939. The following suggestions to inform your recommendations on keeping babies in NNUs safe are mainly applicable to NNUs but some may apply to all healthcare settings.

940. There are already mechanisms in place as part of pre-employment checks to look for previous issues that might indicate risk (e.g. references, DBS checks). However these are fairly blunt instruments and that they have not eliminated cases of healthcare professionals abusing their positions of trust, these alone are clearly insufficient. In situations where competence or attitude is an issue, there are mechanisms to address these. However, individuals who wish to cause deliberate harm are likely to find methods to evade detection.

941. Annual appraisals and mandatory training updates all take place but again only address knowledge and skills.

942. My views on how to try to consider, report and investigate harm caused by malicious intent are detailed as below:
   - All neonatal deaths should be discussed with the coroner and reported directly to CDOP when notifying the designated doctor for child deaths.
   - If the death is unexplained there should be mandatory initiation of the SUDI/C process.
   - All non-fatal collapses requiring cardio-pulmonary resuscitation should be reported via datix and have a local rapid review, with any learning points shared. The data collected and the findings of these reviews should be submitted in a timely manner to the Neonatal Network and any feedback from them provided.
   - As part of routine reporting of deaths or non-fatal collapses (perhaps as part of the Datix report), there should be a mandatory question along the lines of "are there any features that cannot be explained by natural causes? If the answer is affirmative, there should then be a process where the event can be assessed objectively by professionals with appropriate experience and training in neonatology. This should be a mechanism to spot any trends as soon as possible.
   - There should be mandatory training on the process of raising concerns under FTSU, as well as regular data published in each organisation as to how many FTSU concerns are raised and data on outcomes. If staff can be reassured that they are being listened to without fear of detriment they will be less inhibited to speak up.
   - Clear national guidance is needed for staff with concerns similar to those regarding Letby, that sets out a route for appropriate escalation of such concerns and their investigation
   - The Risk and Governance department of any hospital is integral to patient safety. I understand that there is considerable variation between NHS organisations in terms of staffing of these departments and in reporting. I think that there should be more consistency with nationally mandated standards for training and experience for each role in the team and clearly defined objectives to enable them to implement change effectively to improve patient safety.