ian Harvey in September 2016 as my **Exhibit JT/251** **INQ0003123**, a copy of some instructions which are undated as my **Exhibit JT/252** **INQ0003101** and a response from Dr Hawdon dated 29 October 2016 as my **Exhibit JT/253** **INQ0003358** which refers to a letter on 5 October.

364. The case review report was received on 31 October 2016. It is further understood that Dr Hawdon did not visit the Trust or speak to any of the clinical staff in preparing her report – it was essentially a desk top clinical case review. The report highlighted areas where practice could have been different. There were 4 cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that: "*Subject to coroner's post mortem reports, there should be broader forensic review of the cases ... as after independent clinical review these deaths remain unexpected and unexplained."* I exhibit the report which is dated October 2016 as my **Exhibit JT/254 [INQ0014368]**. Dr Hawdon also provided further comments in an email dated 25 November 2016 to Ian Harvey following a review of a number of PM reports, which had been outstanding. I exhibit this email as my **Exhibit JT/255** **INQ0003102**

365. It is not known how the babies whose cases were reviewed were selected, but Dr Hawdon was asked by the Trust to review the case notes of relating to 13 neonatal deaths and 4 'near misses.'

366. It is understood that a meeting took place between Ian Harvey, Nim Subhedar, Julie McCabe, Tony Chambers, Ravi Jayaram and Steve Brearey to discuss how best to share the report with the parents of those babies whose cases had been reviewed. Parents were provided with those sections of the report relating to their baby.

367. On 21 December 2016, Ian Harvey sent an email to Dr Jo McPartland, Consultant Paediatric Pathologist at Alder Hey Children's NHS Foundation Trust. The email requested a review of the pathology/histopathology relating to four cases, following a recommendation from Jane Hawdon for a "broader forensic review" of those cases, as referenced in paragraph 364 above. I exhibit this email as **Exhibit JT/256** **INQ0003136** Ian Harvey advised "further to our conversation on 6th December I am emailing having had the approval of Coroner, Mr Rheinberg to request a review of four cases." He noted that they had discussed that they "had an RCPCH invited review after our clinicians had noticed an increase in the number of neonatal deaths. One of the recommendations of the

review was that an independent secondary review of the individual cases (13 deaths and 4 near misses) was required and this was duly carried out by Dr Jane Hawdon. Dr Hawdon has advised "local forensic review," to include pathology/histopathology of four cases."

368. Within the email, Ian Harvey sets out that the review was to include Child A, Child I, Child O and Child P. Ian Harvey noted "it may be of relevance that our clinicians have reported that one clinical feature that they had noted was that in some cases babies did not seem to respond to resuscitation as they would have expected."

369. On 25 January 2017, Dr McPartland emailed Ian Harvey advising that her, Dr Kokai and Dr Shukla had discussed the "clinical scenarios and macroscopic PM findings and conclusions for these four cases." I exhibit this email as **Exhibit JT/257** INQ0003135 **and** INQ0003196 Dr McPartland attached a summary of their conclusions for each case and noted it was "not a full and formal medicolegal review" and that "if you require an analysis of this depth, it is probably best performed independently by someone from another centre. However, the histology is not available on the first two cases, as per the families' request for disposal."

370. I exhibit as **Exhibit JT/258** INQ0003669 the conclusions of Dr McPartland. The report considers the possible causes of death and they concluded in relation to:

- Child A that they were "in agreement that the cause of death remains Unascertained."
- Child I that "we are in agreement that the cause of death is 1a. Hypoxic ischaemic damage of the brain and chronic lung disease of prematurity due to 1b. Extreme prematurity."
- Child O that "no cause was found at autopsy for the initial collapse" and they noted that "However, the cause of the initial collapse remains unexplained. Toxicology was not performed, and therefore medication overdose cannot be excluded."
- Child P that "there were no significant findings at autopsy" and that "we discussed that the cause of death (which is given on "the balance of probabilities" to the Coroner) could also have been submitted as unexplained/unascertained, and this would be a subjective decision that would vary between pathologist." It was noted "toxicology was not performed, and therefore medication overdose cannot be excluded" and "Referral of this family to Clinical Genetics to discuss potential genetic causes of sudden unexpected postnatal collapse would be reasonable."

371. In February 2017 the Jane Hawdon report was shared with Mr Rheinberg and Mr Moore, Coroner and Deputy Coroner for Cheshire. At the beginning of the report, it notes that this is an opinion and to inform discussion and learning.

372. When the paediatric consultants had sight of the review, Nim Subhedar was asked to conduct an independent review. Following his independent review of the report, he felt there was 7 cases that needed to be reviewed as opposed to 4, which later (following a discussion) increased to 8 cases that needed to be reviewed.

373. Following a meeting of the paediatric consultants, Medical Director and Neonatal Network Lead on 28 February 2017, on 1 March 2017 Tony Chambers received a letter from the paediatric consultants expressing concern with regards to the outcome of the reviews; essentially that there had been no common theme identified and that they were no closer to understanding the reasons for the increased mortality. Ian Harvey also received an email from the consultants expressing concerns on 6 March. The consultants expressed concern that there were a number of cases of unexpected collapses which had not been reviewed by Dr Hawdon. They also stated that the consultants' view was that there were 8 babies which required a further broad forensic review. A further broader forensic review of some cases was one of the recommendations made by Dr Hawdon. They were also of the view that there were some elements of sub-optimal care that Dr Hawdon had not commented on. The consultants were concerned that the events had not been fully investigated. I exhibit this email and Ian Harvey's response and this letter as my **Exhibit JT/259** **INQ0003395** **and** **INQ0003096** Previously, there had been correspondence between Ian Harvey and Dr Hawdon about the consultants' concerns, as demonstrated by an email chain of 14 February 2017 which I exhibit as my **Exhibit JT/260 [INQ0014376]**. There had also been correspondence between Ravi Jayaram and Tony Chambers in which Tony responded as follows by letter of 16 February 2017 which I exhibit as my **Exhibit JT/261** **INQ0003159**

"In summary, there has been a thorough internal and external review into the unexpected increase in mortality levels for new born babies on our neonatal unit for 2015 and 2016 compared to previous years, including:

- *independent external RCPH review;*
- *independent external review of each of the 13 deaths by an experienced independent clinician;*
- *thorough review of activity, acuity levels and staffing profiles of the unit during the past 3 years.*

All this data has been shared fully with these review teams and at all times the allegations made by the consultant team were shared openly too. All conclude that there is no single causal factor to explain the change in mortality rates nor to substantiate the allegations you have made. We now need to look to the future."

374. The culmination of the exchange of these concerns however appears to be that the decision was made to discuss the matter with CDOP and the police. I exhibit a note seemingly prepared by Ian Harvey on 3 April 2017 which summarises the reason for this approach as my **Exhibit JT/262 [INQ0014378]** and the minutes of a meeting of the Trust Board on 2 May 2017 which record this decision as my **Exhibit JT/263 [INQ0003517]**.

375. Dr Hawdon was asked to review further cases in May 2017 – the deaths of two triplets.

CQC inspection 2016

376. I have been referred to the June 2016 CQC report on the Trust which found that services for children and young people required improvement and directed to the following quotes from those statements.

"*Nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM). Between January 2015 and January 2016, 11 incidents were recorded that related to the acuity of patients and staffing breaching BAPM standards and on seven occasions in that period the neonatal unit had been closed to admissions.*"

377. My first statement addresses the nurse staffing levels in the NNU between January 2015 and January 2016 in paragraphs 96-101. As confirmed in these paragraphs, 65% of shifts in the neonatal unit at the Trust during this period were staffed to BAPM recommendations and these staffing levels at the time were comparable to other neonatal units in Cheshire and Merseyside and nationally. The national average compliance rate was 57.96%. Therefore, more shifts were compliant with BAPM staffing recommendations in Chester in 2015 and 2016 than the national average. Any incidents relating to acuity of patients and staffing were recorded on Datix. The majority of non-compliant shifts were caused by the lack of a supernumerary shift leader, a new recommendation at the time. Compliance with the standard for having a supernumerary shift leader was still higher than the national average.

378. The Trust used the Neonatal Clinical Reference Group Workforce Calculator (Dinning) Tool (2013) to support neonatal nurse managers and their colleagues in calculating nursing establishment requirements to meet the national standards. The Cheshire and Merseyside Neonatal Network would send the analysis tool to the Trusts in the region to establish compliance against the BAPM standards, and the Trust would receive the analysis tool once per annum.

379. The Neonatal Unit Mortality Position Paper prepared by Alison Kelly and Ruth Millward dated July 2016, which is referred to in paragraphs 191-195 of my statement above, provided information and data in relation to the number of neonatal deaths during the relevant period.

380. The Position Paper states that analysis of Datix incidents reported confirms that there were incident reports logged regarding various aspects of care in 10 out of the 11 neonatal deaths reported in 2015/16. It is understood that the neonatal unit began inputting nurse staffing and cot occupancy into BadgerNet in October 2014:
"The BadgerNet data for June 2015 – March 2016 has been utilised to assess compliance with the British Association of Perinatal Medicine (BAPM) standards i.e. 1:1 intensive care, 1:2 high dependency care and 1:4 special care. This review has identified that the Neonatal Unit nurse staffing numbers were below the BAPM recommendations (based upon neonatal acuity) at the time of 7 of the neonatal deaths (out of 11 deaths reported June 2015 – March 2016). BadgetNet has calculated the variation from the BAPM standards for these individual shifts as (minus) -0.6 to (minus) -2.6 from the recommended nursing establishment. Following on from this, BadgerNet demonstrates lower than recommended provision of 'Qualified in Specialty' (QIS) nurses. 11 incidents were reported by Neonatal Unit staff during the same period (for June 2015 – March 2016) regarding staffing/acuity concerns. 5 (45%) were in November 2015 and 4 (36%) in December 2015."

381. The Position Paper concluded that nursing staffing levels were a contributory factor in the significant change in mortality rates at the Trust. Evidence showed that the neonatal unit did not consistently meet the BAPM recommended nurse staffing levels or the recommended provision of 'Qualified in Specialty' nurses.

382. It is noted that although the staffing ratios were not always fulfilled according to BAPM recommendations, it is understood that the Trust's staffing levels were comparable to other units nationally at the time. The manager of the neonatal unit at the time complied several workforce plans in an attempt to bring staffing levels closer to the BAPM standards, but

ultimately the Trust did not or could not implement the plans. It was confirmed that this was the national standard and the Trust had to act within budgets at the time.

383. Four business cases were put together by Eirian Powell and Stephen Brearey which outlined the NNU staffing levels and proposals for the Trust, which I exhibit as **Exhibit JT/264** **INQ0003829** **INQ0003830**, **INQ0003831**, **INQ0003832**, **INQ0003820**, **INQ0003821**, **INQ0003822**, **[INQ0014387] and [INQ0014388]**. It is not clear whether all these business cases were ultimately submitted.

384. The Trust has been referred to the CQC statement made in the 2016 report that "Controlled medicines were stored correctly but were not consistently checked as per the trust's policy." As addressed in paragraph 105 of my first statement, controlled medications were stored in the controlled drug cupboard, which was made of steel, double locked and alarmed. There was a unit with two locked compartments within nursery one for the storage of non-controlled drugs, and there was also storage for intravenous fluids in a locked cupboard. The medication cupboards were checked at night every 24 hours, however there were no electronic medication records in use at that time which would have recorded access to medication. However, the controlled drugs (CD) book was checked daily, and all medication was accounted for and signed at the back of the book. When controlled drugs were ordered and sent to pharmacy on return order, the book was required to be signed to state acceptance of the medication. On retrieval of replacement medication, the new stock would have been added to the existing stock and signed by two registered nurses. I understand that some audits were conducted and found that this process was not always followed. I attach the Trust policies on controlled medications applicable during the relevant period as **Exhibit JT/265 [INQ0014389], [INQ0014390], [INQ0014391], [INQ0014392], [INQ0014393], [INQ0014394], [INQ0014395], [INQ0014396] and [INQ0014397]**.

385. The Trust has been asked about the statement in the CQC report of 2016 that "Perinatal and neonatal mortality and morbidity meetings were held separately to allow time for discussion and numbered five and two respectively in the last year. Key messages and learning points were then given to staff." As confirmed in paragraph 83 of my first statement, there were regular Perinatal Morbidity and Mortality meetings held to discuss clinical cases which were attended by paediatric and obstetric doctors. A pathologist from Alder Hey Children's Hospital NHS Foundation Trust also presented at the perinatal morbidity and mortality meetings.

386. As paragraph 54 of my earlier statement confirms, the Perinatal Mortality and Morbidity meetings provided an open forum for the discussion of babies' care and lessons that could be learned. These occurred on average 4-6 times a year, and extra meetings were arranged due to the increase in deaths during the relevant period. Cases were discussed within the meetings with learning discussed and any action to be taken.

387. From the documentation available to the Trust, it seems that four Perinatal Morbidity and Mortality meetings took place in 2015. The first Perinatal Morbidity and Mortality Meeting took place on 28 January 2015. It was discussed in this meeting that it would be easier if a 'UVC pack' were available on the resuscitation trolley, and this was relayed to the NNU manager who would ensure that UVC packs were stocked on the trolley. It was concluded in this meeting that generally there was very good neonatal care provided.

388. The second Perinatal Morbidity and Mortality meeting took place on 24 June 2015 which discussed three incidents. Incident I&S was discussed, and it was concluded that there was generally very good neonatal care, and no issues were identified. The second incident I&S was discussed, and it was noted that there were no developmental concerns at this time and there was a highlighted change to 'cooling criteria'. The third incident discussed was incident Child A and no issues were identified.

389. The third Perinatal Morbidity and Mortality meeting took place on 10 September 2015 where two further incidents were discussed. In both matters the record of care and note keeping was deemed satisfactory and in relation to incident I&S no issues or actions were identified. In relation to incident Child D it was discussed that new doctors starting in August would receive sepsis guidance and training.

390. A final Perinatal Morbidity and Mortality meeting took place on 10 December 2015 which discussed two incidents reported in the neonatal unit; however no specific neonatal issues were discussed.

391. In addition to the Perinatal Morbidity and Mortality meetings, two Neonatal Morbidity and Mortality meetings took place in 2015. These were extraordinary meetings that were arranged due to the fact that there was not enough capacity to discuss all the deaths in the Perinatal Morbidity and Mortality meetings as described above.

392. The first Neonatal Morbidity and Mortality meeting took place on 29 July 2015 and discussed two incidents. A number of actions were created in relation to incident Child C including SB was to discuss cord clamping in preterm babies with the obstetric team, and JG was to discuss baptisms before and during resuscitations with the hospital chaplain staff and nursing staff. Incident Child D was also discussed, and it was noted that Dr ZA would discuss sepsis guidance with new doctors starting in August. No issues in relation to the neonatal unit were identified.

393. The second Neonatal Morbidity and Mortality meeting took place on 26 November 2015 which discussed incidents Child I and I&S In relation to incident Child I it was confirmed that SB would take the incident to the neonatal network and surgical case review, and it was noted that there was 'no coherent and consistent management plan from neonatal tertiary centres or surgical team.' Management was confirmed to be appropriate in incident I&S.

394. It is the Trust's understanding that the meetings mentioned above are the relevant meetings and incidents referred to in the CQC Report, and the minutes of these meetings are understood to have been provided to the CQC at the time of the CQC inspection and report.

395. The Trust has been asked about the statement in the CQC report of 2016 that: "Between January 2015 and January 2016, 254 incidents were recorded by the children's unit, neonatal unit and paediatric outpatient's clinic. Of these, 252 were reported as low or no harm". The Trust has been asked how many of these incidents related to the neonatal unit and about the two incidents that were not reported as 'low' or 'no harm'?

396. In relation to the 252 incidents reported as 'low' or 'no harm', 155 were recorded by the NNU. The incidents are listed in the spreadsheet attached as **Exhibit JT/266 [INQ0014398]**, together with a brief summary of the incident.

397. The two incidents that were not reported as 'low' or 'no harm' are exhibited as **Exhibit JT/267 [INQ0014399] and [INQ0014400]**.

398. The Severe Harm Datix relates to an incident which took place on the NNU on 10 August 2015. A female twin suffered a perfusion injury to the right leg following UAC insertion. The child was transferred to Liverpool Womens NHS Foundation Trust (LWH).

Once at LWH the child developed further complications associated with prematurity and was confirmed to have I&S The child died aged PD days.

399. The Actual Harm Datix is in relation to a member of staff who burnt their hand on a sterifeed bag used to sterilise bottles. This incident does not relate to the care of any of the babies on the indictment.

400. The Trust has been asked about the CQC statement in the 2016 report that "The neonatal unit had four cots designated for babies that required transitional care. These were described as 'floating' cots and were based within the maternity unit but cared for by neonatal staff." The neonatal unit had four cots designated for babies that required transitional care. These were described as 'floating' cots and were for babies who required assistance with feeding but did not need continual monitoring and the cots enabled them to stay with their parents.

401. There were four 'floating' cots located in the transitional unit on the postnatal ward, as was the case in many of the other units across the country at the time. This unit was staffed by midwives from the postnatal unit and nurses from the neonatal unit who would look after mothers and babies who were utilising the four transitional care cots.

Facere Melius review

402. In February 2020, during the period of the police investigations, the Trust Chairman at the time, Sir Duncan Nichol, and then Chief Executive, Dr Susan Gilby, formally commissioned an independent external management review of the decisions and actions the Trust took in relation to the concerns raised in the neonatal unit since 2014.

403. The intention was to review how the organisation had responded to the concerns raised within the organisation in relation to the unexpected neonatal deaths, to ensure the organisation had learnt from those and that appropriate changes had been made. It is understood that both the police and the regulators were supportive of this review. The intention to commission the review was shared informally and privately with board members.

404. It was agreed that Darren Thorne, managing director, and the team from Facere Melius would undertake this review and have access to all the evidence the Trust held as an

organisation, which included emails, file notes, handwritten notes in notebooks and documents produced in dealing with these concerns.

405. The terms of reference for the review are exhibited as my **Exhibit JT/268** **INQ0003419** The Trust understands that a draft of the review report has been provided to the Inquiry and to the police by Facere Melius and has recently been made available to core participants by the Inquiry. The Trust had not previously seen the draft report.

Other reviews/organisations

406. On 25 February 2016, the CQC wrote to Tony Chambers, Chief Executive, following their response to a maternity outlier alert for *'puerperal sepsis and other puerperal infections within 42 days of delivery'* at the Trust. The local inspector, Deborah Lindley, confirmed that they were satisfied that sufficient action had been taken to reduce the risks to patients in relation to the issues identified. As a result, the outlier case was closed. I exhibit this document as **Exhibit JT/269 [INQ0014402]**.

407. On 26 February 2016, a 'table-top' review meeting of the Cheshire and Merseyside Neonatal Network was held at Alder Hey Hospital to discuss the case of Child I. Nim Subhedar, clinical lead and chair, explained that the purpose of the meeting was to allow a multi-organisational review of the events and decisions that led to multiple transfers of a baby in the Cheshire and Merseyside network who ultimately died. Any deficiencies in care identified and lessons learnt would be shared with other network providers. It was acknowledged that this case had previously been the subject of detailed reviews at the Trust and Alder Hey. Actions were agreed as a result of the meeting and the action plan is exhibited as my **Exhibit JT/270** **INQ0006735**

408. On 24 January 2017, Ruth Millward, Head of Risk & Patient Safety, wrote in an email to Alison Kelly, Director of Nursing & Quality, that Deborah Lindley from the CQC had been in touch expressing concerns regarding the number of never events and asked for a number of documents including root cause analysis reports, WHO audits and relevant policies. An engagement meeting was arranged for 17 February 2017 to introduce the new CQC hospital inspector, Jacqui Hornby, and to gain assurances regarding the never events. During the engagement meeting, the Trust provided the CQC with a strategic update on the neonatal service as a key risk area. Ian Harvey, Medical Director, explained that following publication of the external review by the RCPCH, the parents of children that were contactable were informed and the report was shared with them and key

stakeholders. Furthermore, the Coroner had been involved and there were plans to discuss the report further with the paediatricians. Plans were also made for staff to attend Alder Hey Hospital to help maintain their competencies. The minutes note that there were lessons to be learned around transport processes and in the incident reporting system, and that the action plan had been requested and was due for completion in March 2017. I attach this document as **Exhibit JT/271 INQ0008081 and [INQ0014405]**.

409. A conference call was held on 27 April 2017 with Ian Harvey and Stephen Cross from the Trust and Margeret Kitching from NHS England and Vince Connolly from NHS Improvement. Margaret Kitching gave an overview of the concerns as a commissioner, which centred on not understanding the full picture regarding deaths within the neonatal unit and that they did not have full access to the detail of the investigations. It was noted that the senior clinicians in specialised commissioning (within NHS England) believed the police should now be involved to seek an opinion. Vince Connolly is said to have asked if Ian Harvey could provide details of the consequences of the CDOP meeting and bring them up-to-date with the current position. During the conference call, Ian Harvey explained the neonatal unit had requested a temporary downgrade to a level 1 service to ensure safety and given there was only 1 death since then, which was expected, Ian Harvey believed the unit was safe. Moreover, Ian Harvey stated that as a result of the RCPCH investigation, there was no single factor identified and rather it was multi-factorial. It was recommended that an investigation into each of the deaths was undertaken and this was completed by an independent expert who did not identify any significant additional issues. It was noted that a single member of the nursing staff was on duty and attended to most cases but that her full-time status meant this was "probably not unusual'. To this end, the Trust sought an independent legal opinion, and the findings were that they could not see any evidence of criminality. I refer to this opinion earlier in my statement. Following the independent reviewer's recommendation of a broader forensic review, the Trust clarified this with the reviewer, and it was determined that involving CDOP would enable a further consideration which would involve the police who is a member of CDOP. It is noted within the minutes that Margaret Kitching thanked Ian Harvey for his time and briefing and recognised the Trust was doing all they could to resolve this, with the involvement of CDOP and the police being welcomed. Actions were agreed as a result of the meeting and the action plan is exhibited as my **Exhibit JT/272 [INQ0014406]**.

410. On 21 August 2017, Hill Dickinson LLP emailed Stephen Cross and Sarah Harper-Lea at the Trust following instruction from NHS Resolution to investigate the neonatal and maternity deaths and establish whether there are any concerns from a claim perspective

on an individual or generic basis. It was noted that NHS Resolution's intention was to instruct an independent expert to review the cases.

Statement of Truth

I believe that the facts stated in this witness statement are true to the best of my knowledge and belief. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data
PD

Dated: 27 March 2024

Appendix A

a. Meetings of the Executive Directors Group (Executive Team) and/or other meetings of Executives:

1. 1 April 2015
2. 8 April 2015
3. 22 April 2015
4. 9 September 2015
5. 6 July 2016
6. 18 July 2016
7. 27 July 2016
8. 31 August 2016
9. 14 September 2016
10. 24 September 2016
11. 19 October 2016
12. 2 November 2016
13. 9 November 2016
14. 21 December 2016
15. 18 January 2017
16. 1 February 2017
17. 6 February 2017
18. 15 February 2017
19. 1 March 2017
20. 2 March 2017
21. 9 March 2017
22. 15 March 2017
23. 16 March 2017
24. 20 March 2017
25. 22 March 2017
26. 28 March 2017
27. 4 April 2017
28. 5 April 2017
29. 26 April 2017
30. 8 May 2017
31. 17 May 2017
32. 24 May 2017

33. 7 June 2017
34. 15 June 2017
35. 21 June 2017
36. 5 July 2017
37. 19 July 2017
38. 23 August 2017
39. 6 September 2017
40. 27 September 2017
41. 13 December 2017
42. 10 January 2018
43. 18 January 2018
44. 24 January 2018
45. 31 January 2018
46. 7 February 2018
47. 24 April 2018
48. 9 May 2018
49. 16 May 2018
50. 23 May 2018
51. 30 May 2018
52. 6 June 2018
53. 20 June 2018
54. 4 July 2018
55. 8 August 2018

b. Meetings of the Urgent Care Divisional Board on:

1. 28 May 2015
2. 24 June 2015
3. 20 July 2015

c. Meetings of the Trust's Governors on:

1. 7 September 2016

d. Meetings of the Board of Directors on:

1. 14 July 2016
2. 10 January 2017
3. 3 February 2017
4. 13 April 2017

5. 2 May 2017
6. 4 July 2017
7. 13 March 2018
8. 22 May 2018
9. 24 July 2018

e. Meetings of the Women and Children's Governance Board on:

1. 12 February 2015
2. 26 March 2015
3. 21 May 2015
4. 18 June 2015
5. 30 July 2015
6. 22 October 2015
7. 19 November 2015
8. 18 December 2015
9. 14 January 2016
10. 19 May 2016
11. 16 June 2016
12. 21 July 2016
13. 20 October 2016
14. 15 December 2016
15. 26 January 2017
16. 20 April 2017
17. 18 May 2017
18. 15 June 2017
19. 20 July 2017

f. Meetings of the Quality, Safety and Patient Experience Committee on:

1. 16 November 2015
2. 14 December 2015
3. 19 September 2016
4. 15 May 2017
5. 19 June 2017

g. Serious Untoward Incident Panel meetings on:

1. 5 April 2016

2. 11 April 2016
3. 20 April 2016
4. 25 April 2016
5. 3 May 2016
6. 9 May 2016
7. 16 May 2016
8. 23 May 2016
9. 2 June 2016
10. 29 June 2016
11. 4 August 2016
12. 11 August 2016
13. 17 August 2016

h. Other meetings

1. 26 June 2015, at the perinatal mortality/morbidity review meeting
2. 16 September 2015, at the Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group
3. 12 November 2015, at the Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group
4. 26 November 2015, at the Neonatal Mortality Meeting
5. 21 January 2016, at the Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group
6. 26 February 2016, at a table top exercise with clinicians from across the region to consider a neonatal death
7. 16 March 2016, at the Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group
8. 11 May 2016, at a NNU review meeting attended by Ian Harvey, Alison Kelly, Dr Stephen Brearey, Eirian Powell and Anne Murphy
9. 18 May 2016, at the Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group
10. in late-June to early-July 2016, at meetings between medical staff and management outlining concerns about Letby
11. 27 June 2016, at an NNU review meeting
12. 29 June 2016, at an NNU review meeting

13. 30 June 2016, at an 'NNU action planning meeting' and other meetings that day, including with the neonatology consultants
14. 1 July 2016, at an urgent NNU meeting attended by Tony Chambers, Mr Ian Harvey, Dr Stephen Brearey, Ravi Jayaram and others
15. 6 July 2016, at a meeting between Ian Harvey and Dr Brearey
16. 7 July 2016 and 11 July 2016, at an NNU response action plan meeting
17. 13 July 2016, at an extraordinary executives meeting followed by a meeting with the paediatricians (attendees unclear)
18. 18 July 2016, at a meeting between Letby, Yvonne Griffiths and Yvonne Farmer to discuss supervision and training
19. 20 July 2016, at the neonates and maternity daily dashboard
20. 19 September 2016, at a meeting attended by Tony Chambers, Ian Harvey, paediatricians and nursing staff
21. 22 September 2016 to 5 October 2016, at meetings between Letby and Eirian Powell relating to the former's welfare
22. 26 September 2016, at the Cheshire & Merseyside Neonatal Network Clinical Effectiveness Group
23. 10 November 2016, at a meeting attended by Ian Harvey, Lorraine Burnett (LB) and Julie Maddocks (representing the North West Neonatal Network)
24. 15 November 2016, at a meeting with Letby, Alison Kelly and others
25. 23 or 28 November 2016 (date unclear), at a meeting with Letby, Alison Kelly and others
26. 24 November 2016, at a meeting between Dr Brearey, Ian Harvey, Sue Hodkinson and others to discuss the draft Royal College of Paediatrics and Child Health neonatal review
27. 22 December 2016, at a meeting attended by Karen Rees, Tony Chambers, Ian Harvey, Alison Kelly, Sue Hodkinson, a representative from the Royal College of Nursing, Letby and her parents
28. 29 December 2016, at a meeting of a number of executives
29. 30 December 2016, at a meeting between Duncan Nichol, Tony Chambers and Stephen Cross

30. 26 January 2017, at a meeting discussing NNU feedback with paediatricians
31. 1 February 2017, at a meeting discussing NNU feedback with nursing staff
32. 6 February 2017, at a meeting with Letby, her parents and senior management
33. 14 February 2017, at a 'paeds update' attended by senior managers
34. 15 February 2017, at a meeting attended by Ian Harvey and others with the coroner
35. 23 February 2017, at a progress meeting with Ian Harvey regarding neonatal services
36. 28 February 2017, at a meeting attended by Ian Harvey, Dr Ravi Jayaram, Dr Stephen Brearey, John Gibbs and Nim Subhedar to discuss and review neonatal cases
37. 28 March 2017, at a meeting attended by Tony Chambers, Susan Hodkinson, Ian Harvey, Dr Ravi Jayaram, Dr Stephen Brearey, Nim Subhedar and Julie Maddocks
38. 18 April 2017, at a meeting attended by managers and Letby
39. 27 April 2017, at a meeting attended by Ian Harvey, Stephen Cross and representatives from NHSE/NHSI
40. 28 April 2017, at a meeting where Ian Harvey updated on steps relating to external investigations and involvement of the police
41. 2 May 2017, at various meetings held in addition to the meeting of the Board held that day
42. 3 May 2017, at a meeting attended by Alison Kelly, Letby and others
43. 4 May 2017, at a meeting attended by Alison Kelly, Letby and others
44. 5 May 2017, at a meeting attended by Tony Chambers, Ian Harvey, Stephen Cross and the police
45. 9 May 2017, at a meeting attended by senior managers and Letby
46. 9 May 2017, at a joint meeting of obstetricians, gynaecologists and paediatricians considering the future of obstetric and neonatal services

47. 15 May 2017, at a meeting between paediatricians and the police
48. 16 May 2017, at a briefing by Tony Chambers to senior staff
49. 18 May 2017, at a meeting which considered referral to the Nursing and Midwifery Council
50. 22 May 2017, at a meeting attended by Alison Kelly, Sue Hodkinson, a representative from the Royal College of Nursing and Letby
51. 5 June 2017, at the Local Safeguarding Children Board
52. 28 June 2017, at a meeting at which the relationship between doctors and management and doctors and nursing staff was discussed
53. 17 July 2017, at a meeting attended by Letby and her parents
54. 7 August 2017, at a meeting between Stephen Cross and Cheshire Constabulary
55. 14 August 2017, at an 'NNU Planning Meeting'
56. 5 Sept 2017, at various meetings concerning the police investigation and the future of the neonatal unit
57. 25 September 2017, at a meeting where the police investigation and neonatal unit were discussed
58. 8 November 2017, at an update on the police investigation
59. 19 December 2017, at a meeting with the police
60. 17 April 2018, at a meeting between Tony Chambers, Stephen Cross and paediatricians
61. 4 June 2018, at the Countess of Chester Incident Coordination Call meeting
62. 7 June 2018, at a meeting of the Medical Staff Committee
63. 2 July 2018, at a meeting between Ian Harvey and Stephen Cross
64. 10 July 2018, at a meeting of the Incident Coordination Panel
65. 15 May 2020, at a meeting concerning the police investigation