Witness Name: Virginia Bottomley
Statement No.: 1
Dated: 29 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF THE RT. HON. BARONESS BOTTOMLEY OF NETTLESTONE

I, Baroness Bottomley of Nettlestone, will say as follows:-

Introduction

1. My name is Virginia Hilda Brunette Maxwell Bottomley. I make this statement to assist the Inquiry and in response to a rule 9 request dated 3 June 2024.

2. In preparing this statement, I have reviewed copies of documents identified by the Inquiry and the Department of Health and Social Care. However, my independent recollection of these matters is very limited and, on some issues, I have no recollection of them at all and am completely reliant on the documents.

3. I welcome Lady Justice Thirlwall's inquiry into the events at the Countess of Chester Hospital. The crimes committed by Lucy Letby were appalling and my deepest sympathies are and remain with the families of her victims.

Career history

4. In May 1984 I was first elected to Parliament in a by-election for the constituency of Surrey South West. I remained the MP for the same constituency until the 5 May 2005 election. I held the following positions:
   i. Parliamentary Private Secretary to Chris Patten, Minister for Education and Science (1985-1986).
   ii. Parliamentary Private Secretary to Chris Patten, Minister for Overseas Development (1986-1987).
   iii. Parliamentary Private Secretary to Sir Geoffrey Howe, Secretary of State for Foreign and Commonwealth Affairs (1987-1988).
   iv. Parliamentary Under-Secretary, Department of the Environment (25 July 1988 to 28 October 1989).

v. Minister of State for the Department of Health (28 October 1989 to 10 April 1992). The Secretary of State during this period was first Kenneth Clarke (until 2 November 1990) and then William Waldegrave.
vi. Secretary of State for Health (10 April 1992 until 5 July 1995). I was succeeded as Secretary of State by Stephen Dorrell.
vii. Secretary of State for National Heritage (5 July 1995 to 2 May 1997).
viii. In opposition, as Shadow Secretary of State for National Heritage (2 May 1997 to 11 June 1997).

5. In 2005 I stood down as a Member of Parliament. In June 2005 I was made a life peer.

6. Before entering politics, I spent two years as a researcher for the Child Poverty Action Group (1971-1973) and 11 years as a psychiatric social worker attached to the Maudsley Hospital. I am a former Chairman of the Inner London Magistrates' Juvenile Court but ceased to be active as a Magistrate when elected to Parliament.

7. To assist the Inquiry in understanding how the Department of Health ("the Department") functioned during my tenure and to contextualise some of the working practices I refer to below, I set out the following as a guide to the key roles within the Department:
i. Minister of State for Health: the Minister had specific areas of responsibility, often for large and/or high profile subjects. For example, while Minister for Health, I had particular responsibility for personal social services and for NHS management. My successor, Brian Mawhinney, was responsible for NHS reforms, and European Community and international affairs.
ii. Secretary of State for Health: the Secretary of State has overall responsibility for the work of the Department, including high-level strategy and policy, along with the wider responsibilities that come with membership of the Cabinet. The Secretary of State is accountable to Parliament and, ultimately, the public, and leads on major political strategies and policy matters affecting health and social care.
iii. Junior Ministers: the Secretary of State is assisted by a team of Junior Ministers who each manage a portfolio of delegated responsibilities. It was important to me that they had genuine responsibility for their portfolios and that I avoided overly interferring in their decision making. I sought to build a "collegiate" approach to the division of work and felt it was important to have regular formal and informal meetings to allow us to discuss areas of concern and important issues.
iv. Permanent Secretary: Sir Christopher France held this role until 1992 when he was succeeded by Sir Graham Hart. The Permanent Secretary has responsibility for

the management of the Department, both in terms of personnel and the management structure, and was also responsible for liaising with the Cabinet Office. The Permanent Secretary's input was greatest where matters of administration, implementation, and resourcing were concerned.

v. Chief Medical Officer ("CMO"): in my tenure, this post was first held by Sir Donald Acheson, then Sir Ken Calman. The CMO led on public health issues and is effectively the medical advisor to the Department of Health, other Government Departments, and to the Government as a whole, obtaining advice from other specialist advisors on scientific and medical matters where necessary. The CMO provides independent, authoritative, professionally detached, and apolitical advice, which is essential to the good functioning of the healthcare system. The CMO was also responsible for producing an annual report on the state of public health.

The Allitt Inquiry

8. In May 1993, former nurse Beverley Allitt was convicted of murder, attempted murder, and causing grievous bodily harm with intent in respect of the deaths and serious injuries of patients on the children's ward of the Grantham and Kestevan General Hospital ("GKGH") from February to April 1991.

9. Upon her conviction in May 1993, in my capacity of Secretary of State for Health, I commissioned an independent inquiry to establish the facts behind this horrific case in the most rigorous and effective way possible and to ensure that the National Health Service ("NHS") learned any lessons it could to prevent similar events in future. I made an oral statement on 11 February 1994. HC23 7CC586–93.

10. The inquiry was chaired by Sir Cecil Clothier QC. Sir Cecil had served as the Parliamentary and Health Service Ombudsman (a role which now comprises the offices of Parliamentary Commissioner for Administration and Health Service Commissioner for England, Scotland, and Wales) from 3 January 1979 to 31 December 1984. He was eminently well qualified, understood the health service, and had an impeccable reputation. I was confident that he could be trusted to provide a thorough, independent, and timely report.

11. The decision to commission an independent investigative inquiry as opposed to a public inquiry was one made after careful consideration and having discussed the matter with my Permanent Secretary, Sir Graham Hart. From previous experience of investigations into child abuse I considered that, in cases such as this, the truth may more readily

emerge in a private investigation than in a public forum where witnesses may feel under strong external pressure and the tone more adversarial. It was also important to me that this investigation be conducted timeously so that lessons could be identified and acted on. I considered that this format would better facilitate that.

12. The terms of reference were as follows **[INQ0017497_0006-7]**:
    i. To enquire into the circumstances leading up to the deaths and injuries which occurred;
    ii. To consider the speed and appropriateness of the response within GKGH to the incidents and make recommendations;
    iii. To examine the appointment procedures and systems of assessment and supervision within GKGH and the Mid Trent College of Nursing and Midwifery, including in respect of the occupational services available to the College and Hospital, and make recommendations;
    iv. To review the recommendations of the Regional Fact Finding Inquiry into Paediatric Services at GKGH of July 1992 and to advise whether additions or amendments to their recommendations were necessary;
    v. To advise on the most effective way for Health Authorities to be informed of, and to monitoring the handling of, serious untoward incidents in light of the events at GKGH and consider whether and, if so, how, the Regional Health Authority should be informed of such incidents and how they are handled; and
    vi. To consider such other matters relating to the above as the public interest may require.

13. As is clear from these terms of reference, I anticipated (and intended) that Sir Cecil would make recommendations: identifying learning and ways to improve was a key part of his role and my motivation in commissioning the inquiry. The Trent Regional Health Authority had already conducted an inquiry (which ran concurrently with the criminal proceedings) which focused on the quality of services for children at GKGH and which had led to 51 recommendations being made. The Sir Cecil's inquiry was to be more wide-ranging than this. As the terms of reference show, I asked Sir Cecil to review the 51 recommendations as part of his inquiry (see Chapter 6 of the Report, beginning at **INQ0017497_0121**).

14. I understand that many of these 51 recommendations had been acted upon by the time that Sir Cecil reported. For example, changes were introduced to the management at GKGH and responsibility for the provision of paediatric services was transferred to the

University Hospital NHS Trust at Nottingham. However, in my view, it was vital to fully explore the broader circumstances of this incident and ensure that the role of other persons and bodies, including the regional health authority itself, were properly evaluated.

The Report and its recommendations

15. Sir Cecil's report was published on 11 February 1994. I read it at the time and considered it to be of a very high quality: it was thorough, clear, accurate, timely, and fair. Having read it again for the purposes of preparing this witness statement, I remain of this view.

16. The Report acknowledged that many factors contributed to what took place and these went well beyond the actions of Ms Allitt herself **[INQ0017497_0123]**:

> "Without [Ms Allitt's] grotesque and almost unique proclivities the tragedy would not have occurred. But she was admitted to and operated within an environment which somehow afforded her the scope and opportunity to perpetuate her crimes. It is this environment, and those who populated it, that we have been required to examine to try to identify mistakes or weaknesses that might have contributed to, or at least failed to contain, the enormity of the disaster."

17. The Report identified and criticised failures of management and communication within the hospital and concluded that the delays in drawing together the different strands of evidence prevented foul play from being identified sooner. Although it rejected the suggestion that Ms Allitt could have been detected or stopped easily, there were identifiable failings, individual and collective, which led to an environment in which she could perpetuate these crimes **[INQ0017497_0131]**:

> "We were struck throughout our inquiry by the way in which fragments of medical evidence, if assembled, would have pointed to Allitt as the malevolent cause of the collapses of children, lay neglected or were missed altogether. Taken in isolation, these fragments of medical evidence were not all very significant, nor was the failure to recognise them very culpable. But collectively they would have amounted to an unmistakable portrait of malevolence. The principal failure of those concerned lay in not collecting together those pieces of evidence. The initiative and the energy needed to do this was not forthcoming at GKGK. That is the true and ultimate criticism."

18. The report made 12 detailed recommendations **[INQ0017497_0128-0130]** which, as noted by Sir Cecil, related both to attitudes and procedures within the hospitals and individual and collective responses to the events, and issues deriving from loss or oversight in relation to specific matters which, had they been recognised, might have led to the identification of criminal actions at an earlier time.

19. Save for recommendation 10, the recommendations were not directed at specific individuals or Government Departments. Instead, they identified practical measures and outcomes which would require input and action at many levels to achieve.

20. As Secretary of State for the Department of Health, I was accountable to Parliament for the actions of the Department and it was my role to consider these recommendations and lead on the political strategies and policies which would achieve them, insofar as the issues well within my remit (recommendation 2, which concerned coroners, fell under the Home Secretary's remit, rather than the Department of Health). In that sense, I consider that it was my responsibility to consider and implement the recommendations while I held the position of Secretary of State for Health. Insofar as achieving these outcomes required sustained action over time, it is ultimately the office-holder (which changes over time) rather than any individual minister who bears the long term responsibility for carrying actions forward.

21. Achieving the outcomes recommended by Sir Cecil necessarily required expertise and practical working knowledge of NHS systems, organisations, and working practices. I considered my primary role was to ensure that input and expertise was obtained from the right people so that any policies, strategies, and measures put in place would be genuinely effective. I believe strongly in consultation before action and consider it essential to work through the implications of changes before any action is taken.

22. Given this, although I considered that all of the recommendations were sensible, it was still necessary to carry out this consultation work and seek advice before deciding whether to accept them. For those which were accepted, it was equally important to ensure that those with relevant skills and expertise assisted me in deciding how best to implement them.

23. In this task, I worked particularly closely with three individuals whose knowledge and expertise I trusted implicitly: my Permanent Secretary, Sir Graham Hart; the Chief

Executive of the NHS, Sir Duncan Nichol; and Brian Edwards, the Regional General Manager of the Trent Regional Health Authority. Although I cannot now recall the specifics of these discussions, I was reliant on their insight and experience to assist me and I was confident in their ability to do so. In turn, we also drew upon the wider expertise of other individuals including the CMO and the Chief Nursing Officer, Dame Yvonne Moores. For this reason, although I, as Secretary of State, bore the ultimate responsibility for deciding which recommendations to act upon and how, I relied upon a great many more individuals and groups to evaluate the outcomes recommended, identify the most effective ways of achieving them, and, for those which were accepted, to implement the changes required.

Action taken in respect of the recommendations

24. Upon receiving the report in May 1993, I announced the report in Parliament and indicated that Sir Duncan Nichol had that day written to all health authorities and trusts to draw the report to their attention. Although I have not seen a copy of his letter, Sir Duncan was a diligent public servant and I have no reason to doubt that he would have written to all.

25. I believe he took this action because it was important to disseminate widely the findings of the report to ensure that the matters identified by Sir Cecil were understood. The principal finding of the report was that "the Grantham disaster should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events." In my experience, individuals and organisations are often more likely to listen, learn, and act when horrific episodes such as this occur.

26. My understanding is that the health authorities and trusts also received a copy of the Report and recommendations, although it has not been possible to identify documents which confirm this. This would be sensible in my view: the report was clearly written and thorough in its analysis and, because the investigation had not been conducted by way of a public inquiry, it was even more important to share it, both to inform and to reassure that its findings were the result of a rigorous and fair investigation. Disseminating the report would also serve to raise awareness and embed corporate knowledge of the issues throughout the NHS.

27. I am aware that Sir Cecil's report and my statement to the House were reported in the national newspapers.

28. On 5 July 1995 I became the Secretary of State for National Heritage and Stephen Dorrell succeeded me at the Department of Health. Given the time which has passed, I have very limited recollection of the actions taken in response to Sir Cecil's recommendations but I have been assisted by the Inquiry's table of recommendations and by referring to public announcements I made at the time, including an update I provided to Parliament on the progress of the recommendations on 2 November 1994 **[INQ0012450]**. This material provides good examples of the value and importance of consultation and obtaining expert advice on how best to achieve the outcomes identified.

29. For example, recommendation 10 advised that "the Department of Health should take steps to ensure that its guide "Welfare of Children and Young People in Hospital" is more closely followed." The Guide referred to made clear that hospitals themselves should determine the number of staff required to protect the children in their care but also provided recommendations relating to staffing levels. Given this, it was necessary to obtain a clear view as to the position on the ground in respect of staffing.

30. On announcing the Report, I explained that the Department had consulted with the Audit Commission to obtain statistics on the number of nurses qualifying and regional variations in the available workforce. I also noted that Sir Duncan had instructed district health authorities, in consultation with hospitals, to report by 1 May 1994 on their staffing levels. I outlined the results of this survey in my update to Parliament of 2 November 1994, noting that here had been considerable growth in the number of nurses entering training for paediatric nursing: from 183 in 1988 to 819 in 1992-1993 for pre-registration training and from 628 to 811 for post-registration training over the five year period. Training commissions for paediatric nurses rose by 36% between 1991-1992 and 1994-1995 (from 879 per year to 1198) **[INQ0012450_0002]**.

31. In some cases, consultation led to different, but stronger, recommendations than Sir Cecil himself proposed. For example, recommendation 11 advised "that in the event of a failure of an alarm on monitoring equipment, an untoward incident report should be completed and the equipment serviced before it is used again." This recommendation was considered by an Expert Advisory Working Group appointed by the medical agency with responsibility for the safety and quality of medical devices. I understand that the recommendations which they went on to make went further than what Sir Cecil had proposed.

32. I am asked to consider recommendation 3: that the provision of paediatric pathology services be reviewed with a view to ensuring that such services be engaged in every case in which the death of a child is unexpected or clinically unaccountable, whether the post-mortem examination is ordered by a coroner or in routine hospital practice. I did consider this an important recommendation and can see that my update of 2 November 1994 notes that it had been reviewed by the Strategic Review of Pathology Services who had advised that further work was required on a number of detailed operational matters. I indicated that a Working Group would be set up to undertake this analysis.

33. I cannot recall what action I personally took further to this between my update in November 1994 and moving to a different role in July 1995. Given the nature of the recommendation it is likely that the CMO would have played a key role in handling the details. I can see from the Inquiry's table of recommendations that the current position is that a treating clinician is able to request a hospital post-mortem to further investigate a cause of death, but informed consent must be sought.

34. I am asked whether I reviewed the progress made in implementing the recommendations made. As I have explained above, I reported to Parliament on the progress of the recommendations and their implementation on 2 November 1994 (9 months after the publication of the Report). I have not been able to identify any further reports I made to Parliament after this time or any made by my successor after I left the role in July 1995. I am unable to comment on whether any further reviews of progress were made.

The purpose of inquiries and their recommendations

35. I am asked to consider the 'Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues' dated 15 May 2024, which summarises certain inquiries dating from 1967 to the present day, the recommendations made in each, and the degree to which those recommendations have been implemented.

36. I have looked at this document for the purposes of preparing this witness statement but I am in no position to evaluate or comment on its accuracy or completeness. Save for the Allitt Inquiry, I do not have the knowledge required to comment meaningfully on its contents. I do note the Inquiry's analysis that many recommendations made by chairs of inquiries have not been implemented. In my view, there are potentially many reasons why recommendation may not be implemented. In some cases, I consider it likely that changes in ministers, governments, CMOs, and those in key positions within the NHS could lead to recommendations unintentionally falling by the wayside. This is highly

regrettable: the fundamental purpose of inquiries is to learn lessons from events where there have been failings and so, if a recommendation has been carefully considered and accepted, it should be implemented.

37. I am asked to say where I consider accountability lies in cases where recommendations are not implemented. In my view, formal accountability lies with the office-holder to whom the recommendation is made and his or her successors in office. Where a recommendation is made to a government department, it will be the Secretary of State who is ultimately responsible and accountable to Parliament and the public for what the Department does or does not do, including in respect of implementing or not implementing such recommendations. However, it is important to emphasise that the obligation to consider carefully all recommendations does not equate to an obligation to implement them. In some cases, there will be good reasons for not accepting or implementing a recommendation.

38. Insofar as the Secretary of State is accountable to Parliament and the public for the decisions they make it is incumbent upon them to do the work required to understand the potential impact of their decisions. As I have set out above, I considered it essential to obtain expert advice from specialists in the field and to work closely with those who had managerial and operational responsibility for the NHS (and who would ultimately be responsible for putting in place the practical measures required) before I took action. As issues of resourcing and wider strategy and policy are always relevant, decisions in respect of accepting and implementing recommendations must also be informed by the advice of those such as the Permanent Secretary who worked closely with Cabinet and other government departments.

39. If this work of considering and taking advice on recommendations is to be effective, it must be possible for it to sometimes lead to a decision not to implement a recommendation. This does not mean that the recommendation itself was bad: changes in legislation, policies, strategy, working practices, organisational structures, the division of work between different organisations, and resources can all render recommendations redundant or even inconsistent with other important duties and obligations.

40. Every recommendation Should be carefully considered and deference given to the investigation which led to the recommendation being made, it does not follow that every recommendation should be implemented. If having carefully reviewed and evaluated a recommendation, a minister forms the view that there are good reasons not to implement

it, then I consider them duty bound to raise their concerns. If these concerns are not satisfactorily addressed, they ought not implement the recommendation. Where such decisions are made, I would emphasise the importance of openness and transparency: in any case where a recommendation is not accepted or is accepted but not implemented, there should be a public explanation of the reasons for this.

Statement of Truth

I believe that the facts stated in this witness statement are true. 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

Dated: 5 August 2024