Statement: Helen Herniman
Statement No.: 1
Exhibits: 4
Dated: 07 August 2024

The Matter of:

THIRLWALL INQUIRY

WITNESS STATEMENT OF HELEN HERNIMAN

I, Helen Herniman, will say as follows: -

1. This is my first statement to the Inquiry, but it is the fifth statement submitted by the NMC. I took on the role of Acting Chief Executive and Registrar on Friday 4 July 2024.
2. As Acting Chief Executive and Registrar, I hold the most senior executive role at the NMC, and I am currently responsible for leading and managing the organisation's professional, business and financial affairs. I was asked to take up the post of Acting Chief Executive and Registrar after the permanent CEO and Registrar, Andrea Sutcliffe resigned due to ill-health on 4 July 2024.
3. I joined the NMC as the Interim Executive Director of Resources and Technology Services in July 2021 and was then appointed to the permanent role.
4. I am a chartered accountant with experience leading finance and corporate service teams across a wide range of organisations in different sectors, including six years in finance and operational roles at the Law Society where I was the Chief Finance Officer for the membership body and the regulator, the Solicitors Regulation Authority.

Background

5. My thoughts and condolences go out to the families and loved ones of the babies who were killed and harmed by Lucy Letby (LL). We are deeply saddened by the unimaginable extent of the loss and harm caused to so many families.
6. We want to ensure that our role as the regulator of nurses, midwives and nursing associates fulfils our vision of a safe, effective and kind nursing and midwifery practice for

everyone. I welcome the opportunity to provide this reflective statement and evidence to the Inquiry on behalf of the NMC setting out the reviews we have undertaken in response to the LL and Alison Kelly (AK) cases, what we have learned from our reviews, how we have implemented that learning to date, and how we will continue to implement learning going forward to ensure public safety is maintained in the nursing and midwifery professions.

7. The first witness statement of Andrea Sutcliffe dated 2 February 2024 set out:
    a) Our role (paragraphs 9 – 15)
    b) Our governance and management structures (paragraphs 16 – 25)
    c) An overview of our regulatory functions:
        i. education, training and standards functions (paragraphs 26 – 66)
        ii. registration (paragraphs 67 – 74)
        iii. revalidation (paragraphs 75 – 80)
        iv. fitness to practise (paragraphs 87 – 158)
    d) The role of the Employer Link Service (paragraphs 81 – 86)
    e) LL's regulatory journey and a detailed account of the fitness to practise investigation into LL's conduct (paragraphs 177 – 186)
    f) The fitness to practise investigation into AK who was the Director of Nursing (DoN) at the Countess of Chester hospital (CoCH) at the relevant time (paragraphs 189 – 191)
    g) How we work with others (paragraphs 211 – 234)
    h) Our initial lessons learned (paragraphs 235 – 255)
    i) Our current views on management, governance and leadership accountability (paragraphs 256 – 267).
8. This statement outlines our reflections and learning from our handling of the LL and AK cases to date. We have structured the statement according to the regulatory functions that are relevant to our management of LL and AK; registration, revalidation, fitness to practise, Employer Link Service (ELS), safeguarding and data and insights.

Our reflective process

9. We have reflected on how we can learn from our handling of these cases across our teams and directorates. In the first statement of Andrea Sutcliffe dated 2 February 2024 we explained at paragraphs 235 that we had established an internal working group at the end of 2022 to prepare for the verdict of the criminal trial and to review our approach. That working group was overseen by our Executive Director of Strategy and Insight, Matthew McClelland.

10. Our Employer Link Service (ELS) reviewed the way in which we handled the initial interactions with CoCH as well as how our policies, guidance and procedures could be strengthened in January 2024.
11. We also sought legal advice in connection with our reflective process .
12. To assist the Inquiry, we have focused this statement on the specific learning that relate to our regulatory handling of LL and AK. We have highlighted the issues, have set out our reflections, explained the actions we have taken to date, and confirmed what further actions we intend to implement.

Independent Culture Review

13. In addition to the reviews set out above, on 9 July 2024 we commissioned Nazir Afzal and Rise Associates to undertake a review into our organisational culture. This was an independent report and was published on 9 July 2024 **(HH/01)** ('Independent Culture Review'). There are some recommendations in that report that are relevant to the Inquiry's terms of reference, and we have included our reflections on those recommendations in this statement. We have agreed some immediate steps in response to the report as outlined in our Executive team response (**HH/02**) and we are continuing to reflect on the recommendations and are planning what actions we need to take. INQ0102783 INQ0107966
14. The Independent Culture Review highlighted safeguarding concerns and found that people working at the NMC have experienced racism, discrimination and bullying. We have publicly apologised for the failings identified, accepted all the recommendations made, and have committed to delivering a culture change programme.
15. The Independent Culture Review is clear about the link between our regulatory performance and our culture. It found that one affects the other, and that has created a pressurised environment for our people which has contributed to poor behaviours and concerning case outcomes in some instances. The Independent Culture Review found that these issues have seriously undermined our collective efforts to reach quick, fair and safe decisions across all our casework. This statement outlines the lessons we have identified that are specific to our handling of the LL and AK cases; we also know we have much more to do to improve our culture and the pace and quality of our fitness to practise casework.

Appointment of Ijeoma Omambala KC

16. We stated in paragraph 10 of our third statement dated 7 May 2024, that this reflective statement would include reflections on the issues raised in the letters that were exhibited

to that statement. There were concerns raised around our approach to safeguarding and clinical advice and our reflections and actions are covered below.

17. Our third statement also outlined that in October 2023 we appointed Ijeoma Omambala KC to investigate independently whistleblowing concerns that were raised in September 2023 about our handling of some of our fitness to practise cases which include our approach to safeguarding within those cases. We exhibited the terms of reference to that statement **(INQ0018083**). We expect this report to be published in late Autumn, so we are unable to provide any reflections relating to that review in this statement. We will of course reflect on the findings and recommendations of that investigation.

Our Reflections

Registration and revalidation

Summary – health and character and revalidation

18. Andrea Sutcliffe's first witness statement dated 2 February 2024 details the registration process at paragraphs 67- 74. Applicants who trained in the UK must include a declaration of good health and character from the designated signatory at the approved educational institution.
19. We publish guidance on health and character (**INQ0002422**) which sets out what needs to be declared in the application. Once applicants have joined the register, they must tell us and an employer as soon as they can if they receive a police charge, caution, conviction or conditional discharge. It makes clear that a failure to disclose this information may call their fitness to practise into question.
20. Paragraph 20.9 of the Code **(INQ0002419)** states that those on our register need to 'maintain the level of health you need to carry out your professional role'. Paragraph 53 states that if a registrant has a health condition and/or disability which they think is affecting their ability to practise safely and they are unable to manage the impact effectively, then they must tell us as soon as reasonably possible, rather than waiting to do so at renewal.
21. LL's application to join the register was received on 5 October 2011 and it included a declaration of good health and character signed by the designated signatory at the University of Chester. On 18 September 2014 LL renewed her registration, and as part of that renewal process, she declared that her health and character were sufficiently good to enable safe and effective practice. This predated any of the crimes for which she has now been convicted.
22. LL submitted her next revalidation application on 30 August 2017. Our revalidation requirements are set out in guidance **(INQ0002560)**. LL declared on that form that her own health and character were sufficiently good to enable her to practise safely and effectively.

23. We were made aware by CoCH on 29 November 2016 that LL had been moved from the neonatal unit for her own protection and were advised on 18 May 2017 that LL was still working at CoCH. CoCH told us LL had been moved to a different area in a non-clinical role to enable her to work in a different area outside of the pressure of the clinical environment and to protect her from the stress of being under suspicion by the medical team. The police investigation began in May 2017. LL's application for revalidation was accepted by us on 14 September 2017 as she complied with all the standard declarations required as part of the revalidation process at that time.

Lessons - health and character

24. We consider that there may be circumstances where a professional's character may be called into question that fall outside of the requirements we prescribe, which are currently limited to health and criminal charges. We are currently planning to start the review of our Code in 2025 and will consider whether to include any additional requirements regarding the health and character required to carry out the role of a registered professional.
25. We have identified that there is an opportunity before we commence the review of our Code to expand our health and character guidance to include a requirement for registered professionals to make us aware of any changes relating to good character as soon as reasonably possible, and as part of our registration renewal process. Our next guidance review cycle runs from August 2024 to January 2025. Revising our health and character guidance will be included in the work of that cycle. We intend to publish any changes to the guidance in March 2025. If changes are made to our health and character guidance, then reciprocal changes will also be made to our revalidation renewal guidance to ensure consistency.

Lessons - revalidation

26. Revalidation is not about assessing fitness to practise; it is required as a means to promote good practice in line with our Code and standards. Revalidation is based on a system of reflection and self-declaration, including of health and character, supported by a confirmer. LL revalidated in line with our existing guidance. Our analysis of the guidance in light of the LL case has identified the following learning:
    a) Our language about the purpose of revalidation is not wholly consistent between our various documents and guidance. We consider that greater consistency would be beneficial for public confidence in revalidation.

b) LL's revalidation confirmer was employed at CoCH, but was not her line manager. While this is in line with our guidance, we recognise that it could mean the confirmer had less knowledge of LL's practice.

c) Our guidance does not explicitly state that LL needed to inform her confirmer that she was on restricted duties, nor that there were any suspicions raised about her character. This issue will be addressed through the work to strengthen our health and character guidance explained in paragraph 24 above.

d) Our guidance does not preclude someone who is subject to fitness to practise proceedings from acting as a confirmer for revalidation. While LL's confirmer was not subject to fitness to practise proceedings, we consider our guidance should be strengthened in this regard. The recent Independent Culture Review recommended that there needs to be greater transparency over the process of auditing (verifying) the revalidation process to ensure confidence in the effectiveness and quality assurance of that regulatory function. We use an algorithm to select a sample of registered professionals for dip checking revalidation declarations. Where there are applications where the confirmer is not a registrant's line manager, they are more likely to be selected for checking due to the algorithm. We review 2,200 applications selected by the algorithm per year and conduct a deep dive into the applicant's practice and reflective hours. We have accepted the recommendation and also intend to explore options for strengthening verification processes in the future. As part of our current business plan, we have committed to undertaking a review of revalidation. Scoping work has started, although we have not yet determined the timeline for the review. We will engage with internal and external stakeholders and will consult widely on any proposed changes. As part of the review, we will address the learning identified above in paragraphs 25 and 26.

Summary - lapsed registration

27. LL was due to revalidate on 1 September 2020 while she was under investigation for fitness to practise concerns. She did not submit a revalidation application. In order to remain on the register LL also needed to pay her registration renewal fee by 30 September 2020. LL did not pay the fee.

28. Had she not been under a fitness to practise investigation, her registration would have lapsed and she would have been removed from the register. In accordance with our legislation, despite LL not revalidating or paying her renewal fee she remained effective on the register and appeared on our public register as having effective registration.

29. This measure is necessary because we only have the legal power to investigate fitness to practise concerns about people on our register; we cannot investigate concerns about people who have left our register. Preventing a person's registration from lapsing when they are subject to fitness to practise proceedings means that we retain the power to investigate fitness to practise concerns and people cannot avoid potential proceedings notwithstanding any non-payment of registration fees.
30. Although the above means that a person who is subject to fitness to practise proceedings can continue to practise without revalidating or paying their registration renewal fees, if a registrant has restrictions placed on their practice, including interim restrictions, this will appear against their entry on our register. We risk assess all referrals to see whether an IO needs to be sought from our FTP panel to ensure that any person who is under a fitness to practise investigation, who upon assessment may be a risk to the public, is subject to interim conditions to restrict in their practise to minimise the risk of harm to the public.

Lessons - lapsed registration

31. Our public register shows individuals who hold effective registration and any restrictions they may have placed on their registration; it does not make a distinction between those who are being held effective despite not paying their fee or revalidating. We recognise that there is an opportunity for us, as part of our revalidation review, to revisit what information we publish on the public register for those registrants who have neither paid their fee nor revalidated but are being held effective. We need to consider how privacy rights of individuals might be affected.

Employer Link Service (ELS)

Summary - ELS

32. Paragraphs 81-86 of Andrea Sutcliffe's first witness statement dated 2 February 2024 details that the NMC's ELS was set up in April 2016 following recommendations by the Mid Staffordshire NHS Foundation Trust Public Inquiry Report[1]. ELS provides advice and support to employers who have concerns about professionals on our register.
33. Paragraphs 183 (i) to (xii) of our first statement dated 2 February 2024 provides a detailed account of ELS' engagement with CoCH. In summary:

[1] Recommendation 232: 'The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap'.

a) On 6 July 2016, AK spoke to a Regulation Advisor (RA) through our ELS advice line informing them that there had been a rise in mortality rates in the neonatal unit at Countess of Chester Hospital (CoCH).
b) On 15 September 2016 we emailed CoCH to confirm an introductory meeting with them on 29 November 2016.
c) We met CoCH on 29 November 2016 where we were informed that due to the rise in neonatal mortality rates the Royal College of Paediatrics and Child Health (RCPCH) was undertaking a review. We were advised that LL had been moved from the neonatal unit for her own protection. It was agreed there was no grounds for a referral to be made at this stage.
d) 5 January 2017 we contacted AK to discuss the RCPCH review and AK emailed ELS to confirm that the report would be published on 8 February 2017.
e) We contacted AK on 18 May 2017. AK advised that LL had been placed on restricted duties in a non-clinical role, that the police investigation had just begun but LL had not been arrested, charged or named as a suspect at that stage.
f) We attended a meeting with CoCH on 15 June 2017 and AK later advised ELS that the police investigation was ongoing, no arrests had been made, and LL remained on restricted duties in a non-clinical role.
g) On 9 October 2017 AK notified ELS that the police had started interviewing employees.
h) On 3 July 2018 we learnt through the media that an individual had been arrested in connection with multiple deaths at CoCH. ELS contacted AK and she advised that a fitness to practise referral would be made within 48 hours.
i) AK made the fitness to practise referral to us about LL on 5 July 2018. Details of the referral are set out at paragraph 183 (xii) of the Witness Statement of Andrea Sutcliffe dated 2 February 2024

34. Since submitting our first statement, we have been made aware that the RA contacted AK on 23 August 2016 for an update. This was an email didn't contain any advice, but asked AK if there was any update following the discussion between AK and ELS. AK responded on 31 August 2016 to explain that the COCH had undertaken a thorough internal review and that nothing of significance was identified within this, however, AK confirmed that following discussions with the CoCH Board and on receiving views from clinicians, the step was taken to place LL on non-clinical duties (working in a corporate team). LL agreed to this, although AK relayed that LL was 'understandably very distressed'. The RA acknowledged that response on 1 September 2016 (**INQ0002964 and INQ0002965**).

Lessons embedded into new ways of working – ELS

35. ELS was a new service and had been operating for three months when AK first called in July 2016. Since then, the service has significantly expanded, and the number of RAs has increased from four in April 2016 to 12. The 12 RAs in ELS are allocated to specific regions in England and to each of the other nations in the UK, the increased capacity means they are able to take a more proactive approach than they were taking in July 2016. The RAs now have regular contact with employers in each of their respective areas, the regularity depends on the level of concern, but it is at least annually This enables RAs to follow up on potential ongoing concerns.
36. Since 2016 the ELS has matured as a service, its processes have developed and improved. There are five areas where we consider learning is identified and where ELS' new ways of working as outlined in (a) – (e) below are at least starting to address.

    a. Advice offered and referral threshold

37. ELS advised AK on 6 July 2016 call that there was insufficient information at the time to make a referral to us, but that if the police concluded that LL was involved, then a fitness to practise referral would be needed. We consider that ELS provided appropriate advice. Although these were potentially extremely serious concerns, the RA was informed that CoCH was investigating and had not reached any final decision about the next steps. We think it was reasonable for us to wait until CoCH had made a decision about a police referral before taking any further steps
38. Without direct contact with the clinicians, or more detail about the underlying issues and the deaths, and with the assurances provided by CoCH that there were no concerns about the competence of individuals or teams, at the time of the call there was no reason for us to form the view that LL was a person of particular interest to the police, or that there was evidence to suggest she was directly involved.
39. We have also carefully considered the note which was made by the RA following the call on 18 May 2017 with AK. The RA's note stated that, "I advised that at this stage, as she has been advised previously, there is nothing which could amount to an identifiable or sustainable allegation of impaired fitness to practise, however the outcome of the police investigation has the potential to be very significant, and if this individual or any other registrant is identified as having been involved in the deliberate endangerment or murder of any of the infants in question, then plainly a referral / referrals would be necessary. Accordingly, we will need to be updated as matters progress.". Having considered that note in hindsight, it may have given the impression that there was the need for the police investigation to identify a registrant as being involved in deliberate endangerment or murder of any of the infants in question for a referral to be made. However, after speaking

to the RA who took the call, we consider the RA was responding to the issues raised by AK, rather than suggesting that was the bar for a referral to us.

40. ELS advice is subject to quality assurance measures to ensure consistency between RAs and to enable constructive challenge of any advice. These quality assurance measures are outlined in the standard operating procedure **(HH/03**), and include: INQ0108009

    i. Monthly peer to peer review where advice is reviewed by another RA and complex cases are discussed.

    ii. Monthly peer review meetings between the RAs and clinical advisors where complex cases or cases with differing views are discussed and referred to the monthly benchmarking meeting if necessary.

    iii. Monthly benchmarking meeting where RAs, clinical advisors and colleagues from the Screening team review cases and agree next steps.

41. ELS have a standard operating procedure for the advice line **(HH/04)** which links to our fitness to practise online guidance library where we are clear about the types of concerns we consider require referral which was put in place in 2021.

b. Engagement with CoCH

42. Although we consider that it was reasonable to wait until CoCH had made a decision about next steps after we first spoke to AK on 6 July 2016, we recognise it would have been better to have been more proactive and to ask for an update on what decision had been made within a few days of AK making initial contact, rather than waiting until 23 August 2016 when we had been told on 6 July 2016 that a decision on next steps were imminent.

43. We also consider that ELS could have contacted AK before May 2017 to ask for and discuss the outcome of the RCPCH review that had been published in February 2017, but which was not sent by CoCH to us. We should have taken further steps to satisfy ourselves that CoCH was taking all appropriate steps to protect patients and to ensure concerns were being fully investigated.

c. Providing greater scrutiny

44. Throughout our engagement with CoCH we relied on the information that AK gave us. We recognise that our engagement was not as proactive as it could have been, and we did not probe on CoCH's decision not to refer to the police and whether the next steps they decided to take were appropriate. We have set out below how, going forward, we are now actively involved in discussions around emerging risks and issues both regionally and nationally and how we work cross-collaboratively with other partners and regulators. Although no referral was made in July 2016, we could have contacted the GMC or the CQC, or have given advice to CoCH to tell the consultants contact us.

45. We have considered whether we could have also asked for all the details of the deaths and the reviews ourselves to form our own view about the cause of the deaths. However, we do not think that we would be best placed to conduct that review as our focus is on the conduct of individual professionals and, at the time, the conduct of staff at CoCH was only one possible explanation for the increase in neonatal deaths. It was for the CoCH conduct the appropriate reviews with the input of experts, and for us to be proactive in asking for regular updates into those investigations.

d. Working effectively with partners

46. As stated above, we have recognised that there was an opportunity in July 2016 for us to contact the GMC or the CQC to discuss the concerns raised.
47. We attended a North Regional Quality Surveillance Group meeting hosted by NHS England on 16 September 2016. The concerns regarding increased neonatal deaths at CoCH were noted in the meeting pack for that group meeting. Had the concerns about the increased neonatal death not already been raised in the meeting pack and at that meeting, that would have presented an opportunity for us to have raised this with other relevant organisations.
48. At paragraphs 211-214 of Andrea Sutcliffe's first statement we made clear that we have much closer working relationships with both the GMC and CQC now, and there is an opportunity to proactively discuss concerns that may be relevant across the regulators. We consider there are certain categories of cases where we should always contact other regulators and this has been included in our ELS advice line SOP **(HH/03)** which sets out how we have strengthened process for escalation outside routine, scheduled benchmarking meetings.
49. We hold memoranda of understanding (MOUs) with other regulators which set out our agreement on how we will work together and share information when we have concerns. We also share information with organisations with whom we do not hold MOUs if we consider it in the public interest to do so, including organisations such as Disclosure and Barring Service, Disclosure Scotland, NHS Counter Fraud Authority, National Crime Agency, Home Office and Healthcare Safety Investigation Body.
50. We are a signatory of the cross regulatory emerging concerns protocol for England. This protocol allows any one of the signatories to initiate a regulatory review panel with other members to share and discuss any concerns that may arise, to understand if other members have similar or additional concerns and to ensure a coordinated response to concerns. We have both initiated and attended Regulatory Review Panels (RRP) under this process.

51. We are members of the National Joint Strategic Oversight Group (NJSOG), and the National Perinatal Safety and Surveillance Group (NPSSCG), which are both convened by NHS England. NJSOG is a forum of healthcare regulators that meet to consider national policy and risks and exchange learning, intelligence and information at a national level. The NPSSCG supports the timely identification and escalation of concerns from regional teams and insight from regulators and national bodies to inform actions. ELS colleagues also attend Regional Quality Groups. We are therefore actively involved in discussions around emerging risks and issues on both a national and regional level in England and we play an active role in information sharing to enable all bodies to triangulate lines of enquiry that could build a picture that intervention may be required.

e. Record keeping

52. As outlined above, we have been made aware of an email that was sent to AK on 23 August 2016 but it was not recorded on our case management system. At the time there was no code to record a chasing email being sent in our process as there were only six outcome codes (i.e. there were only six actions/outcomes which could be recorded on our case management system, therefore at that time, there was no way of recording that a chasing message had been sent) . This meant that any chaser or follow up emails were not recorded by ELS in the early stages of the service on our case management system. Since 2016, there have been many changes to the codes and there are now codes which cover recording any follow up on a call or requests for further information on our case management system.

Further lessons - ELS

53. There is one further lesson which has been identified in respect of our ELS where we consider that we have more work to do.

f. Our approach when senior leaders are under fitness to practise investigation

AK was the Director of Nursing (DoN) at CoCH when concerns were raised with us about LL. AK as the DoN was our main contact for ELS until 19 May 2021. On 20 May 2020, we received the fitness to practise referral for AK; the case was placed on hold while the police investigation into the neonatal deaths and LL took place. Nevertheless, AK remained our contact at CoCH until she left CoCH in May 2021 but any inquiries about the AK referral were directed to a more senior member of the Trust.

54. Often, senior leaders at Trusts will advise ELS if they are under investigation but we do not have assurance that this happens consistently, nor do we have a formal mechanism internally for advising ELS when referrals are made. Currently, unless we have reason to

believe that a senior referral requires restriction on their practice from FtP colleagues we wouldn't change them as our main contact. We would however challenge any information we receive that doesn't appear to be correct. We recognise that we need to formalise our approach in these situations and will be developing a mechanism for ensuring that ELS are aware of any fitness to practise referrals relating to senior leaders.

Fitness to practise

Summary – LL case

55. A full timeline regarding LL's fitness to practise proceedings is detailed at paragraphs 183-184 of Andrea Sutcliffe's first statement. AK made the fitness to practise referral about LL on 5 July 2018. As part of that referral, AK included the RCPCH report, which said that no clear conclusions could be drawn from the report about LL's involvement in the increase in deaths. AK did however indicate that Cheshire Police were investigating.
56. We conducted an interim order risk assessment on the same day as receiving the referral and we decided not to apply for an interim order at that stage:
    a) We had limited evidence of LL's involvement available to us.
    b) At the time of the risk assessment our understanding of the case law was that there needed to be a prima facie case against a registered professional to apply for an interim order.
    c) We decided that the fact of arrest alone in these circumstances did not provide the evidence needed to apply for an interim order. The police had informed us that the arrest was a step taken to gather evidence and interview under caution. The police did not provide any further detail explaining the information they had to form the grounds to arrest LL.
    d) The RCPCH report had been disclosed to us and that did not find a definitive link between any individual registrants and the deaths of babies.
    e) CoCH informed us it was the lack of definitive conclusions that prompted the referral to the police as opposed to positive evidence of wrongdoing by LL.
    f) LL had been identified as being on duty for all deaths, although not necessarily assigned to the baby in question.
    g) We were told that LL's colleagues and supervisors had no concerns with her clinical practice and described her in positive terms, although we were aware that a number of consultants at the CoCH felt strongly that LL was involved, and they had a 'gut feeling' about it.
    h) We were aware that LL had been removed from clinical duties.

57. Detailed risk assessments and consideration of the interim order position were made on and around 5 July 2018, 30 May 2019, 11 to 13 June 2019, 18 July 2019, 11 November 2020 and 12 November 2020 as set out in our first statement (paragraph 183).
58. LL was charged with eight counts of murder and ten of attempted murder on 12 November 2020. We applied for an interim order and on 20 November 2020 and our Investigating Committee panel imposed an interim suspension order for 18 months, seven days after LL was charged.
59. The interim suspension order was reviewed and extended, and on 12 December 2023 our Fitness to Practise Committee struck LL off the register.

Summary – AK case

60. We received a fitness to practise referral for AK on 20 May 2020. The referral was made by Dr Stephen Breary, Dr Ravi Jayaram, **Doctor ZA** and Dr Susie Holt who were all consultant paediatricians at CoCH. The referral related to how AK had dealt with the concerns they had raised about the conduct of LL. A detailed account of our activities surrounding AK between May 2020 and December 2023 is set out in paragraph 191 of our first statement.
61. We conducted an initial risk assessment on 22 May 2020, and we have continued to conduct risk assessments at regular intervals on the AK case. After the end of the criminal trial, and with the agreement of the police, we requested disclosure of information from CoCH and this was received on 9 October 2023. A multidisciplinary team worked together to review the material we had received and our clinical advisors provided clinical advice in order to inform our assessment of risk. We sought legal advice on risk and whether we should make an application for an interim order in December 2023. On 24 January 2024 we made an interim order application.
62. The Investigating Committee decided on 28 March 2024 not to make an interim order to AK's registration and the case has now been referred to our Case Examiners for a decision. Our Major Investigations Team is liaising with the police as to the sequencing of witnesses for interview to reduce witness fatigue.

Lessons

a. Interim order guidance

63. We conducted an immediate interim order risk assessment on 5 July 2018 when we received the fitness to practise referral for LL and we continued to undertake regular interim order risk assessments. On each occasion, a decision was made not to apply for an interim order for the reasons detailed above at paragraph 57. These decisions aligned

with our understanding, derived from the caselaw, of the evidence required for an interim order to be imposed as well as our application of the guidance in place at the time.

64. As outlined in paragraphs 134 – 135 of our first statement, we updated our INT2 guidance on 2 October 2019 as we considered that our guidance needed to be strengthened to refer more explicitly to the evidential threshold required for an interim order to be imposed and to provide more support for decision makers in considering the sufficiency of evidence. The previous version of the guidance did not include any reference to the evidential threshold and we made this change in light of a decision of the High Court in Northern Ireland in which criticisms were made of us in relation to the sufficiency of our evidence in applying for interim orders in a serious, high-profile case.

65. We now consider that the guidance in place at the time, which suggested that, in the absence of substantial evidence, it would not be right to apply for an interim order on the basis of an arrest rather than a criminal charge, was not sufficiently flexible to enable us to deal with an extraordinary case such as this in which a serious police investigation was underway in relation to potentially multiple instances of murder. We consider that in this case, the fact of the arrest could have been sufficient to justify an interim order application given the serious nature of concerns and the importance of maintaining public confidence in the profession and the NMC.

66. On 25 March 2024, we updated our interim order guidance and the revised guidance now makes clear that we do not always need to wait until a person has been charged before applying for an interim order, and that the seriousness of concerns and the importance of maintaining public confidence must be considered. We have moved the emphasis of the guidance away from a “prima facie evidence” test to focus more on cogency of evidence and given more flexibility to our decision-makers to act on the basis of a known risk, where there is evidence that the risk being seriously considered by other agencies such as the police. Our second statement dated 12 April 2024 provides a detailed account of the changes we made to our guidance and the impact of those changes.

b. Interim order decision making process

67. We considered whether to apply for an interim order at five points before LL was charged. There were differing internal opinions on whether the decision not to apply for an interim order was the right one due to the seriousness of the allegations against LL and the public interest in the case. This difference of internal opinions was particularly impacted by our experience in the high court in Northern Ireland regarding Muckamore Abbey Hospital, and the fact that we were updating our guidance In-house lawyers who conducted those assessments escalated the matter to the Executive Director for Fitness to Practise and Deputy Director for Fitness to Practise at the time, who had oversight of the interim order

risk assessments and accountability for all case work and the decision was not to apply for an interim order.

68. Only three of these considerations on applying for an interim order were described as 'risk assessments' and were part of a formalised process. Two were ad hoc reviews which were initiated after concerns were raised that an interim order application had not been made.

69. Although the case was escalated to senior colleagues, we did not have a standardised escalation process. We recognise that if there had been, we may have sought external legal advice as well as seeking the views of clinical advisors to assist our consideration as to whether the application of the 'prima facie' evidence test was appropriate in this case.

70. Recommendation 32 in the Independent Culture Review report also recommends that we should clarify the relationships between the legal teams across the NMC and the role of legal expertise in multi-professional teams. Work is in train to ensure that in future, we have clearer senior accountability for decision making and risk assessments, and more clearly documented decisions made, at the appropriate level of seniority, based on such advice. While risk assessments were carried out in this case, it would have been helpful to have a process allowing for a greater degree of challenge and flexibility to enable us to depart from our usual processes. This would have made our decision-making process more robust

71. We have already made changes, and in complex or sensitive cases, we have started to have case conferences bringing together expertise from across the organisation, including, where applicable, lawyers, clinical advisors and our safeguarding lead. We will ensure we have a clear framework which covers the whole fitness to practise process and sets out:

    a) The points within our fitness to practise process where we should be considering whether to apply for an interim order and who should make that decision.
    b) The information required to inform the decision whether to apply for an interim order and who should obtain that information.
    c) The expected timescales for decision-making.
    d) Who should have input into the decision, i.e. is there a need for a multi-disciplinary approach.
    e) The role and status of legal advice and legal advisors in the decision-making process and when we might consider seeking external legal advice.
    f) What happens if there is disagreement about whether an application should be made, which will include the process for internal escalation of decision-making and the process for obtaining external legal advice in appropriate cases.

72. Work has begun on developing this document and we anticipate it will be implemented by December 2024.

c. Invoking Article 25

73. AK informed us on 6 July 2018 that CoCH understood from Cheshire police and NHS England that LL's bail conditions prevented her from working in a healthcare environment. The police advised us on 20 July 2018 that LL 'is not to work in any healthcare setting or to have unsupervised contact with anyone under the age of 16'.
74. As outlined in the chronology in paragraph 183 of our first statement, we contacted Cheshire Police on a number of occasions requesting an update into their investigation of LL. In May 2019 we asked Cheshire Police for a copy of LL's bail conditions as these were relevant to the application for an interim order. The police advised us that the one relevant bail condition was that LL cannot gain employment, whether paid or unpaid, with babies or children in a healthcare setting or otherwise.
75. This was a change from the information provided in July 2018 where we understood she was not able to work in a healthcare setting. It showed there were no restrictions on LL practising as a nurse with adults.
76. Article 25(1) of the NMC Order 2001 empowers the NMC to require any person who is able to supply information or produce any document relevant to the discharge of any function to supply that information or documents. In June 2019 we made an Article 25[2] request to the police for disclosure.
77. It was challenging for us to obtain information from the police about their investigation. In paragraph 183 of our first statement dated 2 February 2024, we outlined our engagement with the police. Their focus was on the investigation and updating those directly affected and not prejudicing the criminal process. We have concluded that we should have invoked Article 25 sooner to obtain a copy of the bail sheet as the bail conditions were relevant to our decisions on whether to apply for an interim order and had an impact of public safety.
78. This is not an issue which is unique to our learning from the LL case, gaining information from third parties in a timely way to ensure effective case progression can be challenging across our fitness to practise process. We will look to develop guidance to support colleagues in knowing when to invoke this power. We are also currently developing an MOU with the NPCC to facilitate better working relationships and more timely sharing of information.

[2] 'For the purpose of assisting them in carrying out functions in respect of fitness to practise a person authorised by a Practice Committee may require any person (other than the person concerned) who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function to supply such information or produce such a document'.

d. Whistleblowing

79. As outlined in paragraph 191 (iv)(v) of our first statement we asked the individuals who made the fitness to practise referral about AK whether they wanted to be considered as whistleblowers. Our external review recognised that there was some confusion from colleagues around the status of whistleblowers and a lack of understanding that the protections afforded to whistleblowers would only apply to protection in an employment setting rather than in our fitness to practise processes.
80. We have recognised that the training and guidance for colleagues on what constitutes a whistleblowing concern raised as a protected disclosure needs reviewing and updating. We plan to publish new guidance early next year, which clarifies the position and takes account of recommendations from Ijeoma Omambala KC's independent investigation[3]:

e. Clinical advice

81. We received the fitness to practise referral for AK on 20 May 2020. The initial steps we took are outlined in paragraph 191 (i) – (vii) of our first statement. The case was not assessed as a high-risk case, so our initial activity focused on liaising with the GMC and seeking consent from the referrers. We were advised by the police on 15 February 2021 to place our investigation on hold.
82. We sought clinical advice after the end of the LL criminal trial. The clinical advisor thought there were additional issues identified that had not been identified by the initial referrers including the failure by AK to adhere to the Child Death Overview Panel process, concerns about the RCPCH report and other issues relating to AK's conduct.
83. We consider that it would have been helpful for clinical input to be obtained sooner and obtaining that additional information would have helped to inform our decision making on the seriousness and scope of the allegations as well as whether to make an interim order application.
84. The police had asked us to pause our investigation and they were not providing us with any information relating to their investigation of LL. It would have been very unlikely for us to be provided with any additional documentation as the police investigation was ongoing, however, the expertise of clinical professionals with experience of working in a neonatal unit or similar setting would have helped inform our assessment of the allegations.
85. In paragraph 9 (iv) of our third statement dated 7 May 2024 we stated that our fitness to practise 18-month plan includes work to review how we apply safeguarding and clinical advice across the fitness to practise process. Our clinical advice team provides clinical input into cases as requested and they primarily provide advice to our Screening teams.

[3] terms-of-reference-for-ijeoma-omambala-kc-15-nov-2023-.pdf (nmc.org.uk)

86. Due to our current backlog of cases at the Screening stage, clinical advice is often sought some months after the original concern is received. We have recognised that the skills and experience of our clinical advisors could input into a wider range of cases to improve our decision making. The work aims to identify whether the current approach is right and what changes we might need to make to ensure that clinical advice appropriately supports our decision making throughout the fitness to practise process.

Safeguarding

87. We have considered whether we gave appropriate safeguarding consideration to the LL case. There is no evidence that we sought assurance that the CoCH had made any relevant multi-agency referrals under their statutory obligations. There is no evidence on our case management systems that we considered whether to make a safeguarding referral ourselves and we did not probe on whether appropriate safeguarding processes were in place at CoCH and if those were being followed by senior leaders at CoCH.
88. We introduced safeguarding guidance and training into the regulatory process in 2019. As time progressed, we recognised that we needed to strengthen our approach to safeguarding and so we appointed a Strategic Safeguarding Lead in October 2022 to lead on updating our safeguarding plan, identifying and reporting on safeguarding issues and providing advice and training on safeguarding-related issues across the NMC. We acknowledge that we need to refine and develop our approach to identifying safeguarding risks, and ensure that we have the specialist capabilities to embed an effective safeguarding approach. This will ensure that we are better able to fulfil our statutory safeguarding responsibilities and improve the safety of all stakeholders involved in our processes.
89. Since January 2024, our Executive Nurse Director for Professional Practice, Sam Foster, as the executive safeguarding lead, has led the expansion of resources for the safeguarding team. We brought in two additional safeguarding clinical advisors to support with the fitness to practise workstream and we also now have a safeguarding advisor and safeguarding analyst. Further resource has now been identified to support the safeguarding hub and strengthen the safeguarding approach. This increased resourcing will lead to increased knowledge and training of safeguarding across the organisation, alongside the strengthening our operating procedures. To date we have:
    a) Updated our safeguarding policy that was first published in 2019.
    b) Established a Safeguarding Board which will report to the Executive Board and Council quarterly.

90. In September 2024 we will be establishing a multi professional safeguarding hub. This will achieve the systematic review of all new referrals to identify safeguarding considerations and ensure that they progressed appropriately. The hub will improve the quality of information sharing, provide safeguarding expertise and guidance and ensure we are able to discharge our safeguarding responsibilities effectively. We will then consider our approach to risk assessing cases from a safeguarding perspective already in our FTP process following the outcome of several audits to inform us of actions required. We plan to develop a risk assessment tool for safeguarding, introduce mandatory safeguarding training for all colleagues and improve our safeguarding data collection. We will also be updating our fitness to practise guidance to ensure that it explicitly references the safeguarding considerations needed at each stage of our fitness to practise process. The Independent Culture Review made some specific recommendations in relation to safeguarding which have been incorporated into our plans.

Data and insights

91. The Independent Culture Review recognised that we need to become a more data driven organisation in order to support the more effective and efficient delivery of our regulatory processes (recommendation 34).
92. We know we need to improve our data capture so that we can conduct better analysis of the data we hold, and this is a central theme in our current modernisation of technology services programme. We plan to improve the links between our data sets to make connections between professionals on a register, locations of events and places of work as part of our wider Data Strategy. Our Insight team is doing some five-year trend analysis modelling using our data which it plans to publish in autumn 2024 and this will be one of a number of steps we will continue to take to become a more data driven organisation.

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: _____

HELEN HERNIMAN

Dated: 07 August 2024