THIRLWALL INQUIRY
Dated 04 March 2025

NURSING AND MIDWIFERY COUNCIL
CLOSING STATEMENT

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1. The Nursing and Midwifery Council (NMC) would first like to take this opportunity to reiterate our thoughts and heartfelt condolences to the families and loved ones of the babies who were killed or harmed by Lucy Letby (LL). The impact on the parents and families who have lost babies or those who now have children with lifelong injuries is heartbreaking. 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 all.

2. The Inquiry's review of the tragic events at the Countess of Chester Hospital (CoCH) has been of the utmost importance, unearthing necessary understanding of events with the purpose of ensuring that lessons are flagged for all those responsible for keeping babies in hospital safe and ensuring their quality of care. Over the course of the hearings, the Inquiry has heard powerful testimony from many witnesses, including the families and loved ones of the babies who were harmed or killed. It is not our intention for this statement to repeat the evidence provided to the Inquiry, though we would like to begin our closing submission by acknowledging their evidence and by assuring them that they have been listened to and heard. The events at CoCH should never have happened; the profound impact on the families involved is devastating and cannot be underestimated.

3. The NMC is committed to learning and improving as an organisation from this Inquiry, and to making the improvements necessary to help ensure the safety of the public and help prevent such events from reoccurring. This is integral to the NMC's activities as a professional regulator and for upholding the public's confidence in the NMC, and the nursing and midwifery professions it regulates. The NMC has valued the opportunity to participate in this Inquiry.

4. As outlined in our witness statements, the NMC has reflected on the events at CoCH and its handling of the LL and Alison Kelly (AK) cases and has undertaken a thorough review of its internal processes, to learn lessons and implement changes to help prevent such tragedies from being

repeated. The NMC has continued to listen with great interest to the evidence presented to the Inquiry, to identify further learning and improvement opportunities.

5. The NMC has been asked to address several key points in this closing statement. This statement will start by addressing the key questions raised in the 'Further Note on Written Closing Submissions shared on 04 February 2025'. This statement uses the questions applicable to us as headings, to help address areas of interest to the Inquiry.

6. The second part of this statement will address matters in the 'Note on Closing Submissions' shared on 06 January 2025. Based on evidence previously submitted, this statement will summarise what the NMC has learnt from the Inquiry to date, and from its own review of events at CoCH. It outlines the changes the NMC has made in response to key learning identified and sets out the NMC's plans for taking forward what it has learned.

Please set out clearly how safeguarding duties and obligations operate in respect of the NMC. Is it accepted that child safeguarding duties and / or procedures in respect of babies apply?

7. The NMC has been asked to explain how its safeguarding duties operate, and whether it is accepted that child safeguarding duties and / or procedures in respect of babies apply to the NMC.

<u>The NMC's role</u>

8. To answer the Inquiry's specific questions about the NMC's safeguarding duties and obligations, we would first like to provide a brief explanation of our role. The NMC is the regulatory body for nursing and midwifery professionals in the UK. It is a statutory body, established and governed by the Nursing and Midwifery Order 2001 ('the Order'), in accordance with the Health Act 1999[1]. Our statutory obligations and powers are set out within the Order and our principal functions are to establish standards of education, training, conduct and performance for nurses, midwives and nursing associates, and to ensure the maintenance of those standards[2].

9. The NMC has an essential role to play in protecting the health, safety and wellbeing of the public, including babies in hospitals, by promoting and maintaining proper professional standards and conduct for the nurses, midwives and nursing associates it regulates. This is a role that the NMC takes seriously and is constantly looking to improve.

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[1] Section 60 and section 62(4)
[2] Article 3(2) of the Order

10. The NMC's overarching objective is to protect, promote and maintain the health, safety and wellbeing of the public. As per the Order, the NMC can pursue this objective in the following key ways[3]:

    a. By setting the standards of education, training, conduct and performance that nursing and midwifery professionals must meet to be eligible to practise and approving education institutions to deliver programmes that meet those standards.

    b. By maintaining the register of professionals that meet these standards and are eligible to practise. This includes requiring professionals to meet a number of prescribed requirements for registration and renewal of registration, otherwise known as revalidation.

    c. Investigating concerns raised about nurses, midwives or nursing associates' fitness to practise and investigating whether a nurse is capable of safe and effective practice, where an entry onto the register may have been fraudulently or incorrectly obtained.

11. The NMC's Code [**INQ0002419**], which all professionals on its register are required to follow as a requirement of their registration, has a specific section that clearly sets out what professionals must do to preserve the safety of patients and the public. This includes specific references to protecting people who are vulnerable or at risk of harm, which would include, for example, babies at risk of harm at CoCH. The relevant sections of the Code are as follows:

    a. Raise and, if necessary, escalate any concerns they may have about patient or public safety, of the level of care people are receiving in their workplace or any other health and care setting and use the channels available to them in line with our guidance and their own working practices (16.1).

    b. Take reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse (17.1)

    c. Share information if they believe someone may be at risk of harm, in line with the laws relating to the disclosure of information (17.2).

    d. Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people (17.3).

12. Where a concern is raised about a professional on the NMC's register's conduct or their ability to meet the NMC's professional standards, or where it otherwise appears to the NMC that there may

[3] Article 3(4A) of the Order

be a concern, but a referral has not been made,[4] the NMC has a duty to investigate through its fitness to practise process. Based on this investigation, the NMC will take regulatory action where necessary to protect people who use health and social care services and to ensure public trust and confidence in the professions is maintained. This includes concerns about a professional's failure to meet their safeguarding responsibilities under the Code or more widely.

The NMC's safeguarding duties

13. The NMC has a statutory duty to protect, promote and maintain the health, safety and wellbeing of the public. It can pursue this objective with the powers available to it, and in line with its statutory functions as listed in paragraph 10 (a) – (c) above. The NMC also has a general duty to co-operate, in so far as is appropriate and reasonably practicable, with public bodies or other persons concerned with the regulation or coordination of other health and social care professionals and the provision, supervision or management of health services.[5] This would include other professional and system regulators, and health and social care providers.

14. The NMC also has safeguarding responsibilities set and regulated by the Charity Commission in England and Wales. This includes the expectation that as a registered charity we would take reasonable steps to protect people from harm and report safeguarding matters which come to the NMC's attention to relevant agencies.

15. The NMC plays an important part in a larger network of organisations and bodies who collectively have the responsibility for upholding patient safety and safeguarding children and adults from harm. This network includes a wide range of regulatory, investigatory and prosecutorial bodies, each with different legal remits and obligations for safeguarding and protecting the public. This includes, but is not limited to, bodies such as professional and system regulators, local authorities, health and care providers, and the police. Each organisation has a distinct role to play as well as a responsibility insofar as their legal and investigatory remits allow to effectively collaborate and share information with one another to form an appropriate system-wide response to concerns. The Emerging Concerns Protocol for England is a key mechanism used by us and other agencies to share information that might indicate risk, helping signatories coordinate activity and fulfil their collective roles better. Whilst the Protocol was not in place at the time concerns were first raised about LL, the Protocol reinforces the important role that each participating organisation fulfils as a part of the wider safety network, by establishing clear and distinct roles and responsibilities for each signatory based on their statutory duties and functions.

16. The NMC's role within the wider network of authorities is twofold:

[4] Article 22(6) of the Order
[5] Article 3(5)(b) of the Order

a. The first is the NMC's role investigating concerns raised about nurses, midwives or nursing associates' fitness to practise. This is a statutory obligation. These powers arise where a referral about a nurse, midwife or nursing associate's practise is made by a third party.[6] The NMC also has the power to investigate a professional's fitness to practise where a referral has not been made, but it appears that there should be an investigation.[7]

b. The second is the NMC's role in effectively collaborating with the wider network of agencies with safeguarding responsibilities and powers, to help form an appropriate system-wide response. As explained above, the NMC has a general duty to co-operate with other public bodies or persons concerned with the regulation of health services and the provision and supervision and management of those services. This involves the NMC sharing information that comes to its attention and reporting safeguarding matters to the appropriate agency to respond to and investigate.

17. This statement discusses both aspects in more detail below.

18. The NMC does not have wider investigative powers and duties which have been given to other bodies under legislation such as the Children Act 2004 and the Care Act 2014, such as to actively consider whether action needs to be taken to prevent or stop abuse and neglect. Neither Act lists the NMC as a relevant partner for local authorities to enable them to carry out their safeguarding duties.

19. The NMC's powers to investigate are specific and only arise where there is a concern about a professional's ability to practise safely and effectively. In line with our statutory function, if a referral is made, that a professional on our register may have caused harm to a child or failed to otherwise meet their professional safeguarding responsibilities, the NMC must investigate. However, the focus of these investigations must always be about the professional's fitness to practise. In line with our general duty to co-operate with other agencies, the NMC must also share information with relevant agencies as appropriate to help them perform their role, and as part of the NMC's collaborative approach to public safety and safeguarding. We would also expect that an employer would make a referral to the appropriate organisation. Where a concern is raised by a member of the public and they are not likely to know that another organisation may require notification, then we would liaise with relevant organisations using a memorandum of understanding or direct contact if necessary. If we investigate a nurse, midwife or nursing associate's conduct and we receive information that potentially discloses a safeguarding concern, we will always share this with the appropriate third party to consider in line with their statutory responsibilities. We hold memoranda

[6] Article 22
[7] Article 22(6) of the Order

of understanding (MOUs) with other regulators and partners, which set out how we work together and share information when we have concerns. These are all available on our website. We also share information with organisations where we do not hold MOUs if we consider it in the public interest to do so, which would include safeguarding concerns.

The NMC's role when engaging with CoCH

20. The NMC's Employer Link Service (ELS) was first informed by AK of the rise in neonatal mortality rates at CoCH and concerns about LL on 6 July 2016. This telephone call was followed up by an email [**INQ0002445**] which confirmed that AK informed ELS that each death had been the subject of a clinical team case review and there were no concerns about the clinical competence of individuals or teams. However, as LL was present at nearly all of the incidents, the CoCH Executive Team were due to meet later that day to decide whether to report LL to the police.

21. At the point of receiving the call from AK, the NMC's responsibility was to consider whether the concerns raised about LL were sufficient to require the NMC to take action to investigate, and whether a referral should be made. Whilst it was not the NMC's role to consider whether the Trust was performing its safeguarding functions, which is a matter reserved for the CQC, the NMC did have a responsibility to probe the information provided by AK, to better understand the nature of the concerns and the level of risk, and to understand whether other agencies had already been informed of the concerns. This would have put the NMC in a better position to know whether it needed to share information with other agencies, or follow-up with them, having learnt of the serious concerns.

22. Based on the information provided by AK, ELS advised AK that there was insufficient information provided at the time to open a fitness to practise investigation into LL. If the police concluded that LL was involved in harming babies, then a fitness to practise referral would be needed. We have reflected on this and consider that ELS provided appropriate advice based on the information conveyed at the time. Although these were potentially extremely serious concerns, the Regulation Adviser (RA) was informed that CoCH was investigating and had not reached any final decision about the next steps but was due to determine whether a police referral should take place imminently. We consider that it was reasonable to wait until CoCH had made a decision about a police referral before deciding what steps, if any, to take. Without further information about the concerns raised by 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 basis for the NMC to form the view that LL was a person of particular interest to the police, or that there was a body of evidence which suggested she was directly involved.

23. Although the NMC considers it was not appropriate to open a fitness to practise investigation into LL at the point that AK called, on the basis of what ELS were told, the NMC accepts that it could have been more proactive and demonstrated more curiosity at the time it received the call. For example, by seeking further detail about the consultants' concerns, and by giving advice to CoCH to tell the consultants' to make a referral to us if they felt their concerns warranted regulatory action. We have considered whether we could have also asked for all the details of the deaths and the reviews undertaken by COCH themselves about the cause of the deaths. However, we consider that we would not 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. The police were the appropriate body to investigate potential criminal behaviour. It was for the CoCH to conduct the appropriate reviews with the input of experts and agencies, and for the NMC to be proactive in asking for regular updates into those investigations. Since the original call from AK, it has transpired that there was additional information that should have been shared with the ELS and other agencies, which was not shared at the time. The NMC was surprised to learn about the nature and extent of the information that CoCH had not shared, and in hindsight accepts that if more questions had been asked, it is possible that this information may have been elicited.

24. As explained in Helen Herniman's reflective statement, [**INQ0107926**], the NMC recognises that it would have been better to have been more proactive in seeking updates from AK and to discuss the outcome of the Royal College of Paediatrics and Child Health (RCPCH) review. Since the events at CoCH the NMC has taken action to strengthen how it collaborates with external partners and to improve its ability to proactively share information of mutual interest, to enable a coordinated, system-wide response to concerns raised. In particular, the NMC has been a signatory of the cross-regulatory Emerging Concerns Protocol for England since its inception in 2018. This Protocol allows any one of the signatories to initiate a regulatory review panel with other members to share and discuss concerns or areas of risk, to triangulate information and identify appropriate action as a safety system.

25. The Emerging Concerns Protocol supports professional and system regulators and other partners to work together as a safety system, to ensure all proper action is taken where public safety or safeguarding concerns emerge. Each organisation participating in the protocol has different roles to perform based on their own legal remits and obligations, and the limits for each organisation are made clear in the protocol. Signatories must also collaborate with each other so that risks are appropriately mitigated. Had the protocol been in existence at the time of events at CoCH, the NMC considers that a more thorough enquiry into events at CoCH could have taken place, as well as closer monitoring of the situation by all relevant signatories. In December 2024 we signed up to the MoU for investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life changing harm.

The NMC's engagement with AK

26. As explained in paragraph 11(a) – (d) above, as a registered nurse, AK had safeguarding obligations under the NMC's Code which she was expected to observe.

27. Based on the information AK provided ELS in July 2016, there was no indication at that time that AK was failing to meet her professional safeguarding obligations – she confirmed that the hospital was looking into the concerns, had moved LL from clinical duties, and were considering referring to the police. There was no fitness to practise concern about AK at the time that she engaged ELS, and there was no information to indicate the need for the NMC to use its powers to open a fitness to practise investigation into AK by reason of misconduct or lack of competence.

28. However, whilst the NMC considers that it was appropriate to have confidence in AK at that time, the NMC accepts that it should have approached matters with greater curiosity, for example, by asking more questions about the consultant's concerns, which AK had minimised. The NMC accept that it should scrutinise information provided by third parties, and the conclusions reached by others to inform its decisions about whether further regulatory action by the NMC is necessary or whether action from another relevant agency may be required. In August 2024 the NMC introduced its 'culture of curiosity guidance' (**INQ0108435**) which emphasises the need for curiosity across all its regulatory processes, from first contact with us. An intended outcome of this guidance is that those receiving fitness to practise concerns or wider intelligence will scrutinise more closely the information they are being told and consider if there are other reasonable and proportionate investigative steps to take to clarify what has happened and to ensure an effective response. If a similar situation such as LL were to arise today, the NMC would take steps from the first call with AK, to ask more questions about what specific concerns the doctors had, and we would have reached out to the GMC and other relevant organisations to explore whether they had any further information about the doctors' concerns and to gather broader intelligence.

What safeguarding duties and procedures apply where a member of staff has suspicion or concern that another member of staff may be harming a baby who is in the hospital? What is the process that must be followed and by whom on the occasion of a sudden and unexpected baby death?

29. Anyone with a concern about a professional on our register can make a fitness to practise referral to the NMC, including members of staff with suspicions about their colleagues. The NMC provides information on its website about how to raise a concern, which is publicly available. Concerns from individual staff members are raised by filling out the NMC's online referral form, which encourages the individual to raise the concern with the nurse, midwife or nursing associate or their place of work before making a referral. If a staff member makes a referral, the concern will be assessed by

the NMC's screening team to determine whether further investigation is required, including whether an application for an interim order is necessary.

30. As explained in paragraph 11 above, the NMC's Code and Standards include specific safeguarding responsibilities that professionals on its register must meet. The NMC's 2010 Standards for pre-registration nursing education [**INQ0002417**] also require approved education institutions (AEIs) together with their practice partners to:

    a. ensure that field-specific content in relation to the law, safeguarding, consent, pharmacology and medicines administration and optimisation is included for entry to the register in one or more fields of nursing practice.

31. The NMC sets high level outcome-focused principles in its standards, and AEIs and their practice learning partners are responsible for the development, delivery, and day to day management of their pre-registration nursing programmes.

32. The NMC expects safeguarding to be part of the curriculum in order to meet the outcome-focused principles in its standards. Prior to practice placement learning, AEIs prepare students for the placement, including that they are aware of any relevant local policies, procedures or guidance. As evidence and policy changes, it is the responsibility of the AEI and its partners to update teaching and learning in line with those changes. During the approval process for the NMC's programmes, the NMC scrutinises how safeguarding is formally taught in the curriculum and checks that it is taught in a field-specific way. The NMC's QA visitors also have to include a written narrative in the NMC's QA approval reports which set out the evidence the QA visitors have seen on how safeguarding is taught.

33. Safeguarding training is provided during pre-registration education programmes. Once professionals are registered, employers are responsible for having appropriate safeguarding policies in place and for ensuring that staff are appropriately trained on those policies. As outlined in paragraph 11 (a) - (d) above, the NMC's Code also requires those on its register to comply with local safeguarding policies and guidance.

Learning and reflections

34. The NMC has been asked by the Inquiry to provide an acknowledgment of any failings on its part; the detail of the evidence of changes implemented since the events examined; and the evidence of the effect of those changes.

35. As explained in paragraph 4 above, the NMC has reflected on the events at CoCH and its own processes and has identified opportunities to learn and improve, and some instances where in hindsight we could have done things differently. This part of the statement has been structured according to the NMC's key regulatory functions that are of relevance to the Inquiry: the ELS, fitness

to practise, registration and revalidation, safeguarding and data, insight and intelligence and the lessons we have learnt in respect of each.

ELS

36. The NMC's ELS was set up in April 2016, and one of its roles was to provide advice and support to employers who have concerns about professionals on our register. ELS was first informed by AK of the rise in neonatal mortality rates at the CoCH on 6 July 2016, and they remained in contact with AK through 2016 to 2018, when the fitness to practise referral for LL was received. A detailed chronology of ELS engagement with CoCH is provided in Andrea Sutcliffe's first statement and in Helen Herniman's supplementary statement dated 6 November 2024 **[INQ0108435].** This statement does not intend to repeat these details and will instead focus on the learning arising from our review of our ELS service, how we have responded to date, and what we intend to do in the future.

37. The NMC's ELS play an important part in helping ensure public protection concerns are adequately and promptly responded to. As explained in our opening statement to the Inquiry, the NMC has undertaken a detailed review of its approach to managing the initial concerns raised by AK and has identified the following key learning:

    a. As explained at paragraphs 23-24 above, the NMC's engagement with AK and CoCH could have been more proactive and the NMC could have done more to engage AK for updates, to help inform its view on whether a referral about LL, or any others, was necessary. There were some gaps in communication between the ELS and CoCH and the NMC's record keeping of its engagement could have been better.

    b. As explained at paragraphs 21-22 above, the NMC relied on the information provided by AK. Following our initial contact with AK, we could have done more to be curious and follow up on the CoCH's decision on whether to refer LL to the police and about whether a referral to us was required. We could have also proactively asked questions of AK about concerns raised by the medical team. Had the NMC been made aware of the strength of the consultants' concerns, and the evidence they had presented to AK and the executive team at CoCH, the NMC could have also advised CoCH to ask that the consultants contact the NMC to make a referral.

    c. As explained at paragraph 21 above, when AK first contacted us about the concerns, we could have done more to probe the information provided and to better understand the nature of the concerns and satisfy ourselves that other relevant agencies were aware of the concerns, including the CQC. We could have also contacted the General Medical

Council (GMC) or the CQC to discuss the concerns raised to help build a more complete understanding of the concerns and the interventions required.

d. On 20 May 2020 the NMC received a fitness to practise referral for AK. The NMC maintain a single point of contact (SPOC) list for every Trust, Health Board and large private provider in the UK to liaise with in relation to referrals relating to staff at that organisation. If a fitness to practise referral is received in relation to a person who is our SPOC, we would not discuss their referral with them or any related referral. If a referral is received in relation to our SPOC which is serious and has resulted in restrictions being placed on their practice, then we would change them as our main contact. We have considered our approach in this area and are exploring opportunities to formalise our approach to help ensure that ELS are aware when a senior leader is under fitness to practise investigation.

38. Over time the NMC has made the following changes to improve our ELS function and ways of working. As explained in Helen Herniman's supplementary statement dated 6 November 2024, some changes were made organically over time and before LL's conviction, and some have been made in direct response to our review of how we handled the initial concerns raised by AK:

a. The ELS team was in its infancy when AK first made contact in July 2016. The team has since matured as a service and increased in size from four Regulation Advisers (RAs) in 2016 to 12 currently. Each RA is allocated specific regions in England and to each of the other nations in the UK which enables more targeted and regular communication with employers in each of their respective areas. The increased capacity of the team also enables them to take a more proactive approach to their engagement, with greater opportunity to follow up on potential ongoing concerns.

b. Since ELS's introduction in 2016, there has always been a requirement to record and code any interaction with employers on the NMC's case management system. Over time as the ELS has expanded there have been additional codes added to support better data collection of the increased level of engagement.

c. A standard operating procedure for the ELS advice line was introduced in 2016 and has been updated over time to bring greater consistency and clarity in operational processes. The document was last updated in 2024 to include a strengthened process for internal escalation and include guidance on escalating certain categories of cases to other regulators, helping ensure concerns are acted upon promptly and collaboratively.

d. ELS advice has been subject to quality assurance measures since its inception in 2016, to ensure consistency between RA advice and to consider complex cases. This includes

monthly peer-to-peer review sessions between RAs; monthly peer review meetings with all RAs in ELS and monthly benchmarking meetings where ELS RAs, and staff from the Screening Team review cases and agree next steps. The quality assurance processes have also developed as the service has matured - the monthly peer review meetings with the whole RA team now include the Clinical Adviser and Safeguarding teams that have been established since ELS were first made aware of LL.

e. The NMC has much closer working relationships with both the CQC and the GMC than it did when ELS first received the concern from AK in 2016. We also hold memoranda of understandings (MOUs) with other regulators which set out how we will work together to share information when we have shared concerns.

f. The NMC is a member of the National Joint Strategic Oversight Group (NJSOG) and the National Perinatal Safety and Surveillance Group (NPSSCG), both of which are convened by NHS England. As explained in paragraph 24 above, the NMC is also a signatory of the cross regulatory Emerging Concerns Protocol for England and has been since its inception in 2018. The NMC has initiated and attended Regulatory Review Panels (RRP) under this process. Through membership of these groups, the NMC is actively involved in discussions around emerging risks and issues on both a national and regional level in England and the NMC plays 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.

<u>Fitness to practise</u>

39. The NMC first received the fitness to practise referral about LL on 5 July 2018. The NMC also later received a referral about AK on 20 May 2020. A detailed timeline regarding LL and AK's fitness to practise proceedings is included in the first witness statement of Andrea Sutcliffe.

40. The NMC's fitness to practise process is integral to its role as a professional regulator, enabling it to take necessary action to protect the public and maintain public trust and confidence in the profession. The NMC has reflected on its approach to managing the LL and AK cases to identify potential improvements to how we conduct fitness to practise investigations. A detailed account of the NMC's learning in this area is provided in Helen Herniman's reflective statement. In summary:

    a. The NMC conducted an immediate interim order risk assessment on the same day as receiving the fitness to practise referral for LL and continued to undertake regular interim order risk assessments after this. On each occasion, a decision was made not to apply for an interim order for the reasons set out in paragraph 56 of the reflective statement of Helen Herniman. These decisions aligned with our understanding of the evidence required for an

interim order to be imposed as well as our application of the guidance in place at the time. In March 2024 the NMC revised its guidance on interim orders so that it 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. The NMC 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 its 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.

b. The NMC formally considered whether to apply for an interim order at several 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 cogency of evidence in relation to LL and whether a 'prima facie' case was met based on the available evidence at the time. Although the case was escalated to senior colleagues, the NMC did not have a standardised escalation process in place. If there had been, the NMC may have sought external legal advice or other expert opinion to assist its consideration as to whether the application of the 'prima facie' evidence test was appropriate in this case.

c. On 6 July 2018 AK informed us that LL's bail conditions restricted LL from working in any healthcare environment. We followed up with the police who explained that LL was not to work in any healthcare setting or to have unsupervised contact with anyone under the age of 16. The NMC should have requested LL's bail sheet from the police sooner, rather than relying on information provided in emails from the police and CoCH. In June 2019 the NMC expressly referred to its Article 25 power to request disclosure of LL's bail sheets from the police. Express reference to the NMC's legal basis for disclosure could have been made earlier to help ensure a timelier disclosure.

d. The NMC's response to individuals who made the fitness to practise referral about AK and its application of whether to consider the individuals as whistleblowers should have been better. There was some confusion 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.

e. Obtaining clinical input sooner in relation to the LL matter would have helped us explore issues around referrals and helped inform our decision making on the seriousness and scope of the allegations. The NMC acknowledges that the skills and experience of clinical advisors could input into a wider range of cases to improve decision making.

41. The NMC has made the following changes to implement the learning above. Some improvements identified are still in progress as outlined in more detail below.

    a. As explained in paragraph 40(a) above, we have revised our guidance on interim orders in March 2024 so that it now makes clear that in very serious cases such as LL, we do not always need to wait until a person has been charged before applying for an interim order. If this amended guidance had been in place at the time, an application for an interim order suspending LL may have been made sooner (for example at the point of arrest rather than charge), and an interim order may have been applied at an earlier stage. There would have been a right on the part of LL to appeal any interim order to the High Court

    b. We have instigated a new process of holding case conferences in complex or sensitive cases to ensure that expertise from a range of areas including lawyers, clinical advisors and safeguarding is gathered. We are also preparing a regulatory decision-making document which defines the decision-making process for identifying and responding to relevant cases which may need an interim order. This will improve the quality and accountability of interim order decision-making.

    c. The NMC has provided further training and guidance to relevant staff members on their statutory powers to obtain information from the police and work is ongoing with NPCC to sign a memorandum of understanding to facilitate better working relationships. These efforts will help ensure more efficient and effective information sharing between us and the police.

    d. The NMC is developing guidance to support colleagues in knowing when to invoke its Article 25 power and to clarify the escalation process to follow in situations where organisations do not disclose information requested. An intended consequence of this guidance is that it will help us gain information from third parties in a timelier way.

    e. The NMC will review and update the training and guidance for colleagues on what constitutes a whistleblowing concern raised as a protected disclosure. By the end of March 2025, leads from across the organisation will have been trained on refreshed guidance and there will be a network of whistleblowing champions who will meet regularly to review whistleblowing disclosures to make sure they are being consistently and appropriately handled across the organisation. Later this year we expect to receive an externally commissioned report on how the NMC handles whistleblowing concerns and any learning from this will be incorporated into our whistleblowing as a prescribed person policy.

f. The NMC is reviewing how we apply safeguarding and clinical advice across the fitness to practise process. The planned work aims to identify whether our current approach could be improved and what changes might be needed to ensure that clinical advice appropriately supports our decision making throughout the fitness to practise process.

Registration and Revalidation

42. The NMC's registration and revalidation processes are key mechanisms used to protect the public, by helping ensure those on our register meet our requirements for safe and effective practice and that they continue to do so throughout their professional career. Further details about our registration and revalidation processes are provided in Andrea Sutcliffe's first witness statement.

43. At the point of registration and renewal (revalidation), nurses, midwives and nursing associates are required to complete a health and character declaration. This is to help the NMC decide whether a professional is of sufficiently good character to enable them to practise safely and effectively. On 30 August 2017, LL submitted her revalidation application declaring that her own health and character were sufficient, and this application was accepted on 14 September 2017.

44. Whilst the NMC is confident that LL complied with all the standard declarations required as part of the revalidation process at that time, the NMC has reflected on its approach to revalidation and health and character declarations, and has identified that:

    a. The NMC's language about the purpose of revalidation is not wholly consistent between our various documents and guidance. The NMC considers that greater consistency would be beneficial to enable greater public confidence in revalidation.

    b. Whilst LL's revalidation confirmer was employed at CoCH, they were not her line manager. Though this is in line with current guidance, we recognise that it could mean the confirmer had less knowledge of LL's practice.

    c. The NMC's current 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.

    d. The NMC's 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 that our guidance could be strengthened in this regard.

e. The NMC considers that there may be circumstances where a professional's character may be called into question that fall outside of the requirements currently prescribed, which are currently limited to health and criminal charges.

45. The NMC has identified that LL's revalidation application was accepted despite the NMC being aware that LL had been put on restricted duties and was the subject of a police investigation into very serious criminal offences. LL's ability to revalidate in these circumstances, and the interplay between the NMC's revalidation and fitness to practise functions, has been a topic of great interest to the Inquiry.

46. The reasons why LL was able to revalidate in the circumstances that she did are detailed in the third witness statement of Helen Herniman at paragraphs 34 to 51. In summary:

    a. The NMC's revalidation process is not a formal assessment of whether someone is 'fit to practise'. If an individual on our register declares a proven allegation when revalidating, such as a police conviction or caution, we will then consider the impact on their character, and this could result in their renewal being refused. Furthermore, if someone on our register is subject to either an interim or substantive suspension order, they are not permitted to revalidate until the conclusion of the substantive fitness to practise investigation where we decide whether their fitness to practise is impaired.

    b. However, the NMC's revalidation process is not a formal assessment of whether someone is 'fit to practise'. Whilst local concerns were present at the time that LL revalidated, concerns about a person's ability to practise safely must be referred to the NMC via its fitness to practise process to allow for a fair, objective and thorough investigation. There must be a fair and lawful process for removing a person from the register, and the revalidation process is not an alternative to the FTP process.

    c. Although the NMC is confident that LL complied with all the standard declarations required as part of the revalidation process, we recognise that had LL been the subject of an interim suspension order at the time of her revalidation application, LL would have been unable to revalidate. The NMC updated its Interim order guidance in March 2024 so that it now makes clear that, in cases of the utmost seriousness, it may be appropriate to apply for an interim suspension order before criminal charges are brought, even based on limited information. We cannot say for certain whether, had the guidance been in place, an interim order would have been granted, or whether if granted and then challenged by LL, it would have been upheld by the High Court.

47. The NMC has further reflected on the relationship between its revalidation and fitness to practise functions. Whilst it is important that the distinctions remain, the NMC acknowledges that there are

steps it can take to help clarify and strengthen the links between the two processes. We are planning a wide-ranging review of our revalidation process and health and character guidance which will take forward the learning from this Inquiry. This will include:

a. Exploring opportunities for using the revalidation process as a way of gathering information that might be relevant to fitness to practise. This will include those very serious misconduct cases which might result in us making an application for an interim suspension order, which if granted, would mean the professional would be unable to revalidate.

b. Considering the questions asked of individuals on our register and third parties (such as confirmers) as part of the declarations of good character, and whether there are opportunities to strengthen internal links between our fitness to practise and revalidation colleagues to help ensure intelligence is effectively shared across key parts of the NMC.

c. Considering whether there are circumstances or mechanisms, other than those already covered by an interim or substantive suspension order, where it would be appropriate and lawful to stop the revalidation process and prevent an individual from practising.

48. The NMC has also identified the following lesson with regards to lapsed registration:

a. The NMC's 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 whilst under a fitness to practise investigation, despite not paying their fee or revalidating. We will revisit what information is published on the public register as part of our revalidation review.

<u>Safeguarding</u>

49. As explained above, the NMC has an overarching statutory objective to protect, promote and maintain the health, safety and wellbeing of the public. As a registered charity, the NMC is also expected to take reasonable steps to protect people from harm and report safeguarding matters.

50. Many of the enquiries and referrals received by the NMC concern the risk of harm to vulnerable people (adults and children) and so safeguarding is an important element of the discharge of the NMC's functions. As set out above, unlike other agencies, the NMC does not have specific statutory obligations in respect of safeguarding and its role is not to conduct local investigations. It does however have an important role to play in information sharing across agencies, and in pursuing fitness to practise proceedings (including seeking interim orders restricting practice in appropriate cases) where serious concerns are raised.

51. The NMC has already identified the need to take steps to ensure that it has the specialist capabilities to embed an effective safeguarding approach. The NMC commissioned Nazir Afzal and Rise Associates to undertake a review into our organisational culture which was published on 9 July 2024. The Independent Culture Review made several recommendations that are relevant to the Inquiry's terms of reference which we have accepted. These includes:

    a. Urgently review the NMC's responsibilities regarding the delivery of safeguarding requirements in line with what is expected by the Charity Commission.

    b. Seek to work more collaboratively with other agencies – police, local authorities, other regulators, and healthcare services – in the sharing of information and safeguarding concerns even when the registrant case is not being pursued by the NMC.

    c. Develop a more clearly defined process for managing fitness to practise cases when a criminal case is underway.

    d. Ensure that the development of a safeguarding hub is underway with appropriate levels of staffing to support its safeguarding obligations and that all staff have an awareness of these obligations.

52. The NMC has taken the following steps to support its safeguarding aims:

    a. Since January 2024 the NMC has expanded resources for the safeguarding team, including two additional safeguarding clinical advisors to support with the fitness to practise workstream and a new safeguarding advisor and safeguarding analyst. This increased resourcing will improve knowledge and training of safeguarding across the organisation, alongside the strengthening of our operating procedures.

    b. We have updated our Safeguarding and Protecting People Policy which governs how we identify, manage and escalate safeguarding concerns across the organisation.

    c. In September 2024 the NMC strengthened its governance in relation to safeguarding risks by establishing a Safeguarding Board which will report to the NMC Executive Board and NMC Council quarterly. This will help ensure greater corporate visibility and oversight of safeguarding concerns, raising awareness and the importance of this area.

    d. In September 2024 the NMC also established a multi-professional safeguarding hub, which responds directly to recommendations of the Independent Culture Review. The working of the Hub is now being tested and aligned in the fitness to practise process and

will improve the quality of information sharing, provide safeguarding expertise and guidance and ensure that the NMC is able to discharge its safeguarding responsibilities effectively.

e. The NMC has taken steps to strengthen the training available for colleagues, including the introduction of new mandatory safeguarding training for all NMC colleagues. The NMC is undertaking a comprehensive review of its safeguarding responsibilities, with a view to producing a safeguarding risk assessment framework and plan, which we plan to publish by mid-2025.

Data and insights

53. The NMC has accepted the need to improve the way it captures data to enable more effective analysis of the data and intelligence it holds. The NMC plans to improve the links between its data sets to make connections between professionals on our register, locations of events and places of work as part of its development of a new case management system for fitness to practise during 2026. Improving its data capture will enable more effective and efficient delivery of its regulatory processes and improve its ability to contribute important insights and emerging concerns to the wider system.

Social Media Guidance

54. At Helen Herniman's oral evidence session on 8 January 2025, the NMC learnt of incidents where healthcare professionals shared private information about patients on instant messaging services. We recognise that this must have been extremely upsetting for the families of those involved.

55. The NMC's Code already requires registrants to 'use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, always respecting the right to privacy of others' [**INQ0002419**]. In March 2015 the NMC introduced its guidance on using social media responsibly [**INQ0108841**], to support professionals' application of this standard. We have reflected on our guidance to identify possible improvements. Whilst the current guidance already emphasises that all social media and networking platforms must be used appropriately and explains that it is unacceptable to discuss matters related to the people in their care outside clinical settings, we accept that it could be more explicit about the types of sites and platforms the guidance applies to.

56. We will update our social media webpages to specify that the current guidance applies to all forms of social media and social networking, including those referred to during evidence given to the Inquiry. We will strengthen this wording by Spring 2025. The NMC will also undertake a wider review

of its social media guidance as part of our planned review of the Code, to help ensure its expectations in this area are sufficiently clear.

Please detail any recommendations that the NMC considers the Chair should make

57. The NMC welcomes the opportunity to reflect on recommendations the Chair should make.

58. As explained in Andrea Sutcliffe's first statement to the Inquiry, previous Governments have committed to reforming the legislative framework for professional regulators. Reforms would bring significant changes to the way in which the NMC progresses fitness to practice concerns for the benefit of patient safety. This would include the ability for the NMC to be able to focus its efforts on those cases that really need our attention as well as being able to quickly remove professionals convicted of very serious criminal offences. The NMC continues to work closely with this Government on planned reforms.

59. As explained at paragraphs 15 of this statement, the Emerging Concerns Protocol is a key mechanism used by us and our partners to share and triangulate intelligence that might indicate risk, enabling us to better fulfil our collective roles in the wider safety network. Although the Protocol was not in existence when concerns at CoCH were first identified, the NMC has reflected on the application of the Protocol in the context of CoCH and in situations involving potential deliberate criminal activity and considers that it could benefit from further detail in this regard, clarifying the roles, responsibilities and escalation process to follow for alerting other non-signatory agencies such as the police or other relevant local authorities.

60. The NMC continues to be committed to learning lessons from these tragic events and the NMC will cooperate with any recommendations made which impact on the NMC to ensure that babies in hospitals are kept safe in the future.