

## Only one Doctor was pointing the finger at Letby.

A Divisional Director who knew little about the concerns about sudden deaths on the neonatal unit despite it being part of her patch. From a non-clinical background, she was more concerned with business oversight and planning.

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**S**he was relatively new in post and at the material time was concentrating on an upcoming CQC inspection.

She worked with a team comprising a doctor and nurse but they never alerted her to the suspicions about Letby. If they had had concerns, she would have expected them to put them into the risk register.

She kept reminding the Inquiry that she had no clinical background.

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*She had been shocked when the lead doctor had told her at a catchup meeting in a coffee shop that a member of staff was suspected of harming patients and was worried about the consequences if Letby was left unsupervised on the unit.*

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This was way about her pay grade! It was not a problem she could grip.

**Next the head of Risk and Patient Safety [Nurse] who reported to the Deputy Head of Nursing.**

She had a team of about a dozen. Like colleagues she had been very focused on the upcoming CQC inspection.

She did supervise and review risk registers and fed off the Datix system which required a

review after each patient safety incident. This included a “deliberate harm test” but was never used.

Was the Trust more concerned with limiting reputational damage and comms management than saving babies, Counsel challenges.

No, was the response although she did agree that the CQC should have been told about the thematic review into the sudden deaths.

Some of the Letby deaths had not been recorded as incidents.

She got more than a hundred emails a day and some were just copies to enable others to say later that she had been informed!

She had not reacted to the gossip about Letby knowing that the matter was being dealt with by more senior colleagues.

She thought it had been a competency rather than a deliberate harm issue. You did not refer competency issues to the police.

It was the Executive Team who decided that Letby could continue to work on the unit provided she was supervised.

The Executive Team did not believe the sudden deaths could be attributed to one person but you could not supervise everybody!

*This was a head of safety trapped in nursing hierarchy when she should have been able to question and challenge anybody in the organisation whatever their discipline.*

If her team had just a support and intelligence role it needed statistical skills as well as clinical insight. The Team needed to have direct access

to the Chief Executive. Safety was never an easy option.

**Next the Deputy Head of Nursing who handled some specialist nursing services [transfusion, Macmillan and others] but had no direct line management relationship with the nursing heads of clinical units.**

They reported directly to her boss. She never had a problem with the paediatricians.

She had attended many of the senior executive meetings, often representing her boss, but does not appear to have played a major role in any of them.

She did not remember much of the detail but did recall a mortality review of one of the babies when one of the Consultants had been “twitchy” about what had happened but had never mentioned Letby.

One clinician had reported that he was so concerned that he had retained a bag of fluid that one of the babies had been fed from prior to its unexpected death.

She had consulted the Trust Secretary, who had a legal qualification. He told her to make sure it was retained if there was a suspicion of foul play. This must have raised extremely loud alarm bells!

She had tried to replicate the doctors work on relating the sudden deaths to shift rotas and concluded that it was 80% likely that Letby would be on duty either during or just before a baby collapsed.

**Next, another divisional director who became Chief of Operations.**

As a divisional director she assumed that concerns about excess mortality would be dealt with via professional channels. At one point her clinical colleagues had reassured her that the clinicians had reviewed the sudden deaths and had no concerns.

As COO she had joined the Executive Team which in her view had worked in a very collaborative manner. She asserted that “*the structure and processes for the management and*

*governance of the Trust did not contribute to the failure to protect the babies in the neonatal unit.*

*The systems were place. The people did not use them”.*

As COO she had been unaware initially of the concerns about the run of sudden deaths in the NNU and had been shocked when the paediatricians had told a meeting about their concerns about Letby.

The Trust Chief Executive had wanted Letby excluded from the unit until the issue had been cleared up. Why did it take so long for the police to be called in asks Counsel?

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*We knew nothing about much of the clinical information including the insulin or blood results. We were just told that no explanation for the deaths had been found. If we had known more, we might have taken a different course of action.*

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**Next the deputy Head of HR is challenged as to why suspicions that a member of staff was harming children was not referred to the Local Authority.**

The suspicions were too vague to justify such action was the reply.

She had taken legal advice about moving Letby but assured the lawyers that no malicious issues were involved.

Her understanding was that there was only one person pointing the finger at Letby and that was Dr Stephen Brearey.

He had not provided any evidence to support his allegations. The CEx had told her that the coroner had reviewed all the deaths and that the Royal College had found no common link between the deaths.

We will hear from the chair of Letby's successful grievance appeal later but we find out that the RCN acting on Letby's behalf had been demanding apologies from senior doctors for their "unfounded" allegations about Letby.

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*She agreed that those with concerns and evidence [the paediatrician's] should have gone to the police.*

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It also emerged that our witness had drafted the outcome of the grievance hearing for the chair and had, unwisely she acknowledges, copied Executives into the draft.

She had never spoken to the doctors. They only spoke to the Executive Team she explained.

So, you never heard at first hand their side of the story Counsel countered. In the world of HR suspicion was never enough for disciplinary action. She needed evidence.

Next, we will hear from the Chair of the Grievance Hearing, the RCN and the Royal College who found no linkage between the deaths.

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**Meanwhile in the wider media doubt continues to be expressed at the soundness of Letby's conviction. The Inquiry ignores them but it must be distressing for the families involved.**

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