Witness Name: Helen Herniman
Statement No.: 2
Exhibits: 15 [HH005 - HH016]
Dated: 07.11.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF HELEN HERNIMAN

I, Helen Herniman will say as follows: -

1. This is my second witness statement to the Inquiry in response to the Rule 9 request received on 23 October 2024. This statement focuses on specific questions asked by the Inquiry following the submission of our written opening statement on 30 August 2024 and the presentation of our oral opening on 12 September 2024.

Employer Link Service (ELS) review

2. The Inquiry has asked whether our Employer Link Service team conducted a review of the advice they provided to the Countess of Chester (CoCH) in relation to Lucy Letby (LL). The Inquiry has also asked who conducted the review, whether the findings were submitted to a body within the NMC for approval and if so, what was their conclusion. We have also been asked to submit documentation relating to this process.

3. At paragraph 10 of my first statement, I stated that our ELS conducted a review in January 2024. The review was initiated by the NMC's Assistant Director of National and Regional Outreach and the Head of Strategic Delivery for ELS and was undertaken as part of the NMC's commitment to learning and improvement. The purpose of the review was to:

    a. Identify any gaps or issues related to ELS' involvement during the relevant period.
    b. Consider any changes or improvements that have been made since 2016 that would have an impact on our response if a similar case arose.
    c. Consider whether, with the benefit of hindsight, any further changes should be made if we were presented with a similar set of circumstances again.

4. A small group of Regulation Advisers (RAs) from the ELS team met on 23 January 2024 to review the team's activity from the first contact with the CoCH in April 2016, where a standard

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introductory email was sent to CoCH outlining the benefits of the newly established ELS team, through to the fitness to practise referral to the NMC which was made by CoCH on 5 July 2018. The group included the RA who held the relationship with CoCH when ELS was established in 2016, the RA who took over that relationship in Spring 2017 and the current RA for that region, who had held the relationship since 2020. The Principal RA with oversight of the North West region of England, which covers CoCH also attended. The meeting was facilitated by the Head of Strategic Delivery for ELS.

5. The summary report produced by the team following that meeting was discussed at an Executive Board (Learning) meeting on 19 March 2024 [INQ0108425] **(HH/005).** That meeting was minuted and the discussion was captured under item LEA/24/09 in points (a) to (e) [INQ0108426] (**HH/006**). The Board's conclusions were:

    a. It was good practice for the NMC to review its activity and response to serious events such as LL.
    b. The review was comprehensive with some areas of learning identified, and also assurance that some processes were robust. The Board also questioned whether the use of a 'critical friend', external to ELS could have improved the objectivity of the review. This was agreed by the team and will be included in any future learning reviews.
    c. There had been improvements in ELS since 2016 and ELS could only provide advice based on information it had at the time. However, on the issue of curiosity, the Board questioned the level of scrutiny that ELS had applied at the time, which had been challenged, and whether this would change in a similar situation now.
    d. The review should encourage the NMC to think differently and engage with other organisations such as the General Medical Council (GMC) about similar unusual circumstances where a group of clinicians have raised concerns.

6. The Board had questions and comments following the discussion including around the level of scrutiny applied by ELS at the time and whether that would change in a similar situation now. These questions were answered through a supplementary paper that was considered by the Executive Learning Board on 14 May 2024 [INQ0108427] (**HH/007**). That supplementary paper also included a comparative case which demonstrated how ELS has acted differently to concerns with a similar set of circumstances since we received the call from CoCH in July 2016 (as set out in HH/007). In that case concerns were raised by several nurses about the sudden and unexplained deterioration of several patients cared for by a nurse. In that comparative case we recognised that the Trust was not providing a sufficient level of oversight, so ELS called

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an extraordinary benchmarking meeting to discuss the issues. Benchmarking meetings are an opportunity for the RAs to seek input from colleagues in our Screening team about advice they have provided. It was decided that we needed to have a further meeting with the Trust and at that meeting we agreed a plan of engagement with the Trust as to how they would manage the concerns raised. It was clear that we needed to be far more proactive in this case, in circumstances where we were not satisfied with the initial actions and assurances of the Trust. We now consider that, if a situation such as LL was to arise again, we would take steps from the first call with AK, to ask more questions about what specific concerns the doctors had, and we would reached out to the GMC to explore whether they had been contacted about the doctors' concerns and to gather broader intelligence .

Responses to questions from written opening

ELS system and process changes

7. In our written opening statement to the Inquiry (INQ0107956), we said at paragraph 12(b) that after the ELS spoke to Alison Kelly on 6 July 2016 it 'would have been better to have been more proactive and to ask for an update on what decision had been made [concerning police referral] within a few days of AK making initial contact'. The Inquiry has asked how our systems have changed so that if a similar call were received, we would request an update within a few days.

8. As explained in paragraph 82 of Andrea Sutcliffe's first witness statement, our ELS was set up in response to a recommendation of the Mid Staffordshire NHS Foundation Trust Public Inquiry Report[1]. The team was first established in September 2015 as a pilot. During the pilot the team was led by the Project lead and two RAs, by the end of 2015 there was an Assistant Director, Head of Service Delivery and four RAs. In April 2016, after the end of the pilot period, we recruited two more RAs which meant there were six RAs in total when we received the initial call from CoCH. The number of RAs increased to eight in January 2018 and then to 12 in November 2019.

9. I set out in paragraph 35 of my first statement that in 2016 ELS was still a relatively new service and had only been operating for approximately three months following, the pilot period, when AK first called us in July of that year. At that time, ELS had less capacity and inevitably, less experience than it has today after eight years of running the service. In 2016 ELS was a

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[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'.

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new addition to the regulatory landscape and was at the start of developing its relationships with employers as well as the other system and professional regulators including the Care Quality Commission (CQC) and GMC.

10. If we were to receive a similar call today, we believe we would be in a better position to be more proactive than we were in 2016. Now the team is more experienced and RAs are able to use both their own experience and emerging intelligence to identify emerging concerns. ELS also has stronger relationships with NHS and social care employers than it did in 2016. The team is also larger. Having more RAs and a greater regional coverage means that we have increased capacity to take a proactive, intelligence-based approach, changes in the ELS team are in paragraph 26 below.

11. We also now have regional oversight meetings and can escalate issues to the Intelligence Sharing Hub, which is covered at paragraph 17 below. There is also now a dedicated insight and intelligence team within the NMC and a more established process for gathering and analysing our own insights to help discharge our regulatory functions. This means that the ELS team can now be more thorough, given that they are dedicated to one area, and we have improved internal oversight which would prompt action via the intelligence sharing hub. We also have the Regional oversight meetings, which I cover below.

12. Although there isn't a dedicated system alert to prompt follow up, the RAs ways of working, would mean that they would diarise for follow up. Where an RA has advised an employer to refer a registrant, the RA must do a follow-up check to confirm and record that the referral was received and call the employer back if itis not. This process is set out in the Advice to Refer SOP [INQ0108436] **(HH0016)**. If a referral is not received, this will be reviewed at the next benchmarking meeting and we will consider whether we need to invoke Article 22.6[2], which enables us to make a referral to ourselves.

13. After ELS conducted their self-assessment review in January 2024, the process for escalating concerns was reviewed by senior members of the ELS team and as a result, the peer review and benchmarking standard operating procedure [INQ0108428] (**HH008**) have been strengthened to provide more guidance on the escalation of serious concerns where there is no significant evidence about an individual's fitness to practise. The addition is on pages 9 -10 of the peer review and benchmarking standard operation procedure and includes the following:

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[2] The Nursing and Midwifery Order 2001 (SI 2002/253)

'On occasion RAs will be asked for advice or be provided with information that they consider of serious concern but where there is no significant evidence about an individual's fitness to practice requiring referral.

This could include concerns raised about patterns of poor outcomes where there is a potential that a professional may be accidentally or deliberately causing harm and/or where employers have not responded appropriately to serious concerns (this might come to us via CQC/other advice line calls.

In cases where an RA receives concerning information that warrants discussion in between scheduled peer review or benchmarking meetings, an extraordinary benchmarking meeting can be called'.

14. In paragraph 12(b) of our written opening statement, we stated that 'ELS could have contacted AK before May 2017 to satisfy itself that [the Hospital] was taking all appropriate steps to protect patients and to ensure concerns were being fully investigated'. The Inquiry has asked how our systems have changed, if at all, so that such a delay would now not occur.

15. I summarised our engagement with CoCH in paragraph 33 (a) – (i) of my first witness statement. There was a gap in our engagement with AK at CoCH between 8 February 2017 and 18 May 2017 and we acknowledge that with hindsight we could have been more proactive in following up on the publication of the Royal College of Paediatrics and Child Health (RCPCH) review and ask for an update on what decisions had been made rather than waiting for updates during that time. We could have been more curious as to what actions CoCH were considering including how they were managing safeguarding risks. As I have outlined above, since then, the team has increased in size and experience which means there is greater capacity for the RAs to take a proactive approach to their engagement. If the same situation occurred today, we would have more regular contact with the employer based on the potential risk to patient safety, and due to developed relationships, we would contact the GMC.

16. Our standard operating procedure for scheduling, delivering and recording RA meetings with employers which was last updated in February 2021 [INQ0108429] **(HH/009)** states on page 3:

'The frequency of engagement will largely be determined by the risk prioritisation for that RA's region, country or portfolio and may change over time. It will also be informed by the level of demand from employers and by external events, for example a system regulator report or a high-profile fitness to practise case'.

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17. We are developing a new mechanism for how the Insight team can support ELS to have an intelligence led approach to employer engagement, utilising multiple internal and external data sources.

18. At paragraph 12(c) of our written opening statement, we explained that in July 2016 we could have probed CoCH's decision not to refer to the police, that we could have contacted the GMC or CQC to discuss the concerns raised and we could have advised CoCH to ask the consultants to contact the NMC if we had been made aware of the strength of their concerns. In our oral opening statement, we explained that in listening to Counsel to the Inquiry's opening, we were struck by the repeated and numerous occasions when the consultants raised concerns with the management team of the CoCH. The NMC was not contacted by any of those consultants. We were clear in our opening that we do not seek to criticise them in any way, rather, we would like to understand what barriers, if any, the consultants faced in making a direct referral to us and whether there is anything further that the NMC can do to ensure that anyone who has a concern in the future feels able to contact us directly to initiate a referral.

19. The Inquiry has asked how, if at all, the systems at ELS have changed since July 2016 to ensure that these steps would now be taken if a similar situation were to arise. As outlined in paragraph 11, our process for escalating concerns has been strengthened to cover this scenario. Paragraphs 164 – 170 of Andrea Sutcliffe's first witness statement outlined the other internal and external mechanisms we now have in place since 2016 to share and consider emerging issues or concerns which include:

    a. Our two internal oversight groups - the Intelligence Coordination Group (ICG) was initially established in 2017 and the Intelligence Sharing Hub (ISH) was established in 2022. These groups focus on concerns relating to patient safety which are identified from a variety of sources including our regulatory intelligence work, through the ELS education assurance activity and concerns identified through external inquiries, reviews and media reports.

    b. Being a signatory of the emerging concerns protocol for England which is hosted by the Care Quality Commission provides a clear mechanism for raising concerns and ensures a collaborative approach to proposed actions. In the last two years, we have invoked the protocol and convened a regulatory review panel three times in response to concerns emerging about maternity services in three NHS Trusts.

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c. Our membership of the National Joint Strategic Oversight Group (NJSOG) and the National Perinatal Safety and Surveillance Group (NPSSCG) which are both convened by NHS England

20. Since 2022 ELS has also established four internal regional oversight meetings (ROM) that bring together teams from across the NMC to share insight or intelligence around providers as well as themes or topics relevant to the regions. Concerns raised at this meeting can also be escalated to ISH if appropriate.

21. If we were to receive a similar call today to the one we received from AK in July 2016, we would:

    a. Raise it at the relevant regional oversight meetings and escalate the issue to Intelligence Sharing Hub.

    b. Invoke the emerging concerns protocol to have an intelligence sharing discussion with the system and professional regulators for the North West region.

22. Whilst we think it may be unlikely that this would have made a difference to the advice provided by ELS at the time, due to the information we received at the time from CoCH, these meetings would have provided more awareness of the emerging concerns and may have prompted other organisations to contact us if they had further information and would have been an opportunity to share intelligence. Now, supported by our curiosity guidance, we would also expect that if the same thing happened again, we would be given more information from the relevant Trust, as we would make more enquiries at that initial stage, especially in circumstances where what we are being told is very thin, but potentially extremely serious.

23. We received a fitness to practise referral for Alison Kelly on 20 May 2020 and she remained our contact at CoCH in relation to the Letby case until 19 May 2021. At paragraph 12 (d) we said that we 'recognise[s] that retaining AK as the contact at [the Hospital] after her own referral to the NMC is unlikely to have been appropriate'. The Inquiry has asked how our systems have changed so that an individual subject to a referral to us does not remain the main contact in relation to the issue upon which the ELS is providing advice.

24. In my reflective statement, I outlined changes we have made as a result of our learning and also stated at paragraph 53(f) that there was one further lesson we had identified where we had more work to do.

25. We maintain a single point of contact (SPOC) list for every Trust, Health Board and large private provider in the UK. These SPOCs are contacted by our FtP colleagues to obtain

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information about referrals relating to staff working at their organisation and they are also the main contact that ELS liaise with to discuss FtP cases relating to their organisations. The SPOC at an organisation is often the Chief Nurse or Director of Nursing, but sometimes this responsibility is delegated down the hierarchy. If an FtP referral is received about a SPOC the screening team will contact ELS to advise on the most appropriate contact within the organisation for that referral which would normally be the CEO to obtain relevant employer information. This process is set out in the operational handbook for the screening team and it was first introduced in September 2020:

> *'If the referral is about the NMC point of contact then you must contact their seniors, such as the CEO. Please contact the Regulation Advisor in the first instance'.*

26. We review the appropriateness of retaining the individual as the SPOC on a case-by-case basis. If the FtP referral is serious and may require restrictions of practice or is related to a linked FtP referral, then we would change them as our main contact. We recognise that this is an area where we need to further consider our approach. We have also recognised that we need to formalise our approach in these situations and we are developing a mechanism for ensuring that ELS are aware of any fitness to practise referrals relating to senior leaders.

Correction to Paragraph 13 of our written opening

27. On 3 October 2024, we wrote to the Inquiry to inform them that we had made a drafting error in our written opening statement. At paragraph 13 we listed a number of changes had been made to ELS ways of working following Letby's conviction but we clarified that that was not the case - some of these changes were implemented before that date as we explain below. We welcome the opportunity to provide clarity on these points and we apologise for any confusion this may have caused.

ELS Team Size

28. In our written opening at paragraph 13 (a) we stated that the ELS team had increased in size from 4 to 12 since Letby's conviction. The Inquiry has asked us to clarify when the increases to the size of ELS took place.

29. During the ELS pilot in 2015 there were two RAs and by the end of 2015 this increased to four. In April 2016, we recruited two more RAs which meant there were six RAs in total when we received the initial call from CoCH. The number of RAs increased to eight in January 2018 and then to 12 in November 2019.

Record Keeping

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30. Paragraph 13 (b) states that record keeping has improved to ensure that all ELS interactions can be recorded. The Inquiry has asked what other improvements, save for the additional codes that have been introduced, have been made to the ELS' system of record keeping.

31. There has always been an expectation that all interactions with Trusts are recorded. The requirements for this in 2016, at the time of the call, are documented in pages 49-52 of the Employer Link Service Regulation Adviser Manual (July 2015) [INQ0108430] (**HH010**). We updated our standard operating procedure in February 2021 [INQ0108429] (**HH009**) to provide more detail on this requirement.

ELS Standard Operating Procedures

32. In paragraph 13 (c) we stated that a standard operating procedure (SOP) for the ELS advice line had been created since Letby's conviction. The Inquiry's understanding is that this SOP has been in place since 2021 and has asked for all copies of the SOP.

33. We cannot locate the original advice line SOP from 2016, as it was superseded by the 2018 version but there is advice line detail in the 2015 ELS Manual. I provided the current advice line standard operating procedure as an exhibit to my first statement (HH04).

34. The ELS manual referenced above was also updated in 2018 and I have exhibited that version for completeness [INQ0108431] (**HH011**).

Peer Review

35. In relation to paragraph 13 (d) of our written opening where we talk about monthly peer to peer review sessions of advice, the Inquiry has asked when these were introduced, whether the advice provided by ELS to CoCH in 2016 and 2017 was discussed at these sessions and whether the system of monthly peer to peer reviews has changed since then. The Inquiry has also asked whether the benchmarking process has changed since 2016/2017.

36. Monthly peer review meetings were introduced in 2016 and had clear terms of reference [INQ0108432] (**HH012**). The advice provided by ELS to COCH in July 2016 was discussed at the peer review meeting on 19 August 2016 and due to the seriousness of the concerns it was then referred to the monthly benchmarking meeting and discussed (page 28 [INQ0108433] **HH013**).

37. As I have stated above, since 2016 the ELS team has grown in size so there is now a larger group of RAs who attend the peer review meetings and the meetings also include representation from our clinical advisor team, who sit within our fitness to practise team and also a member of our safeguarding team. Over the last eight years the meetings have naturally evolved and attendees draw upon their relevant experience and expertise that has

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significantly developed over time. This has strengthened the multi-professional input and enables effective peer evaluation of advice and decisions.

38. The Inquiry has also asked whether the advice given to Alison Kelly on 6 July 2016, 29 November 2016, 18 May 2017 and 15 June 2017 was subject to benchmarking and/or peer review. If so, it has asked what the dates were, what were the outcomes.

39. The advice given on 6 July 2016 was taken to peer review on 19 August 2016 and to the benchmarking meeting on 24 August 2016. At the peer review meetings, the RAs peer review advice and discuss whether the advice provided should be escalated or be subject to further scrutiny at the benchmarking meeting. The outcome of the peer review meeting [INQ0108434] (**HH014**) was that it was a 'potentially really serious situation and the RA needed to follow up with AK and the advice should also be taken to the next benchmarking meeting. At the benchmarking meeting [INQ0108434] (**HH013**) the group agreed with the initial advice which was:

    '*Considering the above circumstances, 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. I would also recommend another advice call to take place following confirmation of any Police action.*'

40. The engagement on 18 May 2017 and 15 June 2017 did not come via the advice line, they were calls providing updates and were therefore not automatically subject to peer review or benchmarking, as advice line calls would be. If, during those calls, further information about a specific concern had been received that changed the original advice, it would have automatically been captured on a report produced by the Employer Link Officers in the ELS team. It also then be referred to the peer review and potential benchmarking processes as the advice code would have changed from the original advice. Now, there would be ongoing oversight beyond the individual RA in any event, as a call such as that made by AK in July 2016 would be escalated to the Intelligence Sharing Hub and would be reviewed at the next ISH meeting. If there were still outstanding queries, or further information was awaited by way of update, then the ISH would consider the case again at further meetings.

Emerging Risks

41. In our written opening at paragraph 13 (g) we stated that we are actively involved in discussions around emerging risks both regionally and nationally. The Inquiry has asked when we started being involved in these discussions and were NMC colleagues present at regional quality and oversight groups around July 2016.

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42. When ELS was established, the team was involved in discussions around emerging risks and issues on a regional and national level and that included a presence at regional oversight group meetings. As outlined in paragraph 47 of my first statement, 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.

43. Our discussions with regulatory bodies and other stakeholders have also strengthened and evolved over time and as outlined in Andrea Sutcliffe's first witness statement, we have much closer working relationships with the GMC and CQC (paragraphs 211-214). ELS now has a RA attached to each region in England and they collaborate with the CQC, NHS England (NHSE), GMC and the HCPC. There are also three RAs allocated to Wales, Northern Ireland and Scotland. In England, the RAs attend meetings in each region chaired by NHSE and areas of concern and emerging intelligence are discussed at these meetings. We attend similar forums in the devolved nations. The Integrated Care Systems also hold quality oversight meetings which our RAs attend where relevant concerns are discussed.

Culture of curiosity

44. In our oral opening, having listened to Counsel to the Inquiry's opening, we included reference to our recently published [INQ0108435] guidance on our culture of curiosity and we have exhibited that guidance **(HH/015).** The Inquiry has asked when this guidance was introduced, whether it applies to pre-referral advice provided by ELS and if not, why not. The Inquiry has also asked how this guidance is being implemented in practice.

45. The guidance was published on 30 August 2024 to address learnings we identified by engaging with families involved in the second Ockenden Maternity Review, on the Nottingham University Hospitals NHS Trust's maternity services. As we explained in our oral opening, the guidance promotes and emphasises the need for a culture of curiosity in our fitness to practise investigations, from first contact with us. The sentiment of the guidance is not new, in terms of what is required in our colleagues' approach to potential fitness to practise concerns. Rather, the guidance aims, for the first time, to pull together in one place how we approach enquiries and investigations, spells out why a culture of curiosity is important, and outlines the risks when we are not curious.

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46. The term 'culture of curiosity' was not used in our guidance prior to August 2024 but our view was always that the new guidance helpfully articulated and made explicit an approach to our work which was already in place, in line with Fitness to Practise Principle 1 which commits us to a "person-centred approach to fitness to practise" where we "listen to what people receiving care, their families and loved ones tell us about their experiences so that we can understand what the regulatory concerns about nurses, midwives and nursing associates might be and are better placed to act on those concerns".

47. Our intention is that the guidance will ensure that those receiving fitness to practise concerns will scrutinise more closely the information they are being told and the conclusions reached by others before we decide whether or not to investigate. We further hope that it encourages staff to consider if there are other reasonable and proportionate investigative steps that we should take to clarify what has happened.

48. To make sure all colleagues are aware of this guidance we are socialising this internally through internal training, discussions at team meetings, internal newsletters and by dissemination of learning materials across the NMC. Subject matter experts have made themselves available to answer any questions arising and attend meetings with colleagues.

49. The curiosity guidance applies to all colleagues across the NMC, including ELS who were one of the teams that provided feedback on the new guidance when it was in development. This guidance is particularly relevant to NMC colleagues involved in dealing with any concerns raised with us, whether this is an advice call prior to a referral being made, at the point of referral, screening or investigation. To make this clear, we are planning, by the end of 2024, to adjust the language at the start of the new guidance to clarify that the guidance applies to all NMC colleagues and not just people working in fitness to practise teams.

50. For example, when colleagues take a call from a concerned member of the public, registrant or employer, they will listen to the person raising a concern and consider if it is necessary for the NMC to make further enquiries. We can reach out to the relevant Trust and ask to see relevant internal reports or other evidence that could help us understand the severity of the concerns raised and if a referral needs to be made. We may also escalate concerns with other professional or systems regulators, by, as detailed above, involving the emerging concerns protocol. Where concerns that are most serious in nature are raised, we will take a more proactive approach to examine and explore what we are told.

51. We are aware that members of the ELS team expressed the view that the culture of curiosity guidance focussed on referrals, whereas actually it relates to all teams, from those receiving

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a concern to the end of our regulatory process. This has been clarified to the entire ELS team by meeting with them to address those concerns. They have also been asked to complete training on curiosity, which has been introduced following the publication of the curiosity guidance. We are also planning to amend the introductory wording of the ELS SOP to identify and highlight that the curiosity guidance is integral to all discussions with employers.

52. The NMC welcomes the investigation undertaken by the Inquiry and will continue to learn lessons and cooperate with any recommendations made. The NMC will ensure that we continue to actively engage with other organisations to effectively deliver our role in protecting the public.

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 in its truth.

Signed Personal Data

Dated: 7 November 2024.

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