Countess of Chester Hospital NHS Foundation Trust – Lucy Letby trial

Internal briefing document: For press office use only

Last updated: Wednesday 16 August 2023

Background

Lucy Letby worked as a nurse on the neonatal unit at the Countess of Chester Hospital (part of Countess of Chester Hospital NHS Foundation Trust) from 2011 to 2016.

On 3 July 2018, Letby was arrested by police on suspicion of suspected murder and attempted murder, following an investigation into infant mortality at the Countess of Chester Hospital.

Letby was bailed as the police continued their enquiries and then rearrested on in June 2019 and again in November 2020.

On 11 November 2020, Letby was charged with seven counts of murder and ten counts of attempted murder at Countess of Chester Hospital between 2015 and 2016. Letby has remained in police custody since then.

Letby's trial began in October 2022, and she denies all charges. The jury retired to consider their verdict on Monday 10 July 2023.

Significant media interest is anticipated on conclusion of the case. CQC's national media team has already been approached by BBC News and the i paper with questions about our regulation and oversight of neonatal services provided at the hospital during the time Lucy Letby was working there. It is possible that other media outlets will also have similar or additional questions for CQC when the verdict is announced.

Reactive statement – based on a potential guilty verdict

FINAL SIGNED OFF 18/08/24

Dr Sean O'Kelly, CQC's Chief Inspector of Healthcare, said:

"Our sympathies go out to the families who have been victims of these dreadful crimes. Lucy Letby betrayed the trust of the children in her care and their loved ones, but also the professionalism of our country's dedicated nursing staff.

"This is a horrifying case in which someone who occupied a position of absolute trust abused that trust in the most shocking way imaginable. While Letby's crimes could only have been committed by an individual absolutely determined to do harm and to conceal their actions in the most devious ways possible, this does not change the fact that everyone involved in the provision and regulation of healthcare services must use this case to understand what more we all can do to prevent this from ever happening again.

"CQC carried out a scheduled comprehensive inspection at the Countess of Chester Hospital NHS Foundation Trust in February 2016 during which care provided on the neonatal unit was inspected as part of our assessment of children and young people's services. The team identified concerns about staffing levels and skill mix on the neonatal unit and paediatric wards and made clear to the trust

Commented [KK1]: Can we say this as the data from the time did not put them at a significant outlier?? Also, ,mortality data that we have national access to, ie. Validated data, tends to be reported months, if not a year's lag, so CQC would not have been aware at the time. The trust may have noticed an increase if they were actively monitoring trends of their own data at the time.
See separate email sent to @Hannaford, Kirstin with info from our analysts

Commented [HK2R1]: This is referring to the police investigation - have amended to remove reference to high rates.

that action was needed to ensure sufficient numbers of staff - including those trained in advanced paediatric life support. Inspectors also received some concerns from hospital staff about a lack of support from management when they tried to speak up which we highlighted directly to senior trust staff as an issue that they needed to address.

"In June 2016 as part of our regular engagement with the trust, we were alerted to some concerns that an internal trust audit had revealed regarding an apparent increase in the number of new born baby deaths. The trust went on to downgrade the provision of neonatal intensive care at the hospital and commissioned an external review by the Royal College of Paediatrics and Child Health (RCPCH) to look at neonatal mortality in more detail.

"Children and young people's services were rated as requires improvement for safety as a result of CQC's February 2016 inspection. The hospital was also rated requires improvement overall and remained subject to ongoing monitoring through regular contact with the trust, available performance data and information shared with us by staff and patients. That monitoring included tracking the actions being taken in response to CQC's inspection and also the findings and recommendations that had been made by the RCPCH."

Ends

N.B: To date, requests for comment once verdict reached have been received from the following national and trade journalists:

Michael Buchannan (BBC News)
Lawrence Dunhill (HSJ)
Steve Ford and Connie.Dimsdale@ **I&S** *(The i paper)*
Josh Halliday (The Guardian)
Rebecca Thomas (The Independent)
William Ralston (Vanity Fair)
Evie Cronchey (Sky News)

Media Q&A

1	**When did CQC first become aware of concerns about an increase in neonatal mortality at the trust and what did you do in response?** At the end of June 2016 as part of our post inspection engagement following publication of the inspection report, the trust advised that they had conducted a data review which indicated some concerns around neonatal mortality. We sought further information from the trust to understand the extent to which mortality rates had increased and what action they were taking in response. The trust downgraded* the provision of neonatal intensive care at the hospital and also commissioned an external review by the Royal College of Paediatrics and Child Health (RCPCH) to look at neonatal mortality in more detail, identify any common themes or causal factors and recommend any actions needed to improve outcomes for infants in their care. CQC closely monitored the trust's response to the findings of both the internal investigation and external RCPCH review. We remained in regular contact with the trust, reviewed all

Commented [CL3]: As below - need more details on what this meant in practice @Knapton, Karen @Adams, Jason

Commented [KK4R3]: @Adams, Jason - please could you add in the definitions for the levels of neonatal critical care. In essence it means they took less sick babies, and babies requiring more intensive were transferred to other services. More staffing is required for the higher levels so it would have made staffing levels safer too.

Commented [MA5R3]: Sorry, but does this mean they took in fewer sick babies or babies who were not as sick as others?

Commented [KK6R3]: Definitely less sick, and probably less in terms of numbers but we do not have the evidence for the latter.

Commented [CL7R3]: @Mukhi, Anjali will also send on an email from Jason on this

	available performance data and information shared with us by staff and patients in order to ensure oversight of quality and safety. **The Countess of Chester Hospital NHS Foundation Trust's neonatal intensive care unit was a designated Level 2 local neonatal unit which had 16 cots: three intensive care (IC), three high dependency (HD) and 10 special care (SC). Following a raised mortality rate from June 2015 to June 2016, the unit, in consultation with commissioners and the North West neonatal operational delivery network (ODN), reduced cot capacity in July 2016 to 13 cots (one IC for stabilisation and transfer, two HD and 10 SC). The level of dependency also changed to Level 1 special care unit providing care for babies of 32 weeks gestation and above.* *This meant the unit took lower dependency and less babies on the unit.* *Neonatal units are given a designation level 1 -3* *Level 1 - Special care unit* *Level 2 - Local neonatal unit* *Level 3 - Neonatal intensive care unit*
2	**A number of paediatric consultants said they shared concerns with you during your Feb 2016 inspection but that these were not followed up and are not referenced in the resultant inspection report – why is that?** Some consultants (including those working in the neonatal unit) at the trust shared concerns with CQC during a focus group held as part of the 2016 inspection. Those concerns related to staffing levels, a lack of support from senior management and consultants who felt there was a culture of bullying and where concerns they had raised with management were ignored. We followed up directly with the trust's Medical Director that same day to relay those issues so that action could be taken in response. We have been unable to find any record of a spike in neonatal mortality specifically being raised with CQC during the inspection. However, in June 2016 the trust advised that they had conducted a data review which indicated some concerns around neonatal mortality.
3	**What did CQC do to follow up on the actions being taken by the trust in response to your 2016 inspection findings? Your inspection took place mid-February 2016, but it was June when you were informed but the mortality concerns – did you have contact with the trust prior to June? If not, why not?** Inspectors briefed the trust's leadership team on the key issues and areas for action identified on completion of the onsite inspection in February 2016 so the trust could make an immediate start on the necessary improvement work. A draft inspection report was then shared with the trust on 6 June for factual accuracy comments - as is standard procedure. The report was finalised, quality checked and published on 29 June and the trust was given 28 days to submit an action plan setting out the steps both underway and planned to address all areas of concern. Again, this is standard procedure post inspection visit. At the end of June, the trust alerted CQC to data indicating an increase in neonatal mortality rates and outlined the specific action it was taking to follow that up. An action plan responding to the full findings from CQC's inspection was received from the trust on 20 July and a face to face engagement meeting held in August where CQC and staff at the trust discussed the