Thursday, 12 December 2024

(9.30 am)

DR ALAN FLETCHER (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Thank you very much, Dr Fletcher. Thanks for beaming in this morning.

Ms Brown.

MS BROWN: If you could please give your full name?

A. My name is Dr Alan Keith Fletcher.

Q. Dr Fletcher, you have provided two statements to the Inquiry, one dated 8 March and a supplemental statement dated 6 December 2024. Are those statements true to the best of your knowledge and belief?

A. They are.

Q. Just dealing first with your qualifications and your current role, you are a Fellow of the Royal College of Physicians and of the Royal College of Emergency Medicine, you are currently a Consultant in emergency medicine and acute general internal medicine at the Sheffield Teaching Hospitals NHS Foundation Trust and since 1 March 2019, you have been the National Medical Examiner for England and Wales, which as from 9 September this year is a statutory position, and I believe you perform your roles as a National Medical Examiner alongside your clinical role with approximately

60% of your time being devoted to the role of the National Medical Examiner; is that correct?

A. Yes, it is.

Q. Turning then to your role as National Medical Examiner, you address this in paragraph 3 of your main statement. How would you briefly define your role as the National Medical Examiner?

A. Thank you. My role is to provide the national leadership for the Medical Examiner system components of the reformed processes of death certification that were introduced from a statutory basis from 9 September of this year. Before that, I was the lead and assisted with the design and implementation in the non-statutory phase of the Medical Examiner system which is ostensibly to review the causes of death and the circumstances of all those -- all deaths in England and Wales that are not investigated by a Coroner.

Q. Just to pick up, you covered it but just so that we are entirely clear, you cover Wales; the Medical Examiner system covers Wales but not Northern Ireland or Scotland?

A. Correct, it covers the areas that mirror Coroner responsibilities in England and Wales but not Scotland and Northern Ireland.

Q. At paragraph 7 of your statement, you deal

with the role of the Medical Examiner, obviously those who are doing the job on the ground, and I think you have to some extent, but just summarising what a Medical Examiner will be doing, please.

A. Yes, thank you. The summary really is to ensure that an independent person reviews the documents and circumstances of every -- every person that who has died in England and Wales whose death is not subject to Coronial investigation. And the purpose of that is to ensure that all deaths receive an independent scrutiny to ensure that three principal questions are answered: the first is what is the cause of death and to ensure that it is accurately recorded. The second is whether the case needs to be referred to a Coroner and to ensure that in a timely and accurate way, if necessary, and the third is it establish whether there are any clinical governance concerns that need a further review or look at.

Q. Thank you, and I am going to if I may in a minute work through those but just dealing first with your point about independence. In what sense is a Medical Examiner independent? Can you just explain the safeguards that are in place to ensure that there is true independence between the review of the death and the initial doctor who will have certified death?

A. Thank you. There are lots of layers of independence that are incorporated into the system. In the non-statutory phase, the evolution of the process meant that for the best part of six years, over a million deaths were scrutinised by doctors who were always independent of the case and that is one way in which independence is safeguarded, as set out now in the statutory regulations.

Q. Sorry to interrupt. But independent of the case, you are meaning they had no -- didn't treat that patient at any point?

A. Correct, yes.

Q. But what about independence from the hospital or knowledge of the doctors and so on? I think you are going to come on to that.

A. Yes, I am. And that is also set out in good practice guidelines as well as which now must be adhered to from a statutory perspective, that there must be no conflict of interest for the Independent Medical Examiner reviewing a case, it is such as the world of medicine that acquaintances are made and people know one another and it is a matter of professional responsibility.

One of the benefits of the system ensures that there is a team of medical examiners to enable in any

one office to ensure that if there is a potential conflict there are opportunities to discuss, to escalate to pass the case on to a colleague, and if necessary, seek advice from regional colleagues and, if necessary, me as the National Medical Examiner.

Q. So just in very practical terms, a death that occurs on a neonatal unit in a hospital, the doctor who takes the role of the Medical Examiner, they could not be employed by that hospital?

A. Now, that's not quite right. The way that, from a pragmatic perspective, employment has to -- this was a policy decision taken by the Department of Health and Social Care -- that Medical Examiners and their officers would be hosted within acute hospitals -- within the NHS and that's what the regulations stipulate. Employment does not necessarily mean the same thing as a reporting mechanism.

The reporting of outcomes, deaths, their reviews and scrutiny is passed through the regional structure and through to me as the National Medical Examiner.

Q. So would you ever have a situation where it would be one of the fellow doctors working on the same unit who would be the Medical Examiner for another doctor working within that unit?

A. It is -- it is on, I cannot imagine

a situation where neonatology Medical Examiners -- and we have some -- would scrutinise the death of a baby that occurred on their unit. That is not appropriate and they would not do so.

They would pass that to a colleague and if necessary one of those Medical Examiners might be, for example, a GP or another doctor from a different Trust who is employed, for their sessional basis, to work in that hospital, but that would be an independent person to review things.

Q. When you say it wouldn't be appropriate, it would be clear to them that if that situation occurred and they were asked to review a death, it's clear to them not just as a matter of their own conscience but it would be clear to them that that is something they would not be able to deal with and they would have to pass to someone else?

A. That would not fit with the guidelines, the guidance we provide to say you must be independent of the conflicts and colleagues and relationships that inevitably would, would arise.

Q. And you set out the questions, the three questions: what did the patient die from? Does the death need reporting to the Coroner, and are there clinical governance concerns?

Just dealing with the third of those, the clinical governance concerns. What really is meant in practical terms by clinical governance concerns?

A. There is such a range. If I may, I can explain that.

The Medical Examiner process is a little unique in any local hospital Mortality Review process in that it considers the whole of the patient's journey and for example a patient who is admitted from home, who's had contact with primary care, ambulance services, local authority care for example then in an emergency department or a different, a different department transferring even to another hospital as is often the case for neonates as well, the whole of the journey is considered and along that process if there are any issues that are flagged as unexpected events or acquisition of complications or problems that occurred during that patient's journey, then those would register as matters that would, having been detected, would be passed on for review as clinical governance concerns.

There may be a parallel referral to a Coroner also if there is reason to suspect that those concerns caused or contributed to the death of that person, but they are not necessarily linked; there can be differences, a complaint about long waiting times may not have

influenced death for example but nevertheless is a concern.

Q. So, for example, obviously we are focused on a neonatal unit; if there was a concern that a baby was being -- had either been referred to a unit that didn't have the relevant level of specialty or was being transferred between units or to another unit inappropriately, that would come within governance concerns?

A. It would. I can recall, if I may, an example of a case where -- that's not relevant, not directly linked to this Inquiry -- where the care of a child who had been transferred to a paediatric critical care unit from a district hospital, the care at the tertiary centre was exemplary and it never, looking at the care at the district hospital before that child was transferred, led to concerns being raised.

In fact, I -- by the parents, most significantly and I am sure you are going to come on to that --

Q. Yes. Just staying though with the raising of a clinical governance concern. What about if there was a concern regarding staffing, that there's concern that there may have been inadvertent negligent harm caused by a staff member or, of course, deliberate harm?

A. Well, there are now different -- these are

different kinds of clinical governance concerns as opposed to a complication of treatment for example.

I understand exactly what you mean and there are examples of cases where staff members from a ward have raised concerns about the lack of supervision of junior staff or the lack of Consultant involvement in cases, that, that register as a governance concern and those would absolutely be included as part of the remit of concern raising.

Q. So one's got to a situation where the Medical Examiner, either through reading the notes or talking to the doctor concerned or through speaking to the parents has raised a clinical governance concern. Where does it go from there? How is it followed up in particular?

A. Yes, thank you. As I stated in the statement, in my statement the role the Medical Examiner is to detect an issue and pass it on. It's not our role to investigate that because we neither have the resources nor the scope or jurisdiction to do so.

What happens to a clinical governance depends on local arrangements and the circumstances of -- of the right destination.

As part of the good practice guidance we provided some guidance about the places where concerns could be raised and there are tiers of escalation. They may, for

example, be appropriate to raise to the -- if it is extremely local, to a local nurse ward manager or ensuring that the incident is reported through an incident reporting system framework.

In other circumstances, if the concern is immediate and serious then there ought to be a -- there is a direct link to senior members of the Executive.

Also there is the parallel route of ensuring that the Coroner is notified and a Coroner has the opportunity to, if necessary, escalate that to officers to investigate including police if necessary.

Q. Because of course the situation could arise where a number of concerns arise, none of which are serious or considered serious enough in the first instance to go to the Coroner or maybe to be referred out to the regional Medical Examiner but are necessarily concerns and really the issue is in that case, were you to have different Medical Examiners, all of whom are working several shifts a week, so that that may occur, different Medical Examiners, who all raise a concern that go back to the hospital, is there any mechanism where the Medical Examiner unit would think, "Oh, we have raised these number of concerns and nothing seems to have happened."

Is there a -- I appreciate you are not

investigating, but is there any follow-up to see was anything done with that concern?

A. Yes, thank you. If I may break that down a little. The first point is very well made and what about -- this is -- what of the recurrent or frequent numbers of concerns that arise from different Medical Examiners, who, as you say, they work shifts.

In those circumstances, the -- what we have -- there is the constant of the Medical Examiner Officer in the office who are a kind of glue to keep, keep a review of the whole of the practice that's going on and, therefore, frequent consistent problems that arise are noticeable by that, through the Medical Examiner office.

Each office has a lead Medical Examiner and in my guidance, I have requested that all Medical Examiner officers must conduct review meetings, consider the cases that they -- and concerns that they have, opportunities to detect patterns, trends, themes.

The next tier is, what happens if those are raised and the problem keeps happening? And in those circumstances, again the escalation is set out in my guidance, that all the Medical Examiner officers are supported to escalate those to regional colleagues who have direct access to regional, their regional counterparts, directors of nursing, regional medical

directors and to me. I would expect those to be notified.

In fact, in the last reporting that we had for the quarter, there was an example cited of an apparent cluster of child deaths that were noticed by the Medical Examiner office, escalated and investigations followed.

There is no formal requirement for feedback about those investigations and this is something that I -- I grappled with early on. One of the important aspects of the Medical Examiner system is that it's trusted as a place where people can raise concerns and if necessary will raise them on their behalf.

If we require feedback from other investigators, then there is the risk that the Medical Examiner office is seen to police the system and that's not our role. We can't -- there is no statutory remit to do so and I prefer -- the more informal feedback and the learning that follows, we request it but we can't demand it.

Q. Just to follow up on a few points there. In terms of, you have referred to meetings that were being held to see if similar situations were arising. Is there a system where any decision, made by the Medical Officer/Medical Examiner, is recorded so that someone can say, "Of the deaths that we have reviewed, five have been referred back for a clinical governance problem to

X hospital."

Is it as systematic as that or does it depend on a meeting and these things having been sort of organically noticed?

A. There has to be the organic approach, partly to be able to respond quickly to noticeable clusters of events. For example, if there were post-operative infections arising frequently and unexpectedly from a particular ward or a procedure, I would expect that to be noticed and acted upon directly as soon as it became obvious rather than wait for a meeting.

There is a systematic approach to -- to reviewing data and information and that reflects the quarterly reporting that I request and have done since 2020.

That is systematic, but not thematic. There is an important difference of how that is structured within the constraints of what we have.

The quarterly reporting is reviewed by the -- my regional colleagues in a tiered way and considered nationally at the Medical Examiner Oversight Group. Patterns, trends, deviations from baselines are all part of that, that analysis and review.

Q. The other thing I wanted to ask you about was you referred to the Medical Officer. Is that someone who actually has medical training, any clinical

training?

A. The Medical Examiner officers are definitely trained to do their role. They come from a range of backgrounds and that actually is -- I celebrate this because what they bring is a host of skills and knowledge from different areas -- most of them have a clinical background. Some of them are former Coroner's Officers for example as well, but ultimately there is a professional development strategy, a clear job description that requires analytical skills, clinical skills, personal skills in interacting with doctors and bereaved people and that inevitably requires some clinical knowledge.

Q. But they don't have any -- it's not a requirement they have a clinical qualification, they don't have to be a nurse or a doctor or do they?

A. No, we have a range. They do not have to be because it isn't defined, their role is not defined in statute.

Their delegated functions are undertaken at the request, where appropriate, by a Medical Examiner but if they are not able to do so then the default is that it's the Medical Examiner's responsibility.

Q. Because just considering the situation we are going to come on in a moment to the contact with the

bereaved families. But my understanding is it would be sometimes the Medical Officer that would make contact and as a member of the public if someone was to telephone and say, "I was a Medical Officer", a large majority of the public I suspect would interpret that as meaning they have a medical qualification?

A. So the title is a Medical Examiner Officer and I would, I would say that part of the discussion of the introduction of that conversation, which is sensitive and complex, is their role and responsibility is always clearly described to the member of the public, the bereaved person they are discussing with.

I don't -- I am not aware of issues here.

In the same way that when Coroner's Officers, because it is always Coroner's Officers practically that speak to family members, there is no confusion that it is the Coroner that they are speaking to.

Q. Just turning on then to having laid out the three questions, you talk about the steps that the Medical Examiner would take and one of those is the medical note review. I just wanted to ask you about that.

What they are required to do is a proportionate review of relevant medical notes and I just wanted to understand who is it that decides what is proportionate

and, looking very specifically at neonatal deaths, how the view is taken. Obviously there's situations where the obstetric notes as well as the neonatal notes would be relevant and how that assessment is made of the extent of notes that would be looked at.

A. Thank you. The reason to include the word "proportionate" is because that in some cases it is not necessary to try and to attempt a forensic review of a lifetime's medical records and one will appreciate that this includes all deaths of all people of all ages and there are some patients whose sets of records run to thousands and thousands of pages.

It would be wholly unreasonable to expect a review, going back to the 1960s, of records for somebody who has clearly died from a natural cause in a natural way at the end of a long life and the person who decides what is required is the Medical Examiner applying their clinical judgment when they review that case.

For cases in neonatal units, most cases, if I may say, the records are relatively concise. Some babies have a protracted stay and have extensive records, I do appreciate, and those will take longer.

Along that journey there are, there are sideways directions to review proportionate elements of medical investigations, for example, or observation charts and

focus in on the some of the aspects that occur along that patient's journey.

I -- in one of the learning sessions that I authored originally to describe how to do, to do the work, I describe this as a sort of like reading a person's records a bit like one reads -- reads a book. You start with the last illness as a logical place to commence and review, read the pages and subconsciously have those three questions in mind: what is the cause of death? Does this case need to be notified to a Coroner and are there any issues arising?

So if there is something that crops up like, let's say, an unexpected collapse or a sudden drop in blood sugar, that prompted a flurry of activity and concern, that would always attract attention as you go through the journey.

You mentioned obstetric records and one of the issues here is that the power that the Medical Examiner has under the regulations is via the Access to Healthcare Records Amendment 1990 that permits review of the deceased person's records.

The obstetric records pertain to a live person for whom consent would be required to review those.

I am comfortable with Medical Examiners requesting consent from, from people. However, this is an

extremely sensitive and difficult time for parents and if it's got to the stage where there is concern to review obstetric records, I would have expected this to already have been passed to others; the clinical governance, the Child Death Review process and/or the Coroner that would consider those aspects.

Q. Dr Fletcher, you are I'm sure aware that one of the issues that has arisen in this case, not in fact in terms of the babies that in fact died, but one of the issues is harm being caused by insulin and I am just wondering whether there is any specific guidance that's given to Medical Examiners that if they see, when dealing with a neonatal death, reference to insulin results whether that is automatically something that they should investigate and ask to see results if the results aren't apparent from the notes in front of them, or whether that indeed should be something in the light of what this Inquiry has heard?

A. Well, thank you. Yes, I -- again, this is a matter that I have considered carefully. One, I have to be cautious about providing examples of specific matters to look out for because the list could be exhaustive and overwhelming.

My observations are that unexpected hypoglycaemia, the drop in blood sugar that insulin -- that would

prompt insulin and C-peptide measurements would always flag as an issue of concern. That's regardless of a patient being a neonate.

Medical Examiners are aware of the investigations and issues that have arisen historically and I am minded of the case of Colin Norris in Leeds, a nurse who was tried for the concern of having administered insulin to elderly patients, and the case of Bridget Bock is a case in point that led to a criminal proceedings. There are other examples of insulin being administered.

So Medical Examiners are generally aware of this as an issue. I would expect hypoglycaemia to always prompt concern and, "Uh-oh, what's this going on?"

I am open, I am open to any recommendations about specific matters from this Inquiry, of course, and would just -- would just say that we are currently preparing some joint learning and updating the Good Practice Guideline Series Guidance that I provide about neonatal and child deaths.

I have commissioned my colleagues and neonatal Medical Examiners to do this and I am sure that that could be incorporated or may well be incorporated because it's in association with the British Association for Perinatal Medicine as well.

Q. Moving on. Thank you. Moving on from the

examination of the notes, the next step is the interaction with the attending doctor.

Can you just explain that. Will that always be speaking to just one doctor or if there were concerns, would you speak to for example the resident doctor who had been involved in the care? What's the extent of that interaction?

A. Thank you. The interaction is with the -- the requirement is that the Medical Examiner and/or Officer must speak to the attending practitioner and that is the person who would be completing a medical certificate of cause of death if it was appropriate to do so.

That varies according to every location. It could be a senior GP, it could be the Consultant neonatologist, or paediatrician or it could be a junior doctor on unit. The interaction is along the lines of, "Tell us about the case."

Q. And this is a face-to-face or over the telephone?

A. Or telephone, yes, or in the case of remote interaction for example with a busy GP surgery it might be recorded as a last entry in the medical records for example, "My thoughts about the case are ... and this is the proposed cause of death."

So it's what -- it is about a cause of death and to

ask if there are any concerns that you have.
Q. So there will always be an actual conversation, will there, as opposed to an exchange of emails presuming --
A. For inpatients, for inpatients almost always a telephone or a face-to-face interaction.
Q. In the case we are dealing with, all the babies who died where the resuscitation involved a Consultant paediatrician being called, a paediatrician with some expertise in neonatology and in terms of the expertise of the Medical Examiner, they are drawn from a range of specialties. So you could have a GP, a dermatologist, an orthopaedic surgeon discussing with the Consultant paediatrician the cause of death.
And how effective is that going to be in terms of scrutiny when the disparity of expertise could be vast?
A. Yes, it's a really good question and 1 million cases later it turns out that it's okay and the reason it's okay is because the emphasis is slightly different. It is just looking at things through a different lens.
Medical Examiners look at the -- are trained to look at the generic process of care and there are plenty of aspects that are common to all cases. All the cases involve a human being in the hospital setting where there is, for example, observations, or unexpected

events. They are generic. They occur in every aspect of care.
And in the same way that a Medical Examiner who is a -- it sounds like I am singling out specialists and it's not fair to do that -- but the example would be that a Medical Examiner who is a GP may not have specialist knowledge of the complex haematological oncology patient who is an adult, or a neuro-surgical case and in those circumstances the way that -- the subject matter expert is the Consultant paediatrician, the neonatologist, because they were there and we always say, "This is your case, this is your patient."
And there is a trajectory of learning and improvement of knowledge and skills as we go along acquiring information about, "Oh, okay, that's -- I understand where you are with the cause of death here."
How we may refine that and word it differently on the certificate is the Medical Examiner's expertise, as is knowing the Notification of Deaths Regulations 2019 inside out. So it is a different perspective.
And the final point on that is that the Medical Examiner, who is not a specialist in the unit, can ask the naive but really important question and it's actually, it is a useful challenge to say, "Why did that

happen? Can you explain that to me?"
Q. Do you consider or has it been considered whether specifically in terms of neonatal deaths, which is obviously a particular specialty even of paediatrics, that that is one area where Medical Examiners should call in an expert as an exception to the general rule?
A. Oh, first of all, we make it clear that if there is advice to be -- that's required then calling a colleague is always an appropriate thing to do.
In due course, I, this is -- the knowledge and expertise of Medical Examiners is growing. It's -- they will, in a year, review 2,000 deaths and we are, we have been at an early stage; their experience is maturing.
I think it's fair to say that the knowledge and experience of paediatric and neonatal deaths will be increasing as well, albeit these are relatively rare events that, in the wider complexion of cases that are not notified to the Coroner who are -- that are neonatal deaths is a small number and more concentrated in certain units, they can, they can and will call colleagues.
As we get further, I think there will be an opportunity for wider expertise amongst Medical Examiners. But we don't have the funding or resource or capacity to provide a full network yet of neonatal --

Q. Because of course a Medical Examiner will generally do that alongside their other role. So although, as you say, Medical Examiners, the number of deaths there they are dealing with is going up all the time. An individual Medical Examiner may only work maybe one shift a week and may come across a neonatal death once a year if that; they are very infrequent and it is whether, in those infrequent cases, they have the expertise to be able to know for example when something is truly unexpected or whether a response to resuscitation is unusual. Not to have the expertise but even to have the relevant expertise to ask the right questions?
A. Yes, thank you. I understand the challenge, and I would -- I would expect a Medical Examiner who is confronted with a case like this of -- well, any unexpected death of a neonate I am almost sure would always prompt, "This doesn't sound like it's for us, this sounds like it is for others to investigate."
But if they were uncertain, the structure locally and if necessary regionally provides the opportunity to -- to obtain further advice and expertise from independent people as well as the clinicians directly involved with the care.
Q. Thank you. Just staying with training for

a moment. You will be familiar, I am sure, with the recommendation from the Clothier Inquiry that the actions of Beverley Allitt were to heighten awareness, in all those caring for children, of the possibility of malevolent intervention as a cause of unexplained clinical events and I am just wondering if that specific recommendation is part of the training for all Medical Examiners so that, when they consider any case that possibility is, as a matter of course, considered because we know, in the events of this case, that many people spoke about not being able to think the unthinkable and, clearly, a Medical Examiner, it's very key that they do and I am curious as to what extent that's incorporated in their training?

A. Yes, thank you. Well, it is in the first line of their e-learning, of the training.

As you will be aware from the statement the training is both e-learning, face to face continued, on the job and CPD coordinated by the Royal College of Pathologists, as the lead College. In the first line of the e-learning, Medical Examiners are reminded that their role had the germination from the murders committed by Harold Shipman, the issues at Morecambe Bay, Gosport War Memorial Hospital --

HEARING MANAGER: My Lady, I'm sorry to interrupt,

can we take a two-minute break?

LADY JUSTICE THIRLWALL: We will just take two minutes.

Sorry, Dr Fletcher, if you wouldn't mind just staying there, we will just pause.

(Technical pause)

LADY JUSTICE THIRLWALL: We are ready to restart. Thank you. Ms Brown.

MS BROWN: Thank you. Dr Fletcher, just the final issue on training then is regarding safeguarding training. Again, we know from the facts of this case that safeguarding was not picked up as an issue; even though there were concerns raised, no one saw this as a safeguarding issue, even when harm -- the potential of harm was noticed. "Safeguarding" isn't a word that appears in some of the materials that you have provided us with and I am just wondering whether there is sufficient training of Medical Examiners that, if they think there may be a situation of potential harm being caused, whether in terms of referral to the LADO, those sort of safeguarding measures are, again, part of the Medical Examiner's training or checklist, so to speak?

A. Yes, thank you. I think that's -- that's a very reasonable point, and I have reflected on that as well. The first point is that, as part of all mandatory

training, and my own included, is that -- is the requirement for safeguarding training to be undertaken. It's mandatory training.

LADY JUSTICE THIRLWALL: I am very sorry to interrupt you, Dr Fletcher, but there seems to be a problem with the live transcript. So we will just wait to see what the problem is.

(Pause for technical issue)

LADY JUSTICE THIRLWALL: Has everyone got the "testing, testing" message? I am the only one who hasn't, so we can restart.

MS BROWN: Sorry, Dr Fletcher, you were just dealing with safeguarding, if there is anything you want to add where you were in your answer?

A. Yes, thank you. So first just to reiterate that Medical Examiners must comply with mandatory training requirements which include safeguarding, including of children and young people, the second is that whilst safeguarding is for everyone employed in the NHS, the responsibility for raising safeguarding concerns for a neonate where there may be harm, or an adult for that matter, I would normally expect that to be raised by the treating clinical team after a discussion if it was raised.

So my -- my preference would be for -- after

discussion for Medical Examiners to say: have you raised a safeguarding concern for this case? And are you going to do so?

I suppose it's aligned to are you going -- I think this case needs to be notified to the Coroner, are you going to do so? And if the answer is no, well the -- what we will do is say, "Well, we will do it instead then".

I am open to any advice or recommendations about specific lists because whilst I can see the disadvantage of duplicating a referral, it's probably better that somebody does it more than once if necessary in my mind.

Q. At least the question is asked as to whether there has or has not been a safeguarding referral?

A. If that was -- if it's appropriate to the case, of course.

Q. If we can move on then to a different topic, interaction with the bereaved family because that as you have explained and set out in your statement is very much at the heart of the Medical Examiner's role.

Obviously, the Medical Examiner's role takes place very shortly after the death in the five days and in terms of a neonatal death sometimes the mother will be, potentially having had a caesarean, in hospital herself. I just would like your views on, if you could give your

views, on how that works in practice; the interaction with a family specifically who have just lost a baby in a neonatal unit?

A. Yes, thank you. Look, the first thing to say is that each case is unique. Every death and every family and every bereaved person has -- has always had a different experience. In terms of the approach, timing is everything and choosing the right time to call somebody to discuss the loss of a baby is -- is subject to a value judgment partly on the part of the person making the call but also needs to be respectful, that if traumatic events have occurred in the middle of the night calling somebody who is exhausted and acutely bereaved at 8 o'clock in the morning four hours later would be wholly inappropriate.

So the way this is approached is if this is in a hospital setting, then liaising with the key worker, liaising and offering the opportunity and also most importantly the opportunity not to have a call if that is requested is fully respected.

The --

Q. I'm sorry just to interrupt, who will be making this call because obviously there is the Medical Officer for the Medical Examiner or the Medical Examiner themselves, obviously the person making this contact,

whether it's direct or through a bereavement nurse are two of the key issues?

A. So the requirements, a policy decision taken by the government at the time has been that the Medical Examiner or the Medical Examiner under a delegated authority will make the call to the -- to the bereaved person.

Q. That is the Medical Examiner, that is the Medical Examiner Officer who?

A. Yes, either Medical Examiner or Medical Examiner Officer. I think it is important to recognise that this is not done routinely in every case because if through the initial review of records and/or the interaction of the clinician, that the case has been notified to a Coroner there is no need for that conversation to garner their views or thoughts because there has been taken already to the next stage and those can be explained by key workers and Coroners Officers.

If everything has appeared to be okay, and those -- in those cases after a medical certificate has been completed and there has been interaction with an attending practitioner, at that point, there is an opportunity to have a sensitive call and offer the opportunity to discuss the death of their baby. And that would centre on the proposed causes of death

seeking their opinion on it, if necessary explaining it, and to ask the question: do you have any concerns?

Q. Just thinking that through again in this case the fact there were Families who didn't have that opportunity to discuss and later had concerns, is there a problem that a family in the first stages of grief feel they have in fact lost an opportunity if they are not in a position to respond within those first days, then the Medical Examiner process is shut and they feel that they haven't had the opportunity to express their concerns, can they come back with concerns, how's that dealt with?

A. Yes, that is always on offer at the conclusion of a call and the requirements for the Medical Examiner's involvement is as you stated earlier at the very early stages of this process, so that cases get notified to Coroners quickly if necessary and that funerals can occur. We have similar situations for urgent cases, some parents want to take their baby home and others may have faith or cultural reasons that they want an urgent funeral, for example.

I think it's important to remind the Inquiry that the Medical Examiner system is not one -- is not a single part, the only safeguard for these processes. There are other opportunities for review, for reflection

and opportunities of concern raising.

So whilst that's not, I am not seeking to dismiss the responsibility that an acutely bereaved person may not be thinking clearly at the time of a call, we will do the best we can at the time and understand that sometimes issues can be raised later and we do have that -- I can recall cases of where bereaved relatives have contacted the Medical Examiner Office down the line, even weeks down, and said: do you know, I have been thinking about this, I have had a call with you, and that's what -- we are accustomed to it in those rare occasions. It is rare.

Q. In that situation, you would follow the same process of referring it to a Regional Medical Examiner or back to the Trust depending on the concern that was raised, if the parent came later down the line to speak to you?

A. Yes. Yes, I think it's really important that the Medical Examiners and Officers are not, not a bereaved person's advocate but they must listen and register the concerns. And, I mean, there are -- it's discussing with the bereaved person what -- how they would like to take matters forward as well, because it takes courage to raise a concern and to feel that your voice is heard. The Medical Examiner system -- and

I have done it myself -- will say: listen, you don't have -- if you don't want to raise this concern personally, I will raise it for you. I will take this forward.

In other circumstances, the families feel -- if correctly signposted may well raise the concern themselves. It depends on the case and it depends on the individual and respecting family wishes.

But in any circumstances, if there's -- if there's a concern raised that might require Coroner notification even if it's weeks down the line, that's still appropriate, and Medical Examiners know it.

Q. Just finally with this issue, just to be clear. The contact, would that normally be directly between the Medical Examiner or Medical Examiners Office and the individual parent or would one always go via, for example, a bereavement nurse or a key worker or does it vary?

A. The -- the requirement according to the statute is that there is an interaction with the parents and along the journey of refining practices and guidelines, I took advice from clinicians, practitioners, Medical Examiners, officers and especially parents.

And the -- there is a -- there is a peculiarly

characteristically medical issue that -- that we as doctors often think we know best for our parent patients and their families and where I settled with this is the powerful message I got from parents, bereaved parents and those representing them that why -- that they wanted the opportunity to speak directly to a Medical Examiner or Officer.

I have, there were concerns raised by those involved in the Child Death Review process that this would be duplicative, intrusive and difficult.

In practice, that doesn't -- that's not the case and we have learnt from experience. I feel this was a perceived risk rather than an actual one.

Q. Have there been reviews -- obviously it is a relatively new process, but have reviews been done of feedback from those who have been involved in the process?

A. We -- from a -- from a paediatric and neonatal cases, the feedbacks are -- are recent because they -- they were the later additions to including the development of the Medical Examiner system. Understandably, the larger numbers of adult deaths attracted in terms of simple numbers and establishing offices and experience were the logical place to start and as experience grew, and I think this was a positive

of the system, experience of Medical Examiner Officers, Medical Examiners and processes discussing with colleagues in neonates in obstetrics and paediatrics, the opportunities -- refining processes and learning about how these interactions may occur locally because everywhere is a little different, means that we have our experience of interacting with bereaved parents of neonates is less than the million cases of older ones.

We have had, as part of my guidelines, monitoring effectiveness of the system includes recommendations for obtaining feedback and surveys and there are lots of different ways in which that can be obtained locally including with partners.

Q. Is there a joined-up process between those who are experts on bereavement and who generally talk in terms of having a key worker, a bereavement nurse and having one point of contact and the Medical Examiner -- I understand what you say about the Medical Examiner speaking directly to the parents, but the point is does that go through a conduit or does someone literally receive a call, an unexpected call, from a Medical Examiner?

A. Well, that can happen, but the way in which -- collaborative working and communication is paramount and I could set that out in the guidelines and that's

supported in all aspects of the Child Death Review contact guidelines. The key worker is an ideally placed person to make the introductions, I have no issue with that whatsoever.

The most -- the valuable learning we have had from interactions with bereaved people is that it helps enormously if they are prepared to receive a call. That could be on a ward or from a general practice or wherever it may be to say: this is what happens after death because this is a -- it's -- one hopes almost that it's a once in a lifetime experience, I don't mean just for neonatal bereaved parents, but it is an infrequent event, it's acute, it's raw, it's complicated. Every circumstances is a little different, each requirement.

So guiding people through that process in the new statutory reforms, if they are prepared that a Medical Examiner or Officer will be calling you, you don't have to speak to them if you don't want to, but they will have that. You will be expected to receive a call. That's the best way to preface it.

Q. If I could turn now to the referral to the Coroner and referral to the police. In what circumstances will a case be referred to a Coroner, first of all, before we turn to the police?

A. I -- the -- it is ingrained as part of the

Medical Examiner role and training to know when the notification of death criteria are fulfilled. The Inquiry will be aware of the beautifully crafted words of those -- those regulations which cannot cater for every, every scenario and Medical Examiners are not lawyers.

However, their experience of knowing when their cases need to be notified, if there is reason to suspect based on some tangible fact of evidence, then it becomes a decision for the Coroner to make their independent judicial decision of whether section 1 of the Coroners and Justice Act is invoked.

So they know how to do it and they will fulfil the criteria as set out in those regulations.

Q. In the Countess of Chester, at the time there was a convention that all child deaths would be referred initially to the Coroner and I am just wondering although there wouldn't necessarily be an investigation by the Coroner, but they would be initially referred to the Coroner. Just briefly, how does the -- does that bypass the Medical Examiner or can you explain how the Medical Examiner nevertheless goes on to scrutinise the death?

A. Okay. No, thank you, I like this question because it's actually really helpful to -- to -- this,

some Coroners, including clearly the Cheshire Coroner, requested that all child deaths are notified to their office and that came from a good place, it was because they wanted to take a view of all of those cases.

The -- the downside of it is that it became a routine matter and what the Medical Examiner system provides is ensuring that the right cases are notified to a Coroner, including the correct child and neonatal deaths, and that unnecessary notifications, because there were, were not undertaken.

These are complex areas and what the Coroner depends on is accurate information. The safeguard that the Medical Examiner system provides is that the Medical Examiner's thoughts, reviews, issues are conveyed to the Coroner, alongside the refined and clear notification made by the attending practitioner.

That way the Coroner can make a -- make a properly informed decision on the cases that they are notified.

If one were to dilute that by referring all cases, I fear that that the correct attention may not be focused in the right way on the right cases.

Q. Moving from referral to the Coroner to referral to the police. We know in this case that there was very significant delay even when there were concerns about referring matters to the police. What guidance,

if any guidance, is given to Medical Examiners about when they should be themselves referring matters to the police? Or would they always refer that on to someone else, would there be a situation where the Medical Examiner would say: this I think needs to be referred to the police? And what guidance they are given to help them?

A. Plainly, if I may say, notification to police is a highly significant step for any healthcare professional to make, if it's -- if they are concerned about criminal activity being conducted in -- in the environment of a hospital by members of staff.

I would expect that to be a multi-agency decision.

I would expect the concern to be recognised by a Medical Examiner including a need to notify a -- notify the police, and that that would be best handled either or both by -- it would be by the requesting of the senior management team of the hospital and the environment in which the activity had occurred and via notification of the Coroner.

I am minded of the advice given to me now retired Senior Coroner for South Yorkshire West who used to say, "Tell me about these cases because I have got 1,000 officers in blue uniforms who I can instruct to investigate if I need to" and the logical route is via

the -- via the Coroner.

We -- we also have as part of the scenario based trainings, it isn't specifically concerning a neonatal case but it -- in another example where criminal activity was -- was alleged that notification of the police is covered in that training scenario.

Q. Just going back to the history of the origins of the Medical Examiner system. You have referred to and you set out in your statement that they were introduced of course as a result of Dame Janet Smith's recommendations following the murders of Shipman and so coming out of a report that was published in July 2003.

You say in your statement that you consider that the Medical Examiner system would have prevented or stopped earlier the events that occurred at the Countess of Chester relating to Letby. That inevitably calls into question whether the scheme has taken too long to be implemented because if a scheme was envisaged in 2003 and we have got events that happened in 2015/16 and this system would have prevented it or at least reduced the numbers of deaths, the question is: why wasn't it brought in earlier?

A. Yes, thank you. That's a -- that is a terrible thing to have to consider and I'm sure that the parents of -- of the babies in this case are -- it

would be very difficult to hear that -- that -- my view and my evidence that the a correctly functioning Medical Examiner system would make it extremely difficult for one of those steps, a proportionate review, the interaction with an attending clinician or conversation with families, to fail to detect a problem at an early stage.

I suppose one can never say never in -- as one never does in medicine. But I -- the safeguards, I -- I refer the conversation with family members, for example, as "the Shipman question", because that was the -- the evidence that Dame Janet Smith heard from family members who said: well, I would have said it was really odd because my mum was really well the day before, she was playing golf. And in those circumstances that kind of level of concern is an alarm bell for every Medical Examiner.

Why hasn't it happened earlier? I have set out some of that history in my statement and really, the introduction of this has -- is for government and Department of Health and Social Care to discuss with you.

My -- my perspective is that we have got this over a line after what is a period personally of 17 years of effort and persistence, and I am pleased -- I am very

proud and pleased that we have reached a stage where we can offer the opportunity for early detection and notification.

And I -- I have seen first hand how the system also provides a degree of deterrence knowing that somebody else is going to be looking at cases.

Q. Just a few more questions, Dr Fletcher.

There is a suggestion, again you deal with this in your statement, that there is a danger that there's an overcrowded regulated space in terms of child deaths. We have got the Child Death Overview Panel in case of a sudden death, the SUDiC process, PRUDIC in Wales.

What are your views on that?

A. Thank you. Yes, my view is that it is crowded, I think it is crowded for adults too, actually, the establishment of the various arm's-length bodies and different ways in which things are looked at. I see the positives that, look, reviewing things from different perspectives at different points involving different agencies brings in itself a safety net. I am not the correct person to comment on the efficacy of the Child Death Review process, of course.

What I would like to do is to ensure that the Medical Examiner system as it becomes increasingly established and mature is complementary to those

processes avoiding duplication and is supportive, sharing information, openness, transparency, promoting what I consider -- well, part of the reason that I am here, what I said at the start is that to tell the truth, the whole truth and nothing but the truth is a really good way to practise medicine.

Q. Whilst we are dealing with the CDOP process, one of the issues that arose in this case was that deaths were -- went to different panels depending on where the baby's Family lived. Just in terms of geography and patterns, it's correct, is it, that the Medical Examiners in the case of a number of deaths all occurring in one hospital would all go to the same Medical Examiner's Office, so that wouldn't be a problem in terms of the method, those patterns would be picked up?

A. Yes, a problem on a unit in that -- in that environment would always be picked up by a Medical Examiner Office, that Medical Examiner Office.

Q. I am correct, am I, that because although the Medical Examiners may deal only one shift, for example, per week because it's within an office, a pattern would be -- you would be confident that a pattern would be spotted?

A. I --

Q. Well, there is mechanisms aimed to pick up patterns, I should say?

A. Yes, thank you. Yes, I consider that there are appropriate safeguards and safety nets, yes.

Q. Dr Fletcher, if I can just end by referring you to paragraph 105 of your statement, because that's -- that is where just very briefly you talk through what the scenario of where there is a death or a series of deaths in a neonatal ward and how the Medical Examiner system, as you say, operating at its best would operate and I wondered if it would be helpful for you briefly to set that out?

A. Okay. Yes. Thank you.

I think the first thing to say, and it is relevant to the Inquiry is that the Sudden and Unexpected Death of a baby in a neonatal unit is an outstanding and remarkable matter. So in of itself I would expect that occurrence to generate a level a heightened sense of concern about what happened, what led up to it, what the response was, and why it happened, even though those questions may not be answerable by the Medical Examiner at the time.

And so the process would involve the review of records after notification to the office, a -- an extremely low threshold for notifying the Coroner in

that case, and the interaction with an attending practitioner would include: what happened? What was your -- what do you think happened? And it wouldn't necessarily -- the views of the attending practitioner may be that that that leads to, "Well, I'm not sure, but I think this is a possibility." Well, the heightened -- the naive question of the Medical Examiner or Officer would lead to: well, you know, are there any other possibilities? The most likely is what you might need for completing a medical certificate.

And actually ask what do the family -- what have the family been told? Because that is a really useful question. Are you expected, what are they expecting?

If on that journey there are any concerns this goes to, this gets escalated. This is -- there is a binary approach of, well, surely this is a matter for the Coroner and isn't this a Joint Agency Response case where you would follow the Child Death Review process, it is not for me as a Medical Examiner to require you to do this, but here is a prompt.

If even despite all of that we get through the holes of this particular Swiss cheese where there is an interaction with a family member and one is met with a response, for example: "I don't understand what happened. I'm -- I just don't get -- we were told

everything was fine", a comment like that would -- would and should lead to a the brakes being applied in the nicest -- in the most sensitive way possible to say: I think we need to take a further look at that given the light of your concern and we will take this one away and discuss with a team, others, the review process, the key worker and Coroner and we will get back to you.

I mean, at the end of this, this is -- this is a tragic and desperately sensitive matter. In my experience, bereaved people, including bereaved parents, want to know what happened and they want the truth and they want it as quickly as possible and they may -- even having an apology is worthwhile and I'm okay, as Medical Examiners and Officers, providing that apology saying: I'm sorry this has happened to you.

Ultimately that is something that's familiar to -- whether it's older people or neonates. I have an eldest daughter in hospital at the moment recovering from surgery. I don't think it makes any difference in the nicest possible way whether you are interacting with a person who is a parent of a child who is days old, years old, 20 years old or 60 years old. The feeling is the same.

MS BROWN: Yes, thank you very much, Dr Fletcher. There are, I believe, just some further questions

from ...

LADY JUSTICE THIRLWALL: Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Dr Fletcher, I ask questions on behalf of one of the Family groups.

I don't know if you have had the opportunity to follow some of the evidence given to the Inquiry during the last three months?

A. I have had some opportunity and I have had some -- some updates and briefings from colleagues because as you might imagine other things have been quite busy.

Q. Of course. Very early on evidence was given by Dr Joanna Garstang.

A. Yes.

Q. Were you able to follow that?

A. I have followed that, thank you.

Q. Thank you.

There were a couple of points that she raises that I would just like to put to you just to see what your response is?

A. Of course.

Q. My Lady, just for your reference the two points come from paragraphs 2.8 and 4.2 in her statement to this Inquiry.

LADY JUSTICE THIRLWALL: Thank you.

MR SKELTON: The first point is really about variability and the point she makes is that the Medical Examiner system is not yet being used for child deaths in all areas of England and I wondered what your response to this was?

A. Well, I -- I think matters have moved on. And that was from Dr Garstang's statement and evidence, in the nicest way, the -- it is correct that at the time of my statement not every death of children and neonates were being considered by Medical Examiners.

Since 9 September the statutory regulations mandate that all deaths must be considered by Medical Examiners or a Coroner and so from 9 September, every death of every child and every neonate are being reviewed, either by a direct referral to a Coroner or by a Medical Examiner. So now statutory requirement we are doing this.

Q. Thank you. The second point that she makes and I will just quote the sentence if it helps:

"The Medical Examiner system could help provide an additional safety net but many Medical Examiners know little about the SUDiC, JAR or child deaths so may not have the expertise to recognise when to intervene."

I wonder -- if I may, I am going to take you

through some of the guidelines that you have issued on this issue. I wonder if that is something of concern, that it may be that some of your Medical Examiners don't in fact understand the process that should occur?

A. Yes, thank you, I think that is a reasonable question. The guidelines clearly reference my -- my good practice guidelines published for the commencement of the statutory system, because they had to be refreshed, obviously since the new process has been established, reference to Child Death Review process, the mandatory requirement to engage with it and ensure the criteria because it is linked as part of guidelines and the Good Practice Series papers, which were published in association after careful consultation with colleagues who were engaged in the Child Death Review process.

Further to that, and I recognise the anxieties and concerns about this, I had already requested three -- there are three Medical Examiners, two of whom are neonatologists, one is a paediatric pathologist, to liaise with the British Association for Perinatal Medicine and work to do two things, to -- well three things: one is to work with the BAPM on updated guidance on -- for their colleagues, the second is to update the Good Practice Series document, for child and neonatal

deaths from 2022 to improve that and bring it more into focus, especially in the light of this Inquiry; and the third is to create a specific e-learning module with the BAPM that is -- that works across agencies because I think that it cuts both ways. I think neonatologists and paediatricians need to know what the Medical Examiner system is about as well. It's not just a one-way traffic.

That being a learning module is in development and I am hoping that I will be able to update the Inquiry as we go forward that that's ready and I can mandate -- I will mandate that that is -- must be completed by all Medical Examiners and officers.

Q. I think, Dr Fletcher, you probably pre-empted a lot of the questions I was going to ask about the detail of that.

A. Right.

Q. Because one of the features it may be thought of the guidelines that you have issued recently is that it cross-refers to the SUDiC, the statutory process, but doesn't actually tell the person reading the guideline had it actually is, so it is going to require the Medical Examiner --

A. Yes.

Q. -- if they are particularly diligent to go and

look up a separate set of guidelines and processes and teach themselves in effect, whereas I was going to invite you to consider whether or not your guidelines including the flowcharts in the Royal College of Pathologists guidelines need to include the SUDiC process directly because it actually takes through various steps in a child's investigation which the Medical Examiner needs to know about?

A. Yes, thank you. I think -- I think that's, that's helpful I think that is a helpful observation and I will -- as I have explained, we have got some steps here to improve and educate and inform.

So there are lots -- there are plenty of ways that that can be done and I think that kind of -- that kind of suggestion will be very helpful. So there are ways in which we can do this and we are --

Q. As a Medical Examiner yourself are you familiar with the SUDiC process? In other words, the fact that with a Sudden Infant Death, as Dr Garstang at least explained it, within 24 hours the Joint Agency Response must be initiated, the police involved, the Consultants spoken to, et cetera, et cetera.

Are you aware of that and in your area as far as you were concerned is that how it works?

A. Yes, I don't -- I am aware of it, yes, I do

know that.

I know that I should explain that I have for obvious reasons relinquished my responsibilities to scrutinising individual cases locally as a Medical Examiner because I would be accountable to myself for my actions and that hardly seems appropriate.

But during the 21,000 cases I have reviewed over the -- over a decade and a bit, that included child deaths and I can recall the interactions with a designated doctor who coordinated the Joint Agency Responses for children and neonates who had died unexpectedly and suddenly. So yes, I am aware of it. I have a hesitation about trespassing into territory for Medical Examiners where they do not need to become directly closely involved.

It -- that's not, that's not a -- that's not a refusal to include information and update. It is recognising that the Medical Examiner has no part to play in the Joint Agency Response themselves. They are not a direct component. They can provide information and support but they are not responsible for the -- the Child Death Review process, or even the CDOP, weeks, months, later.

I think we also need to bear in mind that regulations are there to protect and one of the things

that I observe is that if -- just assuming that things are going to work well everywhere as a result of regulations is -- is misguided because there are undoubtedly beacons of excellent practice and then there has to be the reasonable common denominator that ensures that everything is protected and follows appropriate paths.

You are describing that to me ensuring that we make sure that everybody knows and I am okay with that.

Q. Within the Joint Agency Response process that Dr Garstang sets out in the table in her statement, there isn't a role at all, it seems, for the Medical Examiner and first of all, that seems to be concordant with what you have just said; in other words, that process is a statutory process that occurs completely separately from the Examiner system.

But bearing in mind your earlier responses to Ms Brown, is there a danger that some in some localities they will think it is the Medical Examiner's responsibility to do this investigation, and in others the Medical Examiner will think it is the SUDiC process and again you have that variability with responsibilities falling between stools?

A. Yes, I think that's a really good question.

I don't think there is a risk that the Child Death

Review process will assume the Medical Examiner is undertaking an investigation, I don't think that -- I think that would be unlikely because the process has been well-established without Medical Examiner involvement for several years.

The reason plainly that the Medical Examiner's role is not listed as a mandatory component of the SUDiC process, the Joint Agency Response, is because that statutory guidance predates -- that statute became apparent in 2018 and here we are six years later, having just established the statutory role of the Medical Examiner.

There is a need for an update, I believe, and that provides us with the opportunity.

I have always felt that there is a risk in any systems where somebody else is expecting somebody else to do something and in the end nobody does it and that's not -- that is the worst of all worlds.

I think that -- it's my view that there is the layers of care and fierce devotion to this process means that the chance of that happening are remote to say the least and for child and neonatal deaths I -- I think -- I believe strongly that the strength and guidance that we provide, the education and training, will cement and clarify the roles and responsibilities here.

They are overlapping lenses that are looking at the same issue, a family and a deceased child, but from slightly different perspectives and we need to make sure we get that right.

Q. Already with the Coronial system the Medical Examiner is well aware that there are certain cases that must go to the Coroner?

A. Correct.

Q. So is there a similar degree of awareness that is required for the Medical Examiner to say: actually, this is a case that requires the SUDiC process, because in fact the SUDiC process, to be fair to the Medical Examiners, is a much more detailed multi-factoral system than you can provide?

A. Absolutely. Yes.

Q. So might it be that the Medical Examiner needs to do the assessment: this is not for me, this is for others, I need to check that's gone on because this is a SUDiC case, just as you might do for a Coronial case?

A. Yes, and I think it -- I think that is reasonable and in my earlier answers I explained that the point at which a Sudden or Unexpected Death of a child I would expect Medical Examiners to ensure -- ask the question of the attending practitioner, the paediatrician or neonatologist that the case is being

referred through to the SUDiC process.

And I can -- and this discussion will cement that view in future guidance and training.

Q. Can I ask you about the point that Ms Brown raised briefly and you talk about in your statement, particularly at paragraph 123 about this particular case Lucy Letby. And you express a degree of confidence, if I may say so, that the Medical Examiner system would have picked up a concern or the issue of Lucy Letby, just as you say I think in relation to Harold Shipman, and you refer of course to the three questions that would be asked and the three steps that would be carried out.

Can I just test that with you?

A. Yes, of course.

Q. Have you gone through sort of the algorithm of applying the three questions and the three steps to come to that conclusion and if so, could you explain it? First of all, what did the patient die from? That may have elicited a partial view from some of the paediatricians in some cases they had an idea of what the child may have died from, in others they couldn't find an explanation but they were trying to investigate things internally or through the Coronial system? Does the death need reporting to the Coroner? That is

relatively straightforward as a question. Many cases were but some cases weren't.

Are there any clinical governance concerns? Well, to some extent there were but they certainly weren't articulated even between the Consultants themselves, let alone with third parties.

So do you think those questions are going to be sufficient?

A. Yes. The -- the obvious challenge would be would this detect the first case? And for the case, for the extent of the activity of Harold Shipman and Beverley Allitt and others I think that when an unexpected event occurs in a hospital, or outside of hospital for that matter, by and large the first natural response of caring human beings and especially healthcare professionals is not to wonder if something bad happened, has something terrible gone on?

And this is actually quite, must be quite difficult for the Inquiry and the Families to hear, but it may be the case that the first time that something happens it is not recognised as an obvious case of malicious harm having occurred. But the next one and if necessary, and if it happened the one after, must raise concerns as a signal that things are not right.

And these three questions would, because the kind

of question that: we have had the second case that you have had in your unit, this is odd, I mean it's just asking that naive question, how can this be? You have gone weeks, months, without anything and then suddenly this is the case ... that's the interaction with the attending practitioners. The unexpected events that defied explanation would stand out in the records and be notified to a Coroner.

And then, finally, that conversation with family members that says: this is, this is just so unusual ... that together collectively they would -- it would -- I find it unconscionable that a correctly functioning office would -- that that would escape attention and not lead to escalation and investigation.

Q. Just testing that a little bit, if I may, just in terms of asking questions. I think when Ms Brown asked you the questions: what would the Medical Examiner ask, you said: they would say tell us about the case or do you have any concerns.

Those are obviously good, open questions designed to elicit any thoughts, but obviously as we know from this Inquiry there's an immense degree of professional reticence and personal reticence for clinicians articulating the unthinkable, which could be a suspicious of deliberate harm.

Do you think that open question in the context of a child's death is good enough? I don't mean that critically but do you think it should be: is there a concern that this child may have been harmed? Can it -- does it need to be more pointed in order to put the clinician or member of staff on the spot a bit more?

A. If I may say, I think that the tragedies that have unfolded, be they at Morecambe Bay, East Kent or in this case are enough of -- enough for Medical Examiners, who are, I reiterate, attuned to these sorts of issues, being able to ask the question in that way without it feeling like an inquisition.

Now, there are similarities, if I may say, with Medical Examiners who have detected issues with competence and probity about their colleagues and that could be somebody who they work alongside in their unit.

I know that those -- those concerns have been raised by, by colleagues to Medical Examiners, who for quite good reasons the clinicians may have wished to keep their head below the parapet but the Medical Examiner said: that is okay, I will take that one for you, I won't reflect specifically that you have imparted -- quote you verbatim, but raising the concern still within their remit.

Q. I understand that and that makes sense and you

are sort of working from the hypothesis of the perfect Medical Examiner who asks the right questions, but it is not clear that that question or that type of question would in fact be asked from the guidelines and I wonder if it does need to be asked: is there a safeguarding concern, is there a concern this child may have been harmed and that needs to be part of the every day practice, not just the practice of the good examiner?

A. And that is a fair question and observation and I am -- I'm -- I'm -- in giving my responses I would not wish to appear that I am defending not doing so.

I'm open to the suggestions and your questions have opened my mind to that -- to consider whether that's required and I am comfortable with that.

Q. Can I ask you lastly about the specialist question, which is something you consider in your statement. In medicine obviously there are multiple specialties, you are an emergency specialist, there are many, many different sub specialties. But paediatrics in some respects is different from a standard specialty in that firstly that the physiology of a child is different, particularly a neonate and secondly there is a vulnerability attaching to a child which doesn't always attach to an adult although, you know, there are vulnerabilities in a hospital setting. There are of

course specialist pathologists that deal with children and there are safeguarding specialists that deal with children in a hospital setting.

Do you think, bearing in mind this Inquiry's -- the events that are the subject of this Inquiry, and the fact that the paediatrics -- there is something different about paediatrics that actually there is a case for having Medical Examiners with a degree of specialism to deal with neonates because they may not necessarily know to ask the right questions if they don't have that specialist knowledge?

A. Yes, thank you.

I understand the question and it is -- it was discussed and debated and a policy decision taken by DHSC that Medical Examiners apply to all specialties.

I have -- I have a slight issue, I am trained to look after children too as an emergency physician, that children are uniquely special in and different because we are all human beings and we suffer issues with our health in similar ways, diagnoses get missed, the wrong medicines get given, people get overlooked, they wait for treatment, there is a delay in recognition of sepsis, there may be accidents or incidents that happen in hospital or at home that lead to concerns and they are documented. Unexpected clinical events like

hypoglycaemia or a cardiac arrest happen to every patient, group of patients.

And I also take issue that vulnerability is -- is unique to children. It is definitely not. Patients who are unconscious through injury or medical intervention are good examples of people who are utterly vulnerable, similarly people who cannot -- who have got learning disabilities or are adults that way are in a vulnerable position, those who have no family members or people to advocate for them are especially vulnerable. The homeless are very vulnerable.

It is the holistic approach that Medical Examiners take that equip them with that wider base of knowledge that actually means that they are very well placed to ask the -- the reasonable questions and consider these cases.

The important point though is that the opportunity is there to seek advice and asking the question whether that's advice about a legal issue, picking up the phone and speaking to the Coroner is one way.

Asking about medical specialty expertise is something that Medical Examiners do all the time. There may be a paediatrician or a neonatologist in the team of Medical Examiners, for example, and similarly, knowing the limits of one's professional boundaries is

a professional matter. It is -- it is set out in GMC Good Medical Practice guidelines.

There is -- it's -- at the end of it all every specialty could make a case for having a unique Medical Examiner specific to their specialty. And that is neither practical nor appropriate because it's -- this is a -- this is a system that covers all deaths in England and Wales and is learning and maturing even as we speak. My last quarter returns showed that Medical Examiners were scrutinising the deaths of 576 children and neonates. That's -- that's getting on for just over 50% of all cases and I am comfortable.

I'm happy to look at further developments down the line, I think that's an evolution. There is a process here we will learn, we will adapt and change because not everything is set as it is now.

Q. Thank you. Lastly, Dr Fletcher, you have been in post now for many years and there's obviously sometimes a tension between the employee in the Department of Health and their ability to get things done because of financing and the political will and so on, but are there any relevant recommendations or improvements to the system within which you work that you would like to see this Inquiry recommend?

A. Thank you. That's a wonderful question for me

to try and potentially end my evidence on.

I think the important next stages are going to be about consolidation and we have been going for three months now, we need some learning in the statutory phase of this, of course.

One of the things that will -- that will help us a lot will be the digitisation of the medical certification process. I mean that because whilst we are dependent on a paper-based system in the modern era it inevitably creates administrative and bureaucratic distractions from what is the core function of the Medical Examiner system which we have discussed at length in this evidence.

So I suppose my -- my primary wish will be for -- for consolidation, understanding what -- what has happened since the advent of the statutory system across England and Wales for all deaths, including children and neonates. The second point is to establish the digitisation of the process. And the third will be to evaluate the effectiveness of the Medical Examiner system and the death certifications as a whole which are for the Government to undertake.

Q. I understand that, and sorry to push you again, but those things I understand are already happening and you want them to happen. Is there

something else, something that isn't happening which you want to happen ideally?

A. No.

MR SKELTON: Thank you. Thank you, my Lady.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.

If I can just go back a little bit in your evidence, if I may, Dr Fletcher. You were saying that you recently commissioned up-to-date guidance for neonatal deaths for Medical Examiners. Can I just ask what the timeline is for that? When did you start that exercise?

A. I made the request earlier this year. I can't recall exactly when, I think it was probably around April/May time. And it was -- it was timely because it coincided with contact being made by the British Association for Perinatal Medicine and through a discussion with the president and her colleague.

I suggested that we work together to collaborate to make this guidance. It's -- I asked my -- I asked a colleague Lead Medical Examiner who is a neonatologist who kindly agreed to undertake that and I suggested that he work collaboratively with another Lead Medical Examiner who is a forensic -- paediatric pathologist and subsequently involving another one.

Their focus, quite rightly, with the advent of the statutory system has been getting where we need to; there has been an enormous amount of work, my Lady, in getting the system ready for statutory augmentation.

I understand that my colleagues are working on that now the updating guidance and things.

LADY JUSTICE THIRLWALL: Yes, all right, and when do they think it is going to be ready?

A. I don't know for sure. I -- before -- before coming, as you might imagine, I asked the question.

LADY JUSTICE THIRLWALL: I thought you might have checked, yes.

A. And they said: there is a lot going on, we are on it, and I'll keep you updated.

I -- this is a prompt to revisit that question and ask, I am hoping that this will be ready in the early part of 2025.

LADY JUSTICE THIRLWALL: Right. So it started about eight months ago and now for reasons that you have explained well, it hasn't progressed all that far by the sound of it.

So if we might expect and you have said very kindly that you will send it to us but it would be enormously helpful if it could come before the end of February, even if it is the very end of February, that would be

particularly helpful to the Inquiry and I hope helpful to you, if there's a deadline, as it were?

A. I can see that, my Lady. My hesitation is because as the national lead for the e-learning for Medical Examiners, there is -- there is a quality assurance and editorial process for any e-learning that always takes three months. It's --

LADY JUSTICE THIRLWALL: Why does it take three months, do you think?

A. Why, why indeed? I recall asking the same question in November 2009 when I first started the work and the reason is that whilst content is -- the content is for the authors, which would be for my colleagues --

LADY JUSTICE THIRLWALL: Yes.

A. -- there has to be an instructional design process that is to make this -- it's simply a publication of a -- of a document or a slideshow. It has to be constructed in an appropriate instructional design manner according to the Health Education England standards, they are the ones that are responsible for this work.

It goes through quality assurance processes, queries, peer reviews and editorial actions.

LADY JUSTICE THIRLWALL: The peer reviewing -- sorry to cut across you, but the reviewing, who is that

done by? The other subject matter experts?

A. Yes, the way this -- we would put this through both subject matter experts, so enabling the, in this case, British Association for Perinatal Medicine to comment and the Royal College of Pathologists Medical Examiner Committee members who provide oversight of content and ultimately me as the lead editor.

LADY JUSTICE THIRLWALL: So presumably all those things could be done. That could be front-loaded, couldn't it, so that the then -- the later -- I don't want to use "bureaucratic", but the process steps could be taken rather more swiftly, couldn't they?

A. Thank you, my Lady, and I -- your authority will probably enable me to -- to do what I can to accelerate the process. I won't of course specifically say that you have -- that you have asked the question.

LADY JUSTICE THIRLWALL: That won't be a secret, everyone knows I have asked the question so, yes, they will know that.

A. Indeed.

LADY JUSTICE THIRLWALL: And there are others who come after you who may want to help on that.

A. Indeed, and I am -- I'm comfortable absolutely with accelerating this as far as we can. The practical delivery of this in time I'm afraid I cannot give you

that assurance that it will be ready by the end of February, I apologise.

LADY JUSTICE THIRLWALL: No, I wasn't expecting you to be able to give that, it is just the actual getting the material ready seemed to me an essential first step.

Thank you. Just I think one other matter.

Just a swift question about the Medical Examiner Officer and presumably they have some sort of script that they would use, obviously I would imagine they are trained to be empathetic, et cetera. But one hears about confusion that can or is said to have arisen in relation to physician associates who are not physicians and I suppose a concern might be is that a Medical Examiner Officer just needs to make it clear at the beginning that: I am the Officer of the Medical Examiner as the Coroner's Officers do, and I presume that's something that's just made crystal clear right at the beginning so a parent knows who they are talking to?

A. Yes, thank you, my Lady. Yes, it is.

It's absolutely part of the training. There are core, modules, core modules for Medical Examiner Officers that include just that, a template if you like, a script.

LADY JUSTICE THIRLWALL: Yes.

A. And part of that is to be absolutely explicit

that the case, the death, the child has been reviewed by a Medical Examiner and therefore clarifying their Officer status at the start and explaining that the Medical Examiner has reviewed the records and consulted with -- with others.

So it's all part of the script, yes. Thank you.

LADY JUSTICE THIRLWALL: Thanks.

Then one final thing which is if you would just consider this scenario and we are looking at, you know, what could be done to stop what's happened in this case happening again.

You have made the point about first, second, third and well made, if I may say so. What about the situation where a very young baby, a neonate, dies suddenly and apparently unexpectedly, but the treating clinician believes that there is an explanation and as you say they are the subject matter expert and the Medical Examiner, who may or may not -- probably not -- have a neonatal background. I suppose the situation could arise, could it, in fact probably would arise, that the Medical Examiner would accept the view of the paediatrician on cause of death, you know, after a discussion?

A. (Nods). Is that possible? Yes, it is possible, my Lady, it is.

LADY JUSTICE THIRLWALL: Yes, it is just one of the scenarios I am trying to see how you might improve the situation. But that's a different --

A. It is a difficult one because each case is individual, unique, and it depends on the confidence in which people are proposing a cause of death.

I have had cases personally where there was concern raised about the cause of death of a child and the -- there is a triangle here. There is the triangle of the attending practitioner, the Medical Examiner and the Coroner as well and there are situations where to our surprise a Coroner declines to take a case for investigation and the same sort -- it is the same scenario that plays out, this is covered at length in the training, so I think there are parallels, if I may say.

In those circumstances, we advocate picking up the phone and speaking to the Coroner and asking -- and challenging the question: I know you think this, you have said that you declined to investigate. Can you just explain to me why, it helps my learning, because sometimes there are some sensitivities here about challenging that kind of authority.

Asking the question like that, saying: why -- what was it about this? Were you told this? But what about

this aspect of the case? And sometimes Coroners will say: I didn't know that. I wasn't told that. That's a good point ...

Nothing is lost through that conversation. In the case of an expressly confident neonatologist saying, "I believe this is perfectly explainable and natural", I -- I agree with you, my Lady, that there is, there is the possibility that the Medical Examiner would accept that view and say "okay". But if it happened again I think that would be different.

LADY JUSTICE THIRLWALL: Yes. Anybody want to ask anything arising out of my questions?

No. Thank you. Dr Fletcher, we are very grateful to you for making yourself available today, it is clear from what you said earlier that this is a very difficult time for you and your family and so repeated and renewed thanks for being here and we wish your daughter as speedy a recovery as is possible.

Thank you very much indeed.

A. Thank you very much.

LADY JUSTICE THIRLWALL: You are free to switch us off now.

I am grateful to the shorthand writer for sitting through that navigating the various difficulties so we will come back into court at a quarter to 12.

(11.27 am)

(A short break)

(11.45 am)

MR CARR: My, Lady we now turn to look again at evidence from the RCPCH, if I can call please Professor Stephen Turner.

PROFESSOR STEPHEN TURNER (sworn)

LADY JUSTICE THIRLWALL: Do sit down, Professor Turner. Mr Carr.

Questions by MR CARR

MR CARR: My Lady, thank you. If we can start please with your full name.

A. Yes, I am Stephen William Turner.

Q. You have prepared a short witness statement dated 2 December 2024?

A. Yes.

Q. The contents of that statement are true to the best of your knowledge and belief?

A. Yes.

Q. Before I start with my questions, I understand there is a statement that you would like to make.

A. Yes. Thank you. I would like to make a -- pass on my personal condolences and sympathies to the Families on behalf of the College. I apologise to you, the Families, for the role that we played. It delayed

you finding out what happened to your children.

I also apologise to our members, the paediatricians at the Countess of Chester. We didn't behave as we should have done towards you and the College and myself are determined and have learnt from the mistakes that have been made. Thank you.

Q. You gave evidence today in your capacity as the current President of the RCPCH?

A. Yes.

Q. So far as your professional background, you are a Consultant paediatrician at the Royal Aberdeen Children's Hospital?

A. Yes.

Q. And your statement, which is short, the effect of it is to confirm that you have read the much lengthier statements prepared by Robert Okunnu?

A. Yes.

Q. He is the Chief Executive Officer of the RCPCH?

A. That is correct.

Q. He has prepared statements which address the Invited Review that was carried out in 2016?

A. Yes.

Q. And I am going to be asking you a number of questions about that review and the evidence, the

statement that we have from Mr Okunnu on it?

A. Thank you, yes.

Q. If we can start, please, with a brief summary of the Royal College. It is a charity?

A. Yes.

Q. Its objectives are set out in its Royal Charter?

A. Yes.

Q. Amongst the objectives are the aims of raising the standard of medical care provided to children?

A. Yes.

Q. Advancing education of the public and medical practitioners in child health and protection of children?

A. Yes.

Q. It is a membership organisation with over 22,000 members?

A. Yes.

Q. All of your members are child health professionals?

A. Yes.

Q. The vast majority of those are paediatricians based in the UK

A. That is correct.

Q. One of the significant roles of the RCPCH is

in its provision of education?

A. Yes.

Q. The College sets the exam, the MRCPCH, which is a mandatory part of the training pathway for doctors who want to become paediatricians?

A. That is correct.

Q. If we can turn then to look at the Invited Review service and what I am going to do before we look at aspects of the review of the Countess of Chester Hospital is to look at the structure. So the principles of Invited Reviews, as was the case in 2016.

We are going to go to the guide, please, it's INQ0010214. We can see this is the first page. This was a document published by the RCPCH setting out the principles that applied to Invited Reviews.

A. Yes.

Q. This is dated August 2016, but its terms were broadly similar to the predecessor document?

A. Yes.

Q. If we turn, please, to page 4 of that document, we have there definitions and it's paragraph 2.2 at the top the page that we are concerned with because it was a service review that was carried out at the Countess of Chester.

And the definition of a service review is as

stated:
"An invitation to visit and comment upon a current service. This may be the whole paediatric service or a specific element such as safeguarding, neonates or emergency care. It will include meeting the paediatricians, nurses, managers and others who have links with the service. The Terms of Reference will usually be rooted in the quality, safety and efficiency of that service."
It was that sort of service review as defined in the terms that I have just read out that was intended to be provided to the Countess of Chester?
A. Yes.
Q. In broad -- broader terms, Invited Reviews are not, are they, a regulatory process?
A. You are correct.
Q. It's not a forensic investigation?
A. Correct.
Q. It's a peer review which assesses how a service complies with standards?
A. Yes.
Q. That's what it should be?
A. That is correct.
Q. If we go forward, please, to page 9 of this document. And we look at paragraph 8. 1, under the

heading "Process -- Main Review", we can see there it's describing part of the process for an Invited Review; once the clinical adviser has agreed for the College to proceed with an IR, an early pre-review visit may be proposed to familiarise the College representatives with the relevant individuals, issues and arrangement of services on site."
Then if we look at 8.2 before I ask my questions on this:
"Following agreement to proceed, the review manager works with the client and clinical adviser or lead reviewer to clearly define the issues requiring the Invited Review."
Then there are a few more subparagraphs including discussing and agreeing the Terms of Reference.
Now, clinical adviser and lead reviewer, they are both clinician roles?
A. That is correct.
Q. We have heard evidence from the clinical adviser at the time, that was Dr David Shortland.
Two points emerged from the sections of the guidance that I just read: firstly, the guide envisages, doesn't it, involvement from clinicians, either the clinical adviser and/or the lead reviewer, in the decision to proceed with a review and in the formation

of the Terms of Reference?
A. Yes, that is correct.
Q. In the case of the Countess of Chester, that did not occur, did it?
A. That did not occur. This guideline was not followed in the Countess of Chester.
Q. The RCPCH accepts, as it should have, that there should be clinical input both as to the decision whether an Invited Review should go ahead --
A. Correct, yes, we regret that.
Q. -- and as to the Terms of Reference?
A. Correct.
Q. Would that particularly be the case here because this was from the outset an unusual request for an Invited Review given it involved consideration of an increase in death?
A. Yes, I mean this -- this review went wrong from the start and it -- it was unusual. Looking back, it -- it certainly was unusual from the information we have now.
Q. Say that last bit again?
A. So, yes, it was an unusual request and unfortunately the due process that we have in this document here wasn't followed.
Q. And as well as the absence of clinical input

there was no pre-review visit, was there?
A. There was not.
Q. Now, again, given the nature of the review that was being requested, considerations of an increase in neonatal death with unexplained deaths, that would be an example of a review which called for a pre-review visit?
A. It -- it could do, yes.
Q. The benefit of the pre-review visit is that it would give an opportunity to either the clinical adviser or the clinical lead to discuss the nature of the issues to be covered by the review visit?
A. Yes, that would be the purpose of the pre-review visit or contact, yes.
Q. One of the observations made in Mr Okunnu's statement is the lack of an escalation policy for Invited Reviews in 2016. There is now an escalation policy and we will look at that later in your evidence.
But even looking within this guide, there are aspects of it which deal with what to do when concerns arise. If we can start, please, page 7. Under the heading in the second half of page 6 "Where serious concerns are raised" we see at 6.1:
"If issues of patient safety are raised at any time, the reviewers will advise the clients immediately

and discuss what urgent action should be taken, if any.

"If there are concerns about an individual's practice, for example, the client may want to consider restriction of the doctor's practice as set out in the guidance for MHPS England and NCAS or equivalent."

Then at 6.2:

"The College maintains good working relations with NCAS and the GMC and may discuss anonymously or specifically any issues relating to an individual doctor to establish that it is appropriate for the College to act in this capacity.

"Depending upon the issues under review, the College may recommend to a referring client that NCAS or the GMC is a more appropriate body to approach."

So within this section of the guidance, as it applied at the time, there is an indication of some of the steps that might be taken where concerns arise?

A. Yes, there are some, yes.

Q. If we look, please, at page 8, there is at paragraphs 7.5, the subparagraph 7.5, a list of category of cases that the College would not take on for an Invited Review. We see that the third subparagraph is where the expected scope includes behavioural misconduct, bullying, harassment or possible mental health concerns and criminal conduct would obviously be

an extreme form of what is listed there?

A. Mmm.

Q. Then at page 9, please, paragraph 7.7 at the top, it deals with the approach that ought to be taken where any of the issues at paragraph 7.5 arise during the visit.

A. Mm-hm.

Q. So what appears to be -- and correct me if I am wrong -- the process that's envisaged here there is a clear category of case that the College would not take on for a review, if you are at a review and it becomes apparent that it is one of those categories of case and there was a process to be followed?

A. That is correct.

Q. Now, at paragraph 7.7, what is provided for is as follows:

"The review should be completed in relation to its original remit unless advised to the contrary in order to avoid prejudicing other investigations by a public authority or regulator."

If I pause there. The advice to the contrary, who would that come from?

A. Sorry, can you repeat the question? I didn't hear.

Q. The advice from the contrary, so where it

suggests that the review should be completed unless advised to the contrary, advised to the contrary by whom?

A. So if -- sorry, I don't understand the question "advice to the contrary". So, for example, when the Review Team arrived for example if they heard advice that would suggest that there had been misbehaviour then yes, I think -- yes, the -- the review should have been halted then. That was a missed opportunity to stop the review.

Q. Well, what appears to be suggested here is that if you arrive so looking at 7.7, okay:

"If any of the issues listed in 7.5 come to light during an IR, the review should be completed in relation to its original remit, unless advised to the contrary in order to avoid prejudicing other investigations by a public authority or regulator."

Now, what appears to be suggested there is that if an issue arises and we looked at 7.5, so if, for instance, an issue of criminal conduct arises, there are two options: either you continue with the review in relation to the original remit or you stop if advised not to continue with the review because it might prejudice other investigations by a public authority or regulator?

A. Yes.

Q. So it is suggesting --

A. Yes, I agree.

Q. -- a fork and what I am asking, if you know the answer, is where that advice to the contrary would come from?

A. I don't know. It's, the -- the text that is provided to be interpreted by subjectively but I -- I don't know.

Q. Well, one interpretation is that the Review Team could seek advice from the Invited Review board to consider whether or not they ought to continue?

A. Sorry. Yes.

Q. In circumstances where the review is going to continue, the second sentence states:

"Clear scope boundaries should be agreed before further work takes place in order to avoid prejudicing other investigations."

And what appears to be envisaged there is where concerns arise, if you are not going to stop, so you are not advised to stop to avoid prejudicing other investigations by a public authority or regulator, and you continue, you need to have those boundaries in place to avoid the sort of prejudice --

A. Yes.

Q. -- from occurring?
A. Yes, I agree that's what it says, yes.
Q. So whilst there is no formal escalation policy as such standalone document, we have seen from page 7 the circumstances in which concerns may be raised. We see here at paragraph 7.7 where concerns are raised, the steps that need to be taken and the considerations that need to be borne in mind.
Then finally looking at the guide, if we go forward please to page 13, and there are two parts of this page that I want to take you to. The top paragraph on that page which is paragraph 9.7, the sentence that commences on the top line:
"If during a review or follow-up period the College deems that action taken in response to concerns or recommendations is insufficient to mitigate safety concerns, the Invited Review Programme Board reserves the right to authorise further action which may include reporting the findings directly to the appropriate regulatory or commissioning authority."
So this is another example, isn't it, of steps that the RCPCH can take to escalate concerns?
A. Yes, that is.
Q. At paragraph 10.1, which deals with confidentiality, the point that is made there is:

"The College will not disclose to the public, or any individual not directly involved, any details of the review or its involvement without the permission of the Medical Director, Chief Executive, or authorised representative of the client unless there is an overriding reason, for example urgent safety concerns where the regulator and/or Commission must be notified and/or public interest."
A. Yes.
Q. So that's another example of an escalatory step that can be taken?
A. Yes.
Q. So whilst it's right to say that there wasn't a standalone escalation policy as there is now, within the guide to Invited Reviews at the time, there were steps that could be taken or that should be taken where concerns arose during a review?
A. Yes.
Q. If we move away -- we can take this down now, please, thank you. If we move away from the guidance and begin to look at the Invited Review of the Countess of Chester Hospital. The first issue I want to consider is the Terms of Reference and agreement of the Terms of Reference.
If we can address the speed with which they were

agreed. From the point of the initial contact between the Countess of Chester Hospital and the Royal College to the point of the Terms of Reference being agreed, and those are the amended Terms of Reference, it's a period of about two weeks, isn't it, 28 June 2016 to 12 July 2016?
A. Yes.
Q. Mr Okunnu in his statement, it's paragraph 53, about seven lines down he comments:
"From the RCPCH's perspective in 2024 the proposals in terms of reference of the Invited Review at the Countess of Chester Hospital were compiled more quickly than usual. It can take up to 10 weeks to draft and agree Terms of Reference."
A. Mmm.
Q. So we are looking here at about a fifth of that period?
A. Yes, yes.
Q. But you agree with what Mr Okunnu says there about that time?
A. I do.
Q. But it doesn't need, does it, the qualification from a perspective in 2024? For an Invited Review, particularly one that was unusual such as this one, the considerations of an increase in

mortality two weeks is just too short?
A. I agree.
Q. It's particularly too short where it's being agreed by a review manager, a non-clinician without clinical input?
A. Yes, I agree.
Q. If we can consider the Terms of Reference themselves, please. It's INQ0009591. These were the Terms of Reference as agreed and I want to look at, please, the fourth bullet point in the middle of the page which requires or states as follows:
"To consider concerns about the neonatal unit with specific reference to: are there any identifiable common factors or failings that might in part or in whole explain the apparent increase in mortality in 2015 and 2016?"
Now, there are a number of different elements to that particular term of reference. Do you agree that in order to address that properly as part of a review, it would be necessary for the Review Team to consider and determine whether there's an increase in mortality given the suggestion here it's an apparent increase in mortality?
A. Yes.
Q. In respect of individual deaths, the Review

Team would need to consider in those individual cases what are the factors that caused or contributed to the death?

A. Yes.

Q. They would need to consider whether there were failings contributing to deaths?

A. Yes.

Q. Once they have considered causative factors or contributory factors to deaths and whether there are any failings, they would then need to carry out an assessment of whether there is commonality between those factors or failings?

A. Yes.

Q. Now, that exercise is well beyond the scope of an Invited Review as we looked at it at the start of your questions, isn't it?

A. I agree, yes.

Q. We know from the notes of the interview that the very first day the review visit, 1 September, the very first meeting of the review visit with Ian Harvey and Alison Kelly, the first thing that is recorded in the notes is David Milligan, the lead reviewer saying "we may not be able to explore the detail of the deaths"?

A. Yes.

Q. That's because such exploration is unsuitable for an Invited Review?

A. That is correct.

Q. The report ultimately compiled does not identify, does it, any common factors or failings responsible for deaths?

A. That is correct.

Q. Now, in light of all of that, was this a Term of Reference that was doomed to failure from the outset?

A. Yes.

Q. Is it a Term of Reference that should never have been agreed?

A. I agree, it -- it should never have been agreed.

Q. Was the agreement of this Term of Reference a missed opportunity to appreciate that what the hospital needed, what it required was an investigation into the cause of deaths which was something that couldn't be delivered by the RCPCH by way of an Invited Review?

A. Yes.

Q. If there had been discussion, if there had been clinical involvement, is it likely that the fact the RCPCH weren't the appropriate body to deliver on that kind of Term of Reference, that would have been

communicated to the hospital?

A. I believe that to be the case, yes.

Q. If we can turn now -- we can take that down, thank you very much.

If we can turn now to the sharing of information with and amongst the reviewers. Sue Eardley, who was a review manager, she has given evidence to the Inquiry and her evidence was that she was told ahead of the review visit that there were concerns about the association of a member of staff and the deaths at the hospital.

She did not have a recollection of sharing those concerns with other members of the team but she accepts that she should have done so?

A. Yes.

Q. That is quite right, isn't it, a review manager receiving evidence like that should share it?

A. Absolutely, yes, that should have been shared with the team.

Q. David Milligan and Alex Mancini's evidence -- David Milligan by way of his witness statement, Alex Mancini gave evidence to the Inquiry -- is that they had identified a correlation between Letby and the deaths from the documents that they had but they were not aware of suspicions or concerns at the Countess of

Chester Hospital that the Countess of Chester Hospital had, the evidence of Ms McLaughlan and Mr Stewart, the remaining members the Review Team, was to the effect that they were unaware of any concerns about Letby prior to arriving at the hospital for the visit.

Now, as you have explained, any concerns should be shared with the whole team and discussed amongst the team?

A. Yes.

Q. And that would provide a further opportunity, would it, in that forum for discussion by the team ahead of a visit to consider whether an Invited Review was appropriate, an appropriate means of addressing and investigating those concerns?

A. Yes, I agree.

Q. So looking at the issues that we have considered so far, all of which are focused on the period leading up to the review visit. It is a fair summary, isn't it that there should have been involvement of the clinicians, either clinical adviser or lead reviewer, in the decision as to whether to undertake a review in the first place?

A. Yes.

Q. A pre-visit to the hospital to understand and explore the issues calling for a review?

A. That would have been helpful.
Q. Involvement of the clinicians in determining the Terms of Reference?
A. Yes.
Q. In those circumstances that full Term of Reference wouldn't have been agreed?
A. I -- I agree with you.
Q. A sharing of the concerns at the Countess of Chester Hospital which were communicated to Sue Eardley, a sharing of those concerns with everybody in the Review Team?
A. (Nods)
Q. Now, had all of that occurred, it's likely, isn't it, that the Invited Review wouldn't have gone ahead at all?
A. That is correct.
Q. Now, in terms of what happened during the review visit, we know from the notes and from the evidence that we have obtained that the concerns relating to Letby dominated the first two interviews on the first day of the visit, so the interview with Ian Harvey and Alison Kelly, and then the interview with Stephen Brearey and Ravi Jayaram?
A. Yes.
Q. What we can see from the notes is that the

Review Team were told that there were concerns?
A. (Nods)
Q. They were told that there was a correlation between Letby and the deaths and that that correlation, as it were, followed Letby so when she was moved from night shifts to day shifts the collapses changed from night to day, and when she was removed from the shift, the collapses ceased?
A. Yes.
Q. They were told that the deaths and collapses were unexpected/unexplained?
A. Yes, yes.
Q. We know from the notes that we have of the review and the evidence that Ms Eardley gave to the Inquiry that the Review Team during the lunch break discussed amongst themselves different forms of deliberate harm that might explain the deaths?
A. Yes.
Q. There is evidence, isn't there, suggesting that there was a discussion amongst the Review Team as to whether or not they should abort the review on day one?
A. That is correct.
Q. But we don't have a contemporaneous record of that discussion?

A. That is correct.
Q. Paragraph 85 of Mr Okunnu's statement, reads:
"We do not know why the Invited Review team did not stop the review after learning this information ..."
That is a reference to the interviews with Dr Brearey and Dr Jayaram.
"... but we note that in a feedback session at the end of the second day, the reviewer David Milligan said.
"'We considered aborting the review and starting again', but the Terms of Reference indicated it is important to get the background."
Now, is it the RCPCH's view that the Invited Review should have been aborted when those concerns were raised with the team at the beginning of day one of the visit?
A. Yes, it is.
Q. When considering aborting the review, there was a failure by the team, wasn't there, to seek advice from the Invited Review board at the RCPCH?
A. Yes.
Q. And not only was there a failure to abort so that the review continued, there is no evidence, is there, in the notes or elsewhere of consideration of or implementation of clear scope boundaries to avoid prejudicing future investigations as required by the Invited Review guide?

A. You are correct.
Q. If there had been consideration of clear scope boundaries, then a very obvious clear scope boundary would have been: we had best not interview Letby who's not even listed as one of our interviewees?
A. I agree.
Q. Instead, what appears to have occurred is the concerns emerging so clearly during the first day of the visit, a decision to continue with the visit in the review, that not only are there no clear scope boundaries but the decision is made to add Letby to the list of interviewees.
What is the position of the RCPCH as to the appropriateness of interviewing Lucy Letby?
A. Lucy Letby should not have been interviewed by our Review Team.
Q. It's clear, isn't it, because in paragraph 88 of Mr Okunnu's statement we have again the reference to the view of the RCPCH in 2023 and it describes it as being highly unusual that Lucy Letby was interviewed.
But one, you don't need the benefit of hindsight to arrive at that conclusion, do you?
A. I agree.
Q. As you have indicated it's not simply that it was highly unusual; it was wrong and it should not have

happened?
A. I agree.
Q. If we can get up, please, the text messages that Letby sent on the evening following day one of the review, it is INQ0000569, and it should be page 34 of that document.
LADY JUSTICE THIRLWALL: Don't worry, I think it will be enlarged a bit.
A. Thank goodness for that.
MR CARR: It is 18:14, is what I am looking at, it should be page 34/37. Yes.
LADY JUSTICE THIRLWALL: 18:14 on 1 September.
MR CARR: Yes, thank you. It is slightly different to mine but I can see the entry there, is it entry 1274.
So this is a text message or a Facebook message that was sent by Letby to somebody else. It follows the interview that she had with Claire McLaughlan and Alex Mancini earlier in the day.
You can see what she writes:
"Thank you for your help. The team members were nice. They didn't ask much about the babies. It was more about the unit as a whole et cetera. In brief, it looks as though there is the potential for this to go further over a long period of time. H ..."
That is likely a reference to Hayley Cooper, it's

just disappeared, but what it says at the bottom is:
"H thinks we need to look at taking out a grievance case."
Then the next entry: 18:33, it is entry 1281:
"The report will take a minimum of six weeks with a preliminary tomorrow. They off the record told me they think an investigation into the deaths will be a recommendation and I need to prepare myself that as I would play a big part in that overdue to being a common factor and it could take several months."
Thank you, we can take that down. There was also evidence from Hayley Cooper, the Union rep, that the interviewers queried with her whether Letby knew what she was being accused of.
Now, we know that an investigation into the deaths as described in those messages was exactly what was recommended by the RCPCH, wasn't it?
A. Mm-hm yes.
Q. It's important to state that the interviewers both of them, Alex Mancini and Claire McLaughlan dispute having any off-the-record discussion with Letby.
If such a discussion had occurred and if Letby had effectively been tipped off that there would be a large investigation in which she would be playing a big part, what is the RCPCH's view as to the appropriateness of

such a tip-off?
A. That would have been wholly inappropriate.
Q. Dealing now, please, with the issue of escalation. We looked at the entries in the 2016 guidance, although there wasn't a standalone escalation process we looked that there were different points within the guidance which gave the RCPCH power to escalate and address circumstances in which escalation might be appropriate. It's right to say that, isn't it, that nowhere in the notes of the review visit the correspondence following it or the report itself is their advice to escalate the concerns of criminality, deliberate harm by Letby to the police?
A. That is correct.
Q. No advice to escalate to the Local Authority Designated Officer?
A. That is correct.
Q. In his witness statement, Graham Stewart, one of the reviewers states that he provided verbal feedback that included that any concerns of criminality should be addressed by involving the police. But we don't see that documented in the notes, do we?
A. That is correct.
Q. Mr Okunnu's statement, at paragraph 127.3, page 50:

"There is no evidence that RCPCH shared the report or its findings and recommendations with any external scrutiny bodies, regulators, the police or other authorised individuals for consideration after the Invited Review was completed in 2016. We do not know why the concerns were not escalated with external investigations and whether any consideration about this was given at the time in light of the serious allegation that had been made about Lucy Letby during the review."
So does it follow from that, Professor Turner, that the RCPCH accepts that the hospital should have been positively advised to report these concerns to the police?
A. Yes.
Q. Given the sections of the 2016 Invited Review guide that I have taken you to, is it accepted that going to the police is something that the RCPCH could have done itself particularly if the hospital did not?
A. That would have been an option, yes.
Q. The circumstance in which it would have been appropriate to exercise that option would have been, for instance, if the hospital had been told to go to the police and they did not or they were reluctant to do so?
A. I agree.
Q. So one way or another, acting appropriately,

the police would have been informed of these concerns following the review, had a proper procedure been followed either by the hospital directly on advice from the RCPCH or by the RCPCH?

A. Yes.

Q. If we can look, please, now at the feedback letter which followed very shortly after the review dated 5 September 2016, it's INQ0009611, page 2 of this document, please.

Under the heading "Action Required -- HR investigation", the second sentence:

"Our understanding is that an allegation has been made and therefore a process of investigation needs to be put in place which sets out the nature of the allegation and the process you will follow to investigate it."

The reference to an allegation there is a reference to the allegation of deliberate harm resulting in the deaths of babies?

A. Yes.

Q. Does the RCPCH accept that recommending an HR investigation into allegations of murder was wrong and inappropriate?

A. Yes, we do.

Q. Thank you, we can take that down, please.

If we can deal with the reports, and there were two reports produced, a dissemination version and what was called a confidential version, the confidential version dealing with the issues that had been raised about Letby at the review.

Now, it was accepted by Ms Eardley in her evidence that in the confidential report which dealt with the Letby issues, "It was wrongly attributed to the Consultants that they had described their concerns as a gut feeling".

You have seen the transcripts of Ms Eardley's evidence, haven't you?

A. Yes.

Q. The confidential report describes, doesn't it, the Consultants having a subjective view with no evidence or history to support it?

A. Yes.

Q. Now, again, if we think to the clear scope boundaries that ought to have been contemplated and implemented if the review -- if the reviewers decided to continue that review, notwithstanding the concerns raised, one of the clear scope boundaries would be: we are not in a position to be assessing and reporting on evidence of criminality?

A. That is correct.

Q. So the analysis that we see there would not have -- would not have been included?

A. Correct.

Q. The RCPCH accepts, doesn't it, that its Review Team did not have the capability to be carrying out that type of analysis entered into?

A. That's correct, we accept that.

Q. As to the decision to produce two reports, the rationale is explained in the cover letter from Mr Shortland when the reports were sent and we see that at INQ0009620. It is the second paragraph on this page where it reads:

"Aware of the personnel issues. We have provided two reports: one including full details of actions taken and one omitting the confidential HR issues."

Now, just pausing there. The issues omitted -- and I have asked you this question in respect of the immediate follow-up letter, but the issues omitted are not HR issues, are they?

A. I agree.

Q. They shouldn't have been described as such?

A. I agree.

Q. Now, in the course of the evidence, and indeed at the time but subsequent to the report, there have been a number of references to the dissemination version

of the report as a redacted report, but to be clear, it wasn't a redacted report in the sense that somebody who picked up the dissemination copy would look at it and could see that sections had been redacted, so there weren't kind of black marks like you sometimes see in a redacted document?

A. That's correct.

Q. Indeed if we look at this letter, if you look in the top right corner, we can see there is those white boxes with "I&S" in them where certain information has been redacted from this document?

A. Yes.

Q. But what happened in the dissemination version was that the sections dealing with the concerns in respect of Letby, they were just completely removed?

A. Yes.

Q. So anybody picking up the dissemination report and reading it, they would have no clue that it wasn't a full and complete report?

A. That is correct.

Q. There was nothing to indicate that information had been removed?

A. That is correct.

Q. So there was a real risk, wasn't there, that anybody considering the dissemination report, both the

health professionals to whom it was disseminated in the hospital but also third parties, a real risk that they would be misled into thinking that the dissemination report was a comprehensive account of the issues that arose during the Royal College's visit?

A. I agree with you.

Q. What we know occurred subsequently is that in early 2017 the Countess of Chester came to publish a report, it was the dissemination version of the report?

A. Yes.

Q. They came to share that report with a number of third parties. But again, for the most part, it was the dissemination version that was shared with external agencies?

A. Yes.

Q. Now, even if there are circumstances where there are issues which might be considered sensitive or it might be considered warrant redaction, given the potential if information is completely removed for recipients to be misled, shouldn't it be made clear on the face of a dissemination version that it is exactly that; it is a dissemination version and information has been removed or withheld?

A. Yes, I agree with you.

Q. Now, in terms of who the full version of the report ought to have been shared with, does the RCPCH consider that the paediatricians at the Countess of Chester Hospital, those raising the concerns that were removed, that they should have seen the full version and not the dissemination version?

A. I agree, I believe they should have seen the full version.

Q. When it comes to the report being shared with external bodies, particularly if they are external bodies who are concerned about issues at the hospital, should it be the full version or the dissemination version which is shared with them?

A. I -- I think for the majority that would be the full version.

Q. Now, looking at this letter, the cover letter to the report, 28 November, and in the paragraph that has been highlighted, the final sentence of that paragraph states:

"It remains your report though and we will not distribute or share it more widely without your permission."

Now, again, that is contrary to the guidance we have looked at, isn't it, because the guidance we have looked at gave the Royal College the right to disclose

a report where there's an overriding reason to do so?

A. Yes, I agree.

Q. And in light of the concerns that had been raised at the visit, this was exactly the sort of case that might give rise to those overriding reasons?

A. I agree that this case might, might give rise to such a scenario, yes.

Q. So it was wrong, wasn't it, to give that reassurance to the Countess of Chester?

A. Yes.

Q. Can I turn now, please, to information sharing with the Invited Review board.

One of the points made by Mr Okunnu in his statement, it's paragraph 127.2 at page 50, he states:

"There is no evidence that the board of trustees or any other senior group was comprehensively briefed by Sue Eardley or the clinical lead Dr David Shortland about the issues raised during the Invited Review and the implications of them."

At paragraph 128 of his statement, page 51:

"We consider that the ability of the RCPCH's board and other senior bodies to conduct their oversight functions was hampered because they were not sufficiently sighted on the level and seriousness of the concerns that the Countess of Chester Hospital review

entailed."

One of the reasons suggested by Mr Okunnu as to why this was the case was because of the confidential nature of Invited Reviews.

A. Right, yes.

Q. So the question is this: did the confidentiality of Invited Reviews prevent a report, or the concerns arising from a review visit, being shared with the RCPCH board?

A. I don't know.

Q. Well, if it did, that would be a significant shortcoming in the ability of the board to provide oversight if they don't know what is going on during Invited Reviews?

A. Yes, I -- I agree with you.

Q. If I can deal now to the role of the sharing or notification of information to families concerned.

Now, part of the review visit did include a discussion with two patient representatives. But what we know from the review, from the documents that were obtained and by the reports written, including appendix 4, is that there was considerable consideration of medical reports, Morbidity and Mortality Meetings, postmortem reports of a significant number of children for the purposes of the review?

A. Yes.
Q. Now, what is the RCPCH's position on obtaining consent or ensuring that the client has obtained the consent of families before sensitive medical records and reports are provided to its reviewers?
A. We presume that the healthcare organisation has the appropriate permissions in place.
Q. Are there -- were there at the time or have there been implemented since any steps in place to ensure that your clients are discharging their duty of candour when instructing you and are ensuring that permission is obtained?
A. I -- I don't know. What I will say is that we as a healthcare or as a Invited Review service wouldn't be party to contact details.
As part of duty of candour it wouldn't be right for us to have contact, confidential details of parents and families with which to disseminate results of a report like this.
Q. Yes, the question or part of the question is aimed at what steps are taken to ensure that families are aware that sensitive medical records of their loved ones are being sent to reviewers.
Now, one suggestion that was made by Ms Eardley in her evidence is that it could be made a term of the

contract for the purposes of an Invited Review that the client has discharged or complied with its duty of candour?
A. That, that could be the case.
Q. But it sounds like it's not currently the case, it's not currently part of a contractual term or any requirement on the client to ensure --
A. I am not aware that it is. But that might be, that might be my ignorance.
LADY JUSTICE THIRLWALL: So that's something that could be checked, isn't it?
A. That's something that can be checked, yes, my Lady.
LADY JUSTICE THIRLWALL: Thank you.
MR CARR: I referred, when we were looking at the 2016 guide, to the fact that there is now a escalation process and that's a standalone escalation process. That's one of the changes that has been introduced following a review of the Invited Review at Countess of Chester amongst other reviews?
A. That is correct. There have been a series of changes and this escalation policy is one of them.
Q. If we can look, please, at that escalation policy. It's INQ0012813, and if we look at the appendix which is at page 13. Here we have essentially a risk

matrix, don't we, of the types of concerns and how significant those concerns would be divided into: concerns, serious concerns, immediate risk.
Amongst the examples of immediate risk, in the third box on the page, the box at the bottom of the page are significant safeguarding concerns.
Would it be the case that the concerns that were raised at the Countess of Chester review would or should fall within that category of significant safeguarding concerns, immediate risk issue?
A. Yes, absolutely.
Q. It would require, wouldn't it, the Review Team to recognise the concern as both a safeguarding one and a significant one?
A. Yes.
Q. If we turn to page 14 of this document, appendix 2, we can see -- we might need to zoom in -- yes, the box for immediate risk, which sets out the steps that ought to be taken, which include adjourning the review, which is one of the issues that we looked at in respect of the Countess of Chester and in the paragraph that follows, steps of escalation including escalation to external bodies?
A. Yes.
Q. Thank you. We can take that down.

So in addition to this escalation policy, what are the other significant differences between the review process as it exists now and the review process in 2016?
A. Thank you. So following on from the Countess of Chester we had an external review of the Invited Review service called the Crisp Report, which I believe you've heard of previously.
It made 86 recommendations. I will not go into all of them.
Briefly, we have heard about the escalation policy which has changed. If I go through the timeline of commissioning the review, we now have a process whereby it's not just the clinical lead who makes the decision when to proceed with Invited Review; it's a team of two clinicians and two members of staff and they go through a pro forma which explores reasons why we might and might not. So that's one new thing that has come in upfront, if you will, in the natural journey of a review and at that stage the review might be declined.
Then the second main area -- I have covered the initial context, we have covered the escalation policy -- the Terms of Reference which we have talked about. Now they are substantially different. The first thing that is different is that the Terms of Reference are agreed by the healthcare organisation, the College

and also the Invited Review team and it's important that we include those individuals.

Q. So the entire team?

A. For the entire team. And the second aspect of the Terms of Reference which has been brought in is following on from the discussion we have had we make it clear that the healthcare organisation is obligated to meet concerns that we believe are of high concern by a given date and up front in the Terms of Reference we make it clear that if we are not satisfied with the timeliness and completeness of the healthcare organisation's response we will go to the appropriate regulator. And we have actually done this in the -- in the last year or so.

Q. The focus of much of my questions has been on the issues and shortcomings, recognised shortcomings of the Invited Review at the Countess of Chester Hospital in 2016.

But of the service more broadly, what do you consider the benefits of the review process to be to the College and to the clients when properly performed?

A. Yes, thank you. So -- so I think generally the purpose of an Invited Review is for a healthcare organisation, which recognises it has a problem, to invite a professional, external, independent, peer

review group to come in and to help them improve their service with a focus on patient safety.

So the benefits to patients are that there is a focus on patient safety and the staff who were looking after them will gain by reflecting on their practice, by receiving education.

The Review Team themselves will learn from their review and will feed that back to the service and so the Review Team itself does benefit from doing Invited Review because nothing's perfect and each review further improves the service that we deliver.

Q. Thank you. I have one more topic for you, which is moving slightly away from the Invited Review service.

The Invited Reviews are carried out for clients, for clients who are contracting which is usually Medical Director as we have heard. But as you explained at the beginning, the RCPCH is a membership organisation. Your members are paediatricians and the paediatricians at the Countess of Chester Hospital, who were raising concerns with the Review Team, were members of your organisation.

What I would like you to look at and to reflect upon is the support that was provided to your members, the paediatricians at the hospital, following the Invited Review.

We will look at three documents. If we can start at INQ0012734 and we will want to go to -- this is an email chain -- we will want to go to page 4 first.

At the second half of that page, and it goes on into the next page, is an email from Stephen Brearey to the RCPCH President at the time Professor Modi, dated 5 February 2018. That final paragraph on the page:

"I do have a number of concerns regarding the way the college responded to our concerns, particularly after the invited review report was submitted to the Trust. The modified report, which did not include any of our concerns, was utilised by the Trust to follow a plan that gave us all considerable patient safety concerns and was a stressful time for all of us.

"It is quite possible that if the college had intervened at that stage and provided support to its members (the consultant body) ..."

We need to go over to the next page, thank you:

"... then the police investigation might have started earlier. The affected parents were also given information by the Trust in January 2017 regarding the report which was later different to the information given in May 2017."

The final paragraph there deals with the lack of more positive support.

What are your reflections on the concerns that are raised there as to the support provided by the College to its members?

A. I am very sorry that we behaved that way.

I think that we could and should have been more responsive. We should and could have listened more carefully to their concerns.

Q. If we look at the initial reply, so it's page 3 of this document, the initial reply from Professor Modi, it's the same date, 8 February 1800 hours.

In the second half of her response:

"You will appreciate that we do not have authority over what actions are taken by Trusts as a result of our reviews. Did you have something specific in mind when you referred to 'supported by the college in a more positive way'? Please do be aware that given this is now a police investigation it would not be appropriate for us to intervene."

Now, would you accept that's perhaps not the most supportive response in the context of the issues that had just been raised by Dr Brearey?

A. I agree with you.

Q. We see at page 2 of this document, at the bottom of the page is Dr Brearey's email, and the third

paragraph from the bottom starting, "Secondly ..." he is highlighting in particular there the issue of the two versions of the report and the fact that you have one, the dissemination version, which just has large chunks completely missing.

A. Yes.

Q. We can take that down now, please. The next document, INQ0012733.

At page 4 of this document, we see this is a little later in the year. It's the email at the bottom of the page, 4 July 2018, an email from Dr Brearey and the concern that he is raising here is in relation to press cuttings which were being circulated by the Royal College to its membership and those press clippings suggest that the review led to the police investigation and that's something that Dr Brearey wanted to set right, isn't it?

A. Absolutely. Dr Brearey's understandably very cross when he is writing this letter.

Q. He emphasises again that he and his colleagues feel let down and this string of communication led to a meeting, didn't it, between the College and Dr Brearey and another doctor from the Countess of Chester?

A. It did, yes.

Q. That's the final document we will look at.

It's INQ0012742. This is a note of a meeting, 12 July 2019, between the doctors and the RCPCH.

If we look at page 2 of this document, please. We see outlined there, from the third paragraph onwards, some of the particular concerns that were raised in relation to the RCPCH's role and the concerns that we see emerging are similar to some of those we have covered: it's the creation of two reports and the fact that one of those wasn't shared with the paediatricians.

In the current escalation document, there is still -- forgive me, not the escalation document -- in the more recent review, Invited Review policy document, there is still provision that allows for issues that emerge during an Invited Review to be dealt with in a letter separate from a report?

A. Yes.

Q. So how would, today, the RCPCH deal with this very same issue that was a cause of concern for Dr Brearey and the paediatricians of issues arising during a review and then not being documented in the report?

A. Sure. So should this happen now, I think the first thing I would do, I would get legal advice as to what I was and wasn't able to do. Because it might be -- let's just imagine that the legal enquiry, the

investigation into Lucy Letby was ongoing. But my ...

I would speak to the members. I would listen to the members and understand their perspective. That would be the very first thing that I would do in terms of practical engagement with members.

Q. Would you ensure that the report, even if it didn't explore concerns raised in detail, and that was dealt with in a separate document that the report somewhere made the point that there are concerns falling outside the Terms of Reference that have been followed up in an alternative document?

A. If, if that's what we agreed was necessary absolutely. So, for example, if you suggest a supplement or an appendix to the report that we issued, that, that would be an option.

MR CARR: Professor Turner, thank you for answering my questions. My Lady, those are all my questions.

I know there are -- no, I am told there are no further questions so that's it for this witness.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Carr. Professor Turner, thank you very much indeed for coming to give your evidence. It has been very helpful. You are now free to go.

A. Thank you very much. Thank you.

LADY JUSTICE THIRLWALL: Mr Carr, can we take the

full hour for lunch or should we start earlier?

MR CARR: I would propose a slightly shorter lunch, maybe 45 minutes.

LADY JUSTICE THIRLWALL: Shall we say 10 to 2? So we will rise now and start at 10 to 2.

(1.05 pm)

(The luncheon adjournment)

(1.50 pm)

LADY JUSTICE THIRLWALL: Mr Carr.

MR CARR: My Lady, the next witness is Dr Kingdon, who will be giving evidence focusing on Part C and before I call her, in respect of the RCPCH evidence on Part B, we have heard evidence from a number of members the Review Team. The Inquiry has --

LADY JUSTICE THIRLWALL: Do sit down, Dr Kingdon.

MR CARR: Forgive me, the Inquiry has also obtained witness statements from David Milligan who was the lead reviewer, Graham Stewart, who was the neonatologist and who was a part of the Review Team, neither of them were called to give evidence for health reasons.

We will be uploading their statements as well as a statement from Professor Neena Modi who was President of the RCPCH at the time and addresses her comments on 2016 Invited Review.

We will be uploading those statements in due

course.
If I can now call Dr Kingdon.
LADY JUSTICE THIRLWALL: Do come forward.
DR CAMILLA KINGDON
LADY JUSTICE THIRLWALL: Thank you, do sit down.
Questions by MR CARR
MR CARR: If we can start, please, with your full name?
A. My name is Camilla Clare Kingdon.
Q. Before we turn to your statement, I understand that you want to address the Inquiry?
A. Thank you.
I've been a paediatrician and neonatologist for over 30 years and particularly as a neonatologist have cared for families who have lost their babies and their grief is unfathomable and unimaginable and I just wanted to say how very, very sorry I am to the parents of the babies who lost their lives at the Countess of Chester Hospital.
Thank you.
Q. Now, you have made a statement for the purposes of this Inquiry dated 25 March 2024, haven't you?
A. I did.
Q. You can confirm that the contents of that

statement are true to your best knowledge and belief?
A. It is, yes.
Q. The statement addresses principally issues relevant to C of the Inquiry's Terms of Reference?
A. Yes.
Q. I am going to ask you a number of questions on both points raised in your statement and some issues not raised in your statement but which you may be able to assist upon.
Before I do, if I can summarise your professional background. You just commented a few moments ago you have been working in paediatrics for over 30 years and you started working in paediatrics in 1992?
A. Yes.
Q. You became a Consultant paediatrician in 2000?
A. Yes.
Q. Your clinical speciality is neonatology?
A. Yes, it is.
Q. You have a particular special interest in neonatal nutrition?
A. Yes.
Q. Of potentially particular relevance to your evidence between 2014 and 2018, you were the head of the London School of Paediatrics?
A. Yes, I was.

Q. You were responsible in that role for training over 1,000 postgraduate trainees in paediatrics?
A. Yes.
Q. You were also the past President of the Royal College of Paediatrics and Child Health?
A. I was.
Q. May 2021 to March 2024?
A. Yes.
Q. Prior to that you were Vice President for just under three years?
A. That's correct.
Q. Turning to your evidence at paragraph 7, you state that you make your statement on behalf of the members of the RCPCH?
A. Yes.
Q. At paragraph 8 you explain that you have had input in preparing the statement from a number of RCPCH officers?
A. Yes.
Q. To be clear, those officers are working paediatricians?
A. Yes, they are.
Q. So in preparing your statement and giving your evidence today you are drawing on that wealth of knowledge and experience?

A. I am.
Q. So far as your statement you cover three broad topics. The first, governance and management structures in keeping children safe; the second, professional regulation; the third, regulation of senior managers?
A. Yes.
Q. I am going to go through each of those in turn, starting with governance and management structures.
The point that you make at paragraph 9 of your statement, it's page 3, is that mechanisms for overseeing patient safety and the quality of care are not restricted just to governance and management, but there's a number of additional external bodies?
A. Yes.
Q. Do you have in mind there with reference to external bodies NHS England, CQC, professional regulators?
A. Yes.
Q. The final sentence of paragraph 9 states:
"The system of oversight both within hospitals and for external bodies is overlapping and, in the RCPCH's view, sometimes lacking coherence and clarity."
Are you able to elaborate upon that, please?
A. So it -- it can at times as a front line

clinician feel bewildering as to who -- where guidance is coming from and which organisations and structures you are answering to in terms of regulation and governance.

So, you know, there are, there are -- we have NHS England, we have the Department of Health and Social Care, then there is the CQC.

As a doctor I have my regulator, the General Medical Council and so on and so the landscape is complicated and often guidance is -- is overlapping and there's a lack of clarity as a result of that.

Q. Can there be circumstances where there's also a degree of duplication so an issue that you need to raise with one body, that same issue needs to be raised with other bodies as well?

A. Yes. So it's true that sometimes we are reporting data, the same data, but through different channels to different organisations that perhaps have different regulatory activities.

Q. We will come back to data and systems of regulation later in your evidence.

On this section, in paragraph 10 of your statement, you state that:

"In respect of hospital governance and management, the RCPCH consider that the structures in place are more

focused on reacting to concerns raised through incident reporting, than proactively creating and supporting a culture, system and process that prevent harm and ensure quality of care."

So is the point you are making there that whilst there are systems that tell you what to do when something goes wrong, there is not as much attention given to having systems in place that prevent things from going wrong in the first place?

A. I think that is true, although that is a generalisation.

There are certainly some organisations where there is huge attention placed on the culture around promoting safety, and a curiosity about picking up early warning signs and signals.

So it is true that in many, many very busy acute Trusts it -- it is -- concerns are flagged once there's a problem.

But I have certainly seen it done in other organisations, other acute Trusts where -- where the culture is different, where actually signals can be picked up at a much earlier stage, where the culture encourages that kind of curious questioning about early warning signals.

Q. To be clear when you said there are some

organisations you touch upon it but you are talking about NHS organisations, NHS Trusts?

A. I apologise. Yes, I am. Yes.

Q. In your view are you able to help us with what distinguishes the Trust, who -- do you get that culture right or do have a proactive culture and the ones who are more reactive and fire-fighting?

A. On a very practical level, it is often down to time, adequate staffing, adequate resourcing. Because to create a culture that asks front line clinical staff, you know nurses, doctors, the whole professional team, to take time to think about and reporting early warning signs around the potential for harm to be done to patients, that -- that genuinely requires some headspace that you cannot expect of staff when they are working in rotas that are half filled or where there is just a lack of resource to undertake these kind of activities.

Q. You go on in your statement, it's paragraph 11, you observe that there's no standardised national mandate on how to ensure that effective hospital governance or management structures are in place to prevent harm.

Now, what would the kind of mandate you are referring to here, what would that look like? In your previous answer you identified the difference between

hospitals who have a good culture and those who are struggling and more reactive being about time and resources. So if there was a national mandate, what kind of things would it cover?

A. Well, I think NHS England has published something that we call PSIRF which stands for the Patient Safety Incident Reporting Framework. Actually, that's a framework that can be a really helpful vehicle for just creating opportunities to think about themes around early warning signs as I have been describing.

So you can -- you can have a framework but unless you have got staff with time and expertise, you know, who have had some training about actually how to use these frameworks, you know, how to look at hospitals have systems whereby they report encourage staff to report near misses or indeed incidents and some organisations call those Datix, other call them IR-1s, there's various names they give them, but let's call them incident reporting systems.

All hospitals have that, but how you encouraged your staff to use those reporting systems, there are thresholds you might suggest to them, so some organisations will say to their staff: we want you to report everything that you have noticed that isn't quite right or where you think we as a clinical service can

learn from. Whereas others will be saying to their staff: we don't want you to report unless you have had a discussion before because this might look bad for the organisation.

So it's how you equip your clinical teams to use the frameworks that exist and give them the -- both the time and the wherewithal to do that meaningfully.

Q. So on that example, so that we understand, the thresholds for reporting generally is left to the Trust to decide on a Trust by Trust basis. There are obviously certain incidents that have to be reported?

A. Of course.

Q. But outside of that, you are saying -- well, you will see different thresholds applied by different Trusts?

A. Yes.

Q. Are you suggesting that where that threshold is set is one of the factors or is a factor which might tell you something about the culture of safety in a particular Trust?

A. I would say that, yes.

Q. So when you talk about a national mandate, for instance, it could apply a standard across all Trusts?

A. I think technically the answer to that question is probably yes. But I don't know how you

mandate a culture.

Q. If we address, please, your reference to the paper by Fulop & Ramsay. Because in the context of culture, one of the things that you consider in your statement is the role of management leadership and the impact that that can have on a culture?

A. Yes.

Q. The reference is INQ0012274. And this is a paper on governance and leadership, under the heading "Improving Quality and Safety in Healthcare".

It is a document that you have cited in your witness evidence. Is the importance of this document that it identifies and explores the role that governance and leadership can have in improving quality in healthcare, improving a safety culture?

A. Yes.

Q. If we can look at the summary of conclusions at page 32.

Now, it's obviously a long document, this is page 26 of the narrative and this paragraph here brings together the conclusions. What appears to be identified is about five lines down, the authors say:

"We have described conditions that might help to ensure that performance measures, targets and regulatory activities support rather than hinder organisations so

you have got one factor conditions."

Next sentence:

"We have outlined behaviours that might help boards focus more effectively."

The next sentence:

"We have also set out how different leadership approaches contribute to delivering major system change."

Then the fourth sentence on what appears to be the fourth factor:

"Finally we have shown how person-centred and team-centred leadership may influence the ways in which teams work together."

Now, what do you consider to be the significant or important takeaways from this piece of work, this document?

A. I think my reading of this paper points to the kinds of -- essentially the culture that you would hope hospital board, the senior Executive Team in the hospital would set because that then filters down to behaviours and practices across the entire organisation.

And what I mean by that is if your board and your senior Executive Team are accessible, are making a point of getting out and about interacting with front line clinical staff, asking simple questions like, you know:

what worries -- what is worrying you at the moment? What could we be doing better? What are you observing that are some issues, you know, what's your top patient safety concern at the moment?

Open questions like that that allow front line clinical -- particularly clinical staff an open opportunity to report from the front line about what they are seeing and they are worried about. If you can create that style of leadership, that promotes those -- that sort of soft intelligence that allows you to detect concerning areas early and create a culture of openness where staff are free to speak up and feel heard.

Q. If we look at the next page then, page 27, which has box 6 and again summarises some of the lessons to be learned and we see they are divided into macro level, meso level and micro level.

Your previous answer I think focuses on meso level systems and organisations and micro level clinical teams and that is where you see this work being important?

A. Yes.

Q. If we go to the start of this document, please, page 7, under paragraph 2.1:

"The role of governance and leadership in quality and safety."

This is the first page of the text of the document.

The paragraphs there identify the central role played by governance and leadership in the actions and inactions relating to quality of care and patient safety. It notes that:

"That has been repeatedly identified by Inquiries and investigations into major organisational failings."

It picks up in particular on the 2002 Inquiry into paediatric heart surgery at Bristol Royal Infirmary, the final paragraph on the page refers to the Mid Staffordshire NHS Foundation Trust investigation and then right on the last line, the Morecambe Bay Maternity Services.

In your view, or the view of your members, is there a problem in healthcare in implementing and complying with recommendations made by Public Inquiries?

A. I -- I think it's true that if you look at the various Public Inquiries we have had that the recommendations tend to follow very, very similar themes. So I think the answer to your question is I would agree that there's a problem with implementing the recommendations.

Q. Would you make any recommendation to ensure that recommendations made by Inquiries are implemented, for instance should there be an Inquiries Unit to implement and monitor compliance with --

A. Sorry, I'm afraid I missed the first bit of your question?

Q. What I am interested in is whether you consider there ought to be steps taken to ensure that when recommendations are made by Inquiries, Public Inquiries, they are followed and they are complied with?

A. Yes, of course they should be complied with.

Q. Now in particular, do you consider there should be an Inquiries Unit to ensure that recommendations made by Inquiries are implemented and to monitor their implementation?

A. The answer to that question has to be yes.

But if I may, it does beg the question as to whether there is some underlying problems that mean that these, the various Inquiry recommendations, there is a problem with implementing them because I -- I know I speak on behalf of our members and I am sure this is true across the entire healthcare workforce, people come to work largely to do a really good job and to care for their patients. So if there is a problem implementing what are really important and salient recommendations from, you know, key Inquiries, then there's a more fundamental problem.

Q. Do you know what that is or you are simply identifying that there is a more fundamental problem or

are you able to help us with what that fundamental problem might be?

A. I think the honest answer is that it's very complex. But a significant problem is lack of resource and particularly lack of workforce and that's particularly true in my specialty. But I think it's fair to say it's true across the National Health Service.

Q. Yes, resources is one of the issues that you touch upon and we are going to come to that specifically in a few moments. In paragraph 12 of your statement you make the point that whilst hospital organisations are likely to have appropriate governance in place on paper to support patient safety and quality care, you have identified or the RCPCH has identified five elements that it is considered must be in place in practice on a consistent basis to meet those aims.

Now, is the inference that should be drawn there that having the appropriate governance in place on paper and actually delivering patient safety can be quite different things?

A. So the inference there is that the structures are there to deliver on patient -- on patient safety. So the theory -- the theory is correct, the structures are correct. It's the process of implementation that

needs more attention.

Q. So having the appropriate structures on paper is just really the first step?

A. Exactly.

Q. Now, the five elements that have been identified are: resource, appropriate data matrix, an established safety culture, appropriate lines of accountability and timely response; and action when concerns are raised.

If we look at the first of those, resources. You have already touched on that in your answer, both addressing implementation of Inquiry recommendations and also thresholds for noting or reporting concerns, the point that you make in your statement are that hospital services are under immense financial pressure?

A. Yes.

Q. And as a public service that is something that we would all be familiar with but the particular theme that emerges in your evidence is in circumstances where there are financial stresses, the problem for children's services is that they are not prioritised?

A. That's correct.

Q. You give as an example NHS England's 2023 Annual Operational Planning Guidance, which focuses mainly on systems for adults?

A. Yes.
Q. The point that you make is that where the performance of a hospital is going to be examined against essentially national standards which are focusing on adult outcomes, it's not surprising if within hospitals children's services aren't viewed as a priority because they are not prioritised in national standards?
A. That's correct.
Q. To read directly from your statement, at paragraph 18, you write:
"... the RCPCH observes that in general the focus in hospitals, and central decision-making and prioritisation by NHS England and Government, is on adult focused indicators, such as cancer care waiting time standards, predominantly higher volume low complexity elective care for adults, and waiting times in A&E."
A. Yes.
Q. So is the point that in circumstances where you are dealing with limited resources, if children's services aren't included, or targets which are not specific to children aren't included, in national and local standards, it's easy for them not to receive resources and to be, as you describe it, deprioritised?

A. Correct.
Q. As to the impact of that, you describe and the document reference is INQ0012295, and this is an RCPCH publication from May 2023, and here we can see the headline:
"Record High: over 400,000 children waiting for treatment amidst child health crisis".
This statement, this page going into the next page, that's your statement, isn't it?
A. Yes, yes, it is.
Q. It is a statement in your name?
A. Yes.
Q. Going back to the first page and looking at the bottom, I think this supports the observation that you make between focusing on adult outcomes sometimes at the expense of the child outcomes you say:
"We have seen considerable progress made in shrinking the adult backlog but the children's list continues to rise at an unprecedented rate. Our children are not being prioritised."
A. Yes.
Q. Over the page, page 2 of this document, the final paragraph, you express on behalf of the RCPCH, and this was a statement made whilst you were President:
"The RCPCH is deeply concerned with the

deprioritisation of children and young people in current health policy."
In your view is this record high waiting list, is this an example of a lack of resources and a lack of focus on child outcomes with the result that children's services are deprioritised?
A. Yes.
Q. Okay, we can take that down, please. Thank you.
Another example of the consequences of a lack of resource is addressed at paragraph 19 of your statement, where you refer to the significant workforce restraints, particularly in children's services and a decline year-on-year in neonatal nurse staffing.
Again, is that, as far as you are concerned, a resource issue?
A. Yes.
Q. These are problems that you consider are likely to increase, that is the impact and consequences of under-resourcing, at paragraph 17 of your statement seven lines down, you say:
"The RCPCH considers that current demands from the rising volume and complexity of health needs of children already exceeds the workforce in place to provide care and future demands on children's services is likely to

increase further as children are surviving with more medical complexity from advances in medicines and treatments."
A. Yes.
Q. If we can turn, please, to how this has an impact in particular on issues of safety, quality of care and safeguarding issues. What you say at paragraph 15 of your statement, page 5, eight lines down:
"RCPCH members generally agree that hospital management are supportive of patient safety initiatives and will support clinicians to escalate concerns about safety. However, it is more difficult to secure management support if there is a financial implication associated with taking forward an action to prevent harm or respond to a patient safety concern for example making changes to the clinical environment or recruiting additional staff."
Now, firstly, are you able to give examples of why you or your members believe management support is lacking if preventing harm incurs a cost?
A. Well, this -- I mean, this can play out in a number of different ways. I suppose firstly more broadly if we are talking about creating an environment which encourages the reporting of near misses and

opportunities to learn from patient safety examples, you need -- you need staff to take a lead for that. That requires time in people's job plans or you may need to recruit a nurse who is going to particularly focus on governance and patient safety and in other words not be clinically facing for a proportion of his or her working life.

I mean, that represents a cost pressure. Making the case for that can be very, very difficult particularly in an environment where there are significant financial constraints.

So that's on a kind of specific patient safety level. But there are too many examples of where a member of staff might go on maternity leave, the post is frozen, gaps arise, the opportunity is seen to -- it appears that the Trust see it as an opportunity to for some months not fill that gap because there is some money to be saved and those sorts of stories we hear around the country and across the clinical workforce.

And when you have got a workforce that's already working at maximum capacity actually it really matters if just one or two people are off sick or on maternity leave or have left and months drag by before they are replaced and that does compromise care.

Particularly our nursing staff are already working

at -- at extremely stretched capacities and in an intensive care environment on neonatal units nurses already look after two patients rather than one patient which is what you expect in any other intensive care environment.

So actually it doesn't take many gaps in your staffing complement for that generally to translate into a patient safety issue.

Q. Particularly on the issue of management not being supportive, where there is a financial implication with safety measures, how widespread is that view amongst your membership that they won't get management support if that patient safety measure required is going to cost money?

A. That's very widespread.

Q. Does that mindset mean in practice that your members won't raise patient safety and safeguarding issues that cost money because they know it's going to be marked against a cost, there's not going to be the management support for it?

A. I think, I think I -- I wouldn't go so far as to say that because I think genuinely a paediatric nurse or doctor who was deeply concerned about a patient safety issue of course they would -- they would -- they would flag it.

But if we are talking about creating a culture where you are looking for early warning signs, where you want to sort of embed that in the way you work, that is in other words not just being reactive to -- to safety concerns, then that's an entirely different endeavour and that does require people with time and head space to do justice to that programme of work.

Q. There are two proposals which are made in your witness statement, two measures that the RCPCH put forward. The first, ring-fenced funding to meet safety and quality needs in neonatal units and presumably the reason for ring-fenced funding is because of the issues that we have identified which was deprioritisation of children's services when they are not included in national targets?

A. Yes.

Q. The second is the appointment of a Neonatal Safety Champion and can you explain what that role is, where that person would work and what they would be doing, what difference they would make, what is a Neonatal Safety Champion?

A. So the Neonatal Safety Champion was a recommendation from NHS England in response to one of the Inquiries -- forgive me, I can't remember which, one of the maternity -- it links in with Maternity Safety

Champions, so it will have been one the maternity safety Inquiries. And the role of the Neonatal Safety Champion, as I understand it -- well, as I know it exists, is a member of staff of a level of seniority who has an ability to access members of the board, particularly the board Non-Exec Director who has -- who is named for paediatric and neonatal safety and so has a clear channel of communication and essentially the Neonatal Safety Champion would be someone within the clinical arena who is aware of -- who has got time to understand where the safety issues are, focus on them, look for themes and then have clear escalation pathways to the NED, the Non-Exec Director on the board who's named for safety -- maternity and neonatal safety.

Q. So it would be an additional role for a clinician working in a hospital?

A. Yes.

Q. It would give them access to -- easy access and clearly defined access to the board --

A. Yes, and access to data and, you know, the metrics to be able to do the job thoroughly.

Q. With a specific mandate on safety --

A. Yes.

Q. -- within neonatal care.

If we move now to the second element required to

support patient safety and quality of care, that is data and metrics. At paragraph 21 of your statement, you address that data collection and we have already touched upon this in your evidence.

Data in respect of reporting incidents focuses on measuring past harm and what you propose in your statement is consideration of data and metrics that can be helpful in assessing present safety or future safety.

Now, in this context in your statement you cite the Manchester Patient Safety Framework Tool and that is at INQ00122766. Earlier in your evidence you refer to PSIRF, has PSIRF replaced --

A. Yes, I think the Manchester Patient Safety Framework was an example of a framework but PSIRF, as I understand it, is an overarching framework that probably supersedes the Manchester one.

Q. Does it do a similar job?

A. Yes, yes.

Q. So if you can help us to understand what this framework is. We need to look first, please, at page 2 and at the bottom it's difficult to see on the screen. Well, there we go.

So the third section "Evaluation sheet sample" and we can see there are a number of measures there with rankings A, B, C, D, E.

We will look at what those ranks mean in a moment but effectively what this tool appears to propose or to comprise is essentially self-evaluation completed by staff --

A. That's correct.

Q. -- in a hospital. They would fill out this section.

If we look at page 4, they would rank each of those categories A, B, C, D, E, and that reflects a spectrum from A, pathological -- why do we need to waste our time on patient safety issues? -- to E, what's described as generative: managing patient safety is an integral part of everything we do.

So E is closer to what you described earlier in your evidence of Trusts who are proactive and have a good safety culture?

A. Yes.

Q. B is what you see in some other Trusts who were much more reactive?

A. Yes.

Q. Now, when a self-evaluation tool like this is completed, what happens, why do you consider that that's a helpful data point for assessing present and future risks as opposed to past incidents?

A. Well, I -- where I have seen it work well in

organisations that have a mature approach to patient safety, it starts as I think I have already mentioned with having really encouraging staff to have a very low threshold to complete incident reporting, incident reports, basically. And then the self-reporting exercise is essentially -- usually takes the form of a monthly meeting where all reports are looked at and themes are derived.

And within patient safety incidents there are some very common themes. In paediatrics and the neonatal world probably the commonest theme are medication errors as an example. So you may well put out a theme around medication errors. The idea then would be to dig into that theme to really understand, you know, what is going on, why is it that we have got this problem with, you know, whatever it is around administering medicines to children?

Then the critical question is: what's the learning? What do we take away from this and what are we going to do differently going forward?

So that is quite a sophisticated mature conversation with some actions that then need to be followed up on.

That is where I have seen it that would be for me that, you know, number E, that would be the mature,

ideal way in which self-assessment becomes the opportunity for developing a safer system.

Q. Yes, so is the emphasis there on it becomes an opportunity because simply having an evaluation probably isn't going to move you towards category E alone, it's just going to tell you what your staff think, but if you want to move towards category E then one of the first steps might be self evaluation to see where realistically you are?

A. Yes.

Q. But that begs the question of where the hospital is and where they want to go?

A. Absolutely.

Q. Are there other tools or measures that you would recommend that would help with assessing data that tells you about safety in the present or safety in the future beyond self-evaluation?

A. Well, there are other metrics that one can draw on to assess whether how your service is benchmarking, for instance against other equivalent similar services. So this -- this mode of, this is reacting to incident reports and self-assessment. But there are other ways in which one can develop an objective sense of how your service fits in against similar services nationally.

Q. In your statement when dealing with data and metrics you refer to three different programmes, two of those, as I understand it, are national audit programmes so we have got the National Neonatal Audit Programme, NNAP, and that's operated by the RCPCH?

A. Yes.

Q. We have then got the National Maternity and Perinatal Audit, the NMPA, which is led by the Royal College of Obstetricians and Gynaecologists but the RCPCH also contribute towards that and at paragraph 24 you deal with the Perinatal Mortality Review Tool.

Now, in broad terms can you set out what those tools do and your recommendation for more information sharing amongst those tools?

A. So I -- if I begin with the NNAP, the National Neonatal Audit Programme, this is an audit programme that derives its data from an electronic database that every neonatal unit in the country inputs into -- well, they did up until about just over a year ago.

But when -- so NNAP essentially pulls data from a platform that is called BadgerNet which up until about a year ago every single neonatal unit in the country was entering their data into and it derives -- it's an audit programme that then reports every three months, so

there's a rapid, you know, response time and turnaround time for clinicians to be able to interrogate the database in order to be able to see where my neonatal unit fits compared to other neonatal units, or in fact the whole country.

It reports around 10 outcome measures which are -- which are everything from mortality to, you know, how well we are establishing breastfeeding rates to are parents present on Consultant ward rounds? There are a range of outcomes that are reported through that audit programme and there's a very high level of clinician buy-in so it is a trusted resource.

Because it reports every three months it actually genuinely can, you know -- again if you have got a service that's interested in how it's performing or maybe worried about how it's performing, this is a programme that they can go to in real-time to understand actually how well or not they are doing.

I am caveating it slightly because with the rollout of electronic health records across the NHS, many Trusts are having to abandon the BadgerNet platform because it doesn't speak to the electronic health -- speak as in a computer IT sense speak to the BadgerNet programme.

So --

Q. So they are unable to upload their data to ...

A. The data doesn't, yes.

So some Trusts would double-enter their data so some poor soul at midnight each night has to enter manually into the Badger system in order to produce the NNAP return but actually many Trusts can't spare somebody to do that and if they have now got an electronic health record they won't be completing their audit collection for NNAP. So that's that is a very serious missed opportunity now because NNAP really, really has got an opportunity to be a lever for improvement.

Q. Has a solution been identified for how to work with BadgerNet records?

A. No.

LADY JUSTICE THIRLWALL: Was the problem identified before?

A. Yes.

LADY JUSTICE THIRLWALL: So it was foreseeable, foreseen and still --

A. It was. I mean there are many databases that don't speak to these electronic health records but because of course there is a national move to move away from paper notes to electronic records, that has been prioritised over the --

LADY JUSTICE THIRLWALL: The data collection.

A. -- smaller local audit programme.

LADY JUSTICE THIRLWALL: Yes.

MR CARR: What is likely to happen? Is NNAP going to -- is it likely to be abandoned or is it going to have to be adjusted so it can read electronic ...

A. It would be a disaster if it was abandoned. There is -- there are fixes but there needs to be -- somebody needs to prioritise it and create -- find some fundings to create a patch. But the problem is because there are numerous electronic health records being bought by NHS Trusts, it is not like it is a single electronic health record that needs to devise a single patch to speak to this BadgerNet platform. This is going to have to be done piecemeal across many systems.

Q. NMPA, the National Maternity and Perinatal Audit, does that do a similar thing, but ...

A. Yes, I mean, in the neonatal world we don't tend to use that nearly as much because it is much more maternity-focused. But of course the Royal College of Obstetric and Gynaecology are of course collecting data around newborn outcomes because that informs our practice. That is not actually a tool that we as paediatricians will be using in practice.

Q. One of the issues that you identify both in respect of these audit tools but also more generally is

data flow between maternity and neonatal services being inadequate. You make the point as between these two tools but, as I understand it, you also make the same point in terms of in hospital, so maternity data not being transferred or made available to neonates and you recommend that there are appropriate links between the two.

Now in practical terms, what is it that you would propose? Is it not just a case of handing over the records from one unit to another?

A. Well, so for instance NMPA, which is the second audit programme that we have mentioned there -- actually, if that was a maturer audit programme, that actually could fulfil precisely that outcome. So because we don't want to separate mothers from babies, we want to be able to think about them holistically and if you really, really want to improve care both for term babies but particularly preterm babies, you do need to look at them as a single entity. So actually NMPA, and the reason why we as the Royal College of Paediatrics and Child Health are so invested in NMPA, is because we -- we value that cohesive data collection and would like to see it become as mature as the Neonatal Audit Programme is or was until recently.

Q. So when you are talking about data sharing

between maternity and neonatal, it is for the purpose of analysing for these sorts of tools rather than actual clinical care being given to patients?

A. Yes. And I have to say on the positive side these electronic health records that Trusts are rolling out actually are allowing mothers and babies' notes to be closely linked. Certainly as a neonatologist, I can interrogate in a huge amount of detail any one of my patient's mother's notes. So that is an advantage of these electronic health records.

Q. So easier at a micro level but problems at a macro level --

A. Yes.

Q. -- because of the auditing systems?

A. Yes.

Q. Finally the PMRT, the Perinatal Mortality Review Tool, what does that do that NNAP doesn't do and what do you see as the significance of --

A. Well, so PMRT only looks at death whereas NNAP is looking at mortality but also quality of care across a number of parameters. So of course analysis of death gives us a lot of learning opportunities. So yes, it is a really important tool but it's addressing a different set of questions. PMRT looks at essentially 20 weeks gestation through up until 28 days of life, should the

pregnancy give rise to a live birth. It then stops at 28 days. So NNAP goes on throughout the neonatal admission but PMRT will stop at 28 days.

Q. It sounds as if it gives you more information that that is relevant to mortality?

A. Yes, and thinking much more around the causes. So that interacts much more with the pregnancy and outcomes very early on in life.

Q. Staying with then data and metrics and although not touched upon in your statement, there are a number of different organisations to whom deaths have to be reported. MBRRACE PMRT collects information the Child Death Overview Panel. What's the view of the RCPCH as to these parallel reporting obligations?

A. So with respect to death, we have -- we have a requirement to report to our Child Death Overview Panel, so that is CDOP, we also have a requirement to fill out PMRT which feeds into MBRRACE which is the maternity death and confidential Inquiry database.

They -- so when a baby dies one is inputting information to both those systems. They are asking -- of course they are both curious about the death but they are asking very different questions, some of which you can sort of see a bit of relationship but they kind of diverge off into different directions.

It would be much more efficient if somehow they were aligned. But they are funded separately. You know, the CDOPs are funded by local government and they report their death data into the National Child Mortality Database, whereas PMRT is part of MBRRACE, it is much more of a research tool. It was set up as a research tool. It's entirely different to the CDOP process which is a statutory process.

So they are not at all well aligned and hence the -- you know, the need for dual reporting.

Q. Does the RCPCH consider that there is inefficiency in having to report the same thing in many different ways?

A. Yes.

Q. In respect of the Child Death Overview Panel, are there any particular observations that you have as to the benefits and working of that system?

A. So the Child Death Overview Panels have been in existence for some years now and of course the healthcare landscape has changed a lot in that time and I am thinking particularly of the introduction of integrated care systems.

So the geography, what would be ideal is if each integrated care system had one CDOP process. Because if we really want -- if we believe in the integration of

other healthcare systems, and actually at RCPCH we really do believe that integration is a really important tool for improving child health outcomes because understanding children in your geography, in your place, allows you to think about them in a unique way and understand how you can improve children's health and wellbeing.

So what would be ideal would be if the CDOPs, you know, literally linked directly to an integrated care system and spoke really closely to it but we -- we haven't got into that place yet because the ICS came into being after the CDOPs were set up.

Q. Thank you.

If we can move to your third element, an established safety culture.

At the end of your paragraph 25, you state:

"The RCPCH has concerns that patient safety policies are not being implemented effectively because safety culture is not always embedded in hospitals."

What are the barriers to embedding safety culture, is it the point that you have already made in respect of resources or are there additional barriers?

A. I -- it is partly resources but we also know that in places there may be racism, there may be bullying and undermining, and these are all barriers to

A. Yes.

Q. The key part of it, it seems -- but tell me if I am wrong -- is page 2, the second paragraph, when looking at assessing culture, there is reference there to second sentence:

"Within the MatNeoSIP programme in England a comprehensive safety culture, SCORE, Safety, Communication, Organisational Reliability, Engagement survey took place across all maternity and neonatal services between 2017 and 2018. There were plans in place to repeat these surveys."

So that looks again like some form of self-evaluation tool to assess culture.

Is this the reason that you have cited this document?

A. Yes. I mean, I think it's the document in totality which is essentially suggesting a number of different tools. I mean, they mention for instance trainee feedback surveys which is another really valuable way of getting insight into your kind of services, culture and so on. Trainees who rotate around the region and don't have a vested interest necessarily in your service are often much freer to speak up so they provide a very important kind of resource to kind of illuminate areas where perhaps you might need to focus

people essentially having psychological safety to be enabled to speak up about, you know, the kinds of unsafe practice they might be observing in their day-to-day clinical practice.

Q. So toxic work environments essentially?

A. Yes.

Q. You have referenced in this section of your evidence at your paragraph 26 the British Association of Perinatal Medicine guidance to support service Leaders. We can get up the document if necessary, but that appears to be another essentially self-evaluation tool, the SCORE system.

Is that similar to the Manchester Patient Framework, but just with a different focus -- a similar tool but a different focus?

A. I believe so. I'm afraid I would have to look at it, but --

Q. We can get up the document you have referenced, it is INQ0012282. What you describe in your statement is that:

"The British Association for Perinatal Medicine has developed guidance to support service leaders and healthcare professionals to understand and evaluate its culture in neonatal care ..."

Then you have cited this document?

attention on improving culture.

So I think the totality of this document is just about providing ways in which services might be able to assess their workplace culture.

Q. For completeness, so you have referred to trainee feedback surveys which is on that page. We also see in the paragraph that follows robust reporting mechanisms. If we go to the final page of that document, page 3, it describes in -- forgive me, page -- the final page of the text, page 3, second paragraph refers to specific scales to examine interprofessional working?

A. Yes.

Q. So it's all of the measures described in this which you think can assist in improving safety?

A. Yes.

Q. When you describe then in your statement at paragraph 26, that front line healthcare staff could be made more aware of these tools, it's all the different tools in here that you are saying should be communicated or should be within the awareness of front line healthcare staff?

A. Yes.

Q. Now, you conclude this section by commenting that the RCPCH are supporting BAPM with a call for the

appointment of a national Neonatal Safety Champion to work alongside the champions for obstetrics and midwifery.

Now, does it follow from that that there were already Safety Champions for obstetrics and midwifery, National Safety Champions for obstetrics and midwifery?

A. My understanding is that they are -- well, the last time I -- my understanding is that the two -- the Chief Midwife and the National Clinical Director for women's are acting as co-National Maternity Safety Champions.

Q. Are these different to the Neonatal Safety Champions that you described earlier --

A. They would be, yes.

Q. -- which would work within hospitals and have access to boards?

A. Yes, so that would be within every organisation you would have that.

Q. So this is a single national --

A. Correct, yes.

Q. What would they do, what would they achieve?

A. Well, that national oversight would allow, you know, all Trusts to feed into a single -- a single person. I think also a Neonatal Safety Champion working closely with the Maternity Safety Champions actually

start providing that kind of more comprehensive thinking around the continuum of maternity and newborn care and the safe delivery of that care and it means also that the baby doesn't get forgotten. Because so often -- and I do understand this. And many of our maternity inquiries, the focus has been very much on the mother for very, very good reasons.

But the -- it is often forgotten that there is a baby and particularly if that baby has been born early that actually they have very specific needs and safety issues are paramount. So it's just about, I guess, parity of mother and baby and keeping the baby central to the safety message.

Q. If we look, please, at your fourth element, "Appropriate lines of accountability up to Board level". The point that you make here is that your members are confident using existing mechanisms to escalate safety and risk concerns within paediatric departments but where there is a lack of clarity is how that risk is going to be managed and beyond the paediatric department and the reporting responsibilities to board level.

What is recommended it appears to address this, is a children's lead at the highest level of every NHS organisation?

A. Yes.

Q. So can you elaborate on what they would do and how that would help to address the lack of clarity on managing risks emanating from the paediatric department?

A. So yes, we have advocated for a named Non-Executive Director on every acute Trust board as well as a named member of every Integrated Care Board -- sorry, a named lead for children on every Integrated Care Board.

And this is because we have seen so many examples of where children and babies essentially slip between the cracks and so unless somebody is speaking up for thinking about children, they often get forgotten or deprioritised. I think, you know, there is an assumption that children are generally healthy and well and don't need the kind of level of focus that we know they do.

I think particularly as the landscape around the kind of care we are delivering for children in this country is changing, and complexity of care is increasing as not only is it risky but actually these children deserve a profile that is on a par with adults.

Q. Again, to be clear, this would be different to a Neonatal Safety Champion?

A. Well, ideally you want somebody who speaks up for all children. I don't think we would -- we

definitely wanted. So, for instance, my own Trust the -- the -- that person reporting to board level would be speaking on behalf of all children and babies. I don't think we are necessarily suggesting duplication of roles -- but that person needs to be clear that they are responsible for articulating the safety concerns of babies and children because they may be in different departments.

Q. Your fifth element, which is related to your fourth element, is timely response and action when concerns are raised. So the fourth element was appropriate lines of accountability.

You reference there the lack of clarity when safety concerns are raised by paediatricians. In your fifth element, you describe the fact -- and this is your paragraph 30 -- that where safety and risk issues are raised by paediatricians, there is rarely communication back to describe what actions are being taken or what the timelines are, there is a lack of clarity about who's responsible for responding to concerns?

A. (Nods)

Q. You identify that there is no national standard setting out when patient safety concerns should be responded to, in what time or in a timely and proportionate manner. Is that a recommendation proposal

that you on behalf of the RCPCH make?
A. It is, and if we had the structures in place, along the lines of a clearly named board level member speaking, you know, with a remit for children and children's safety, then that would be the obvious vehicle to try and deliver on clarity around escalation of concerns for children in an organisation and a kind of reporting back mechanism.
Q. So what you are -- what you would be proposing is a national standard which identifies that where risks or concerns are raised by paediatricians, this is the person who should deal with it, this is the time frame in which it should be dealt with and communicated back to the paediatrician?
A. Yes.
Q. You identify and explain that the system as it is at present with a lack of response, that can undermine the confidence that a paediatric department has?
A. Yes.
Q. That deals with your five elements in respect of governance and management structures.
There are two further points you deal with in your statement, the first is professional regulation and what you identify is that there are a significant number of

different regulatory organisations or organisations with regulatory influence.
Do you have those paragraphs?
A. Yes, sorry.
Q. Paragraphs 31 to 33. In particular you cite a paper from the BMJ, it is INQ0012289, the title is.
"Patient safety regulation in the NHS: mapping the regulatory landscape of healthcare."
It has the useful chart if we can go to it, please, it is page 5 of the document. If we can rotate it, if that's possible. There we go. This sets out what this paper identifies and you have cited in your statement the 126 organisations exerting some regulatory influence in the NHS.
A. Yes.
Q. Now, as acknowledged in the paper, a significant number of these bodies are not regulators. So, for instance, we can see there is a section, there is a box underneath the word "Trust" in the middle "Royal Colleges" and your organisation, the RCPCH, would not consider itself a regulator?
A. Yes, that's correct.
Q. But the point made in this paper is that there can be organisations that have regulatory influence because they are concerned, as the RCPCH is, with

patient safety and they seek to influence standards and with their external legitimacy they exert what is described as regulatory influence on provider organisations?
A. (Nods)
Q. Now, if we can go to the conclusion of this paper, please, at page 8., it is on the right of the page, that there are two broad points that are made, one the regulatory system in -- of the NHS has evolved, so it's not been created by design, and it is suggested that it is not fully understood, even by professional regulators and it's very difficult -- impossible is the word used -- for the general public to navigate the system and that there is a suggestion that the overall impact of the regulatory system hinders its effectiveness.
Now, this appears to be a point that you are echoing in your statement. What is the position of the RCPCH in respect of professional regulation and what proposals do you make?
A. Well, I mean, regulation is important so we are not suggesting that isn't the case. But I think when you have such a kind of I guess bewildering landscape and actually since this paper has been published, I think there already it's now inaccurate

because other groups have superseded some of them, so (inaudible) my world is now Maternity and Neonatal Safety Inspectorate which is a group of -- branch of CQC, it's constantly evolving and I think we -- in a perfect world, it requires somebody or a body to have a fresh look at it all and try and create some clarity because and almost certainly there will be some redundancy or overlap within these numerous structures.
I think for the --
Q. I think the -- forgive me, sorry, carry on?
A. I think for the individual clinician or group of clinicians who may be worried about safety in their own environment it is -- it is perfectly conceivable they really wouldn't know where to go to for help.
Q. So the concern is confusion on the part of the professionals who have to use these regulators. Is their concern that the number of bodies in that confusion means that you are at risk of having issues fall through the cracks?
A. Yes.
Q. Is the proposal that there should be consideration of harmonisation and improving efficiency --
A. Yes.
Q. -- of the regulatory landscape.

We can take that down. Thank you.

Regulation of senior managers. You deal with this at paragraphs 34 and 35 of your statement. You identify that the RCPCH has already expressed support for regulation of NHS managers. It did so in response to the Inquiry -- the Northern Ireland Inquiry into hyponatraemia-related deaths, INQ0012287. It is a joint response by a number of organisations as we can see there from the first page, and it is page 15 of that document.

As I understand it, it's under 5.1, specific recommendations. In response to Recommendation 55, it says we agree -- Recommendation 55 is that:

"Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives."

The response is:

"We agree this recommendation is a starting point but strongly advise that new models of regulations and accountability to assess the performance of medical managers and Trusts should be developed."

So that is the section that you are citing in your statement; is that right?

A. Yes.

Q. The RCPCH's position is that there ought to be regulation of NHS managers?

A. We -- we don't have an established position as such. We -- in light of Justice O'Hara's findings, we were supportive of it but that, but there is an active consultation happening at the moment and we will be contributing our viewpoints to that.

Q. Does the RCPCH have a view as to the impact that regulation of managers would have on patient safety?

A. I think our view is that, you know, doctors and nurses are regulated. And because -- as the health service has developed into a very complex ecosystem, we now know that our managers who are not nurses and doctors actually are making really key decisions for instance around resource allocation and so on that are as germane to patient safety as the kinds of decisions I might make as a clinician and therefore it does seem anomalous that they are not regulated. But we also recognise that doctors and nurses have clear training pathways and the opportunities to regulate possibly are clearer and more straightforward.

So, you know, I don't think we are pretending that this is a straightforward outcome to achieve but it certainly, we will be participating in the consultation

because we do think there is value in thinking about this very carefully.

Q. Moving away from your statement, and I am getting towards the end of my questions now.

I want to address first the issue of safeguarding and particularly given your experience that you have in teaching paediatricians. A feature that has emerged from the evidence that the Inquiry has heard is that whilst there is safeguarding guidance Working Together to Safeguard Children, statutory guidance, there was not a referral to the Local Authority Designated Officer as soon as possible concerns of deliberate harm were suspected and even when the RCPCH reviewers went in, obviously included some experienced paediatricians, this issue of safeguarding guidelines, referral to the Local Authority Designated Officer, does not did not seem to be engaged with.

What is the level of understanding of raising safeguarding concerns amongst paediatricians when those concerns relate to fellow members of staff?

A. So safeguarding is a core activity for all paediatricians and all paediatricians and children's -- anyone working directly with children have to undertake what is called Level 3 Child Protection Training and there is a curriculum that's been developed and that is

actually mandated by every Trust and we are required to, you know, revalidate it every three years.

So -- but the-- this case having highlighted the deficiencies and people's understanding of the role of the Local Authority Designated Officer in looking at our Level 3 Safeguarding Training, actually that is not referred to. So it is the case that for most paediatricians, they will actually not have heard of a Local Authority Designated Officer.

Q. So hitherto, that wasn't -- that didn't form part of the Level 3 training?

A. That's correct. And unless you were a named doctor for child protection, in which case you would undertake Level 4 Child Protection Training, or a designated doctor, which is Level 5 Child Protection training, there the role of the LADO is part of the training but that is a small subset of paediatricians.

Q. Yes. So that is a deficiency on the training --

A. It is.

Q. -- because the statutory guidance makes clear it should be read by everybody working in healthcare with children. Has that now changed, has that deficiency been addressed?

A. It hasn't changed yet but it -- it will.

Q. When?
A. Well, as -- I -- I will take that away and action it with the College as soon as possible.
LADY JUSTICE THIRLWALL: Perhaps you could give us an update on that when that's been done?
A. We can, yes.
MR CARR: A related issue, and again it arises from statutory guidance, Working Together to Safeguard Children, although there are also local guides on it, Sudden Unexpected Death in Childhood, so SUDiC guidelines. There seems to be or seemed to be at the time at least a level of confusion as to whether those guidelines applied to sudden deaths in hospital rather than in the community.
Again, what is your understanding as to the teaching of when SUDiC guidelines apply, if they should apply in hospitals, and has that changed as a result of the events at the Countess of Chester?
A. So it -- I think it's true to say that up until very recently the teaching and our curriculum has not highlighted Sudden Death in Infancy and Childhood well enough. That has been remedied because we have an outcomes-based curriculum which is very easy to update, so that has been updated.
That's not enough. So we are now actively working

with e-learning for health, which is an online learning platform, NHS learning platform, to create an online resource, and as a College, we will be providing a bespoke course.
Q. What support and/or training is given to paediatricians or guidance as to their communications with Coroners? Is that something that forms part of their training, the duty to communicate fully with Coroners, raising concerns with Coroners and communicating with pathologists, how does that feed into the training?
A. It's certainly part of the neonatal sub specialty curriculum. Neonatology is a specialty that deals with a lot of death and so it is -- so we have a requirement, for instance, for our trainees to attend postmortems, be familiar with and have undertaken the full completion of the recording and reporting of death including interaction with the Medical Examiner, thresholds, speaking to the Coroner; that is absolutely part of neonatal training.
Q. Would you expect neonatologists to know the difference between a forensic postmortem and a non-forensic perinatal postmortem, is that something that you would anticipate neonatologists knowing the difference between and knowing when to request one

rather than the other or would that be left to the Coroner?
A. I think -- I mean, all doctors know -- should know the difference between a forensic postmortem and a standard postmortem. Truthfully in the neonatal world, I have not come across that specifically. But that -- the crucial step in any postmortem discussion is around having the conversation with either the Coroner or the pathologist around what the clinical question is.
So I am not trying to hedge your question. Because I -- I probably wouldn't use the word "forensic". But that doesn't mean that if I have got some very specific questions that I wouldn't be on the phone discussing it with the person performing the postmortem so that they know what the clinical uncertainty is.
Q. So where there are particular concerns, direct communications between the neonatologist and the pathologist is something that should in your view occur?
A. Absolutely.
Q. The final question that I have, please, is in respect of leadership training. So the RCPCH plays an important role in educating paediatricians. Within neonatal units, within paediatrics, there are clinicians who will rise to take up leadership roles.
Does the RCPCH provide specific training for those

roles and are there any recommendations that you would make in respect of the approach to training for leadership?
A. Our new curriculum now has formalised leadership as one of the learning -- it is a core curriculum outcome for anyone completing training to the level of a Consultant paediatrician.
And there is a whole kind of sub-curriculum that goes with that. For paediatricians who wish and take on formal leadership roles we offer a variety of resources and have an ongoing continuum, you know webinar -- type leadership professional development series and then in addition most Trusts will put on leadership development programmes and then we signpost to organisations like the Faculty of Medical Leadership and Management who have, you know, very -- very expensive but very good courses.
Q. The courses are very expensive?
A. Yes.
Q. Are they funded by the Trust or are they funded by the individual?
A. Well, all Consultants will have a study leave budget, but my experience is most of these courses are way in excess of your annual budget so yes, most people end up paying for themselves.

MR CARR: Dr Kingdon, thank you for answering my questions.

My Lady, those are all the questions I have.

LADY JUSTICE THIRLWALL: I think we have got questions from Mr Skelton first off.

Questions by MR SKELTON

MR SKELTON: Dr Kingdon, I ask questions on behalf of one of the Family groups. Can I just ask you a little bit more about the SUDiC process, if I may?

A. Yes.

Q. It might help if I have on screen INQ0016484, can I ask you these questions with both your hats on, so your Consultant neonatology hat and your past President of the Royal College hat, if I may?

A. Of course.

Q. So this is the guidance I think which was -- is from your hospital although I think it was October 21 to October 24, so it may in fact have been superseded recently but I think it is still probably representative. If we go to page 3. It will probably have to be expanded a bit but if we expand the top -- that is it -- left, you can see the notification process which now includes the Medical Examiner system?

A. Yes.

Q. And down at the bottom left there is the

unexpected child death aspect, if you can move it down and the Joint Agency Response or JAR which we have heard a lot about. Can you see that? I appreciate it is quite small, bottom left?

A. Yes.

LADY JUSTICE THIRLWALL: Bottom right, I think.

MR SKELTON: Sorry, bottom right. Sorry.

Now, I don't know whether you were here this morning for the evidence of Dr Fletcher?

A. No, I'm afraid I wasn't.

Q. Is it your understanding that the Medical Examiner process can run in parallel with the Joint Agency Response or are they separate and one takes precedence?

A. My understanding is that both are both well, they run in parallel.

Q. So a child -- so many of the children as you know suddenly deteriorated at the hospital --

A. Yes.

Q. -- without medical explanation, so on the face of it they would meet the criteria or at least one of the criteria for JAR, a Joint Agency Response; is that right from your perspective?

A. As a -- if I am answering as a neonatologist, so if these are babies on a neonatal unit who suddenly

deteriorate --

Q. Without it being expected, and die?

A. That's not an uncommon scenario on a neonatal unit. Preterm babies can deteriorate very suddenly and it may be that you don't get the explanation until for instance potentially a blood culture result comes back which may be after death. So it's not uncommon to have an unexpected death on a neonatal unit.

Q. So the scenario in this case is that the children were stable and not expected to suffer collapses or deteriorations and then they didn't respond appropriately to resuscitation, which caused alarm on the part of the paediatric team for obvious reasons.

So can I just be clear, is that not the type of scenario that you would envisage falling within the SUDiC criteria?

A. I wouldn't, no.

Q. You would not?

A. It's -- it -- but for a baby to be on a neonatal unit they are -- they are not normal healthy babies. So -- so and we know that, for instance, infection, a nasty complication of prematurity in relation -- in relation to the gut, can strike very, very suddenly and lead to unexpected death. So the -- we -- we would always discuss with the Medical Examiner.

I am afraid I don't know how often the JAR would be activated in a preterm baby that had collapsed on a neonatal unit.

Q. Dr Garstang who gave evidence who works in Birmingham and is also a safeguarding Professor --

A. Yes.

Q. -- she said that in her jurisdiction, if I can call it that, the SUDiC process would be triggered automatically for a death of a child in hospital because you need to do every -- a belt and braces investigations for every child no matter whether you -- no matter what their background and it involves -- without judgment it involves a multi-agency approach and you can rapidly presumably rule out foul play and things like that, but it is from the start that process needs to be triggered and followed through. Dr Brearey, the lead neonatologist at the Countess of Chester, didn't take that approach. Dr Subhedar in Liverpool and Alder Hey didn't take that approach.

So it is clear there is quite an inconsistency of view. It may be felt that in the context of this Inquiry that the Dr Garstang approach is the safest approach?

A. That might be -- might well be correct. I don't know if Dr Garstang is referring to a neonatal

unit, she may be talking about death within Birmingham Children's Hospital which doesn't have a neonatal unit.

Q. So as far as you are concerned, you would not see it as being appropriate, would you, to trigger?

A. I am not saying it is not appropriate I. Am saying I am not surprised the other people you mentioned wouldn't have thought of activating it.

Q. It may be felt that it is something that ought to be changed --

A. It may well be.

Q. -- that children that die in hospital, and even neonates who are by definition very small and very unwell, still need to have that form of investigation in order to exclude causes of death which wouldn't otherwise be identified including foul play; do you understand that?

A. Oh, of course I do, yes.

Q. The existing guidance, both I think the joint guidance that Baroness Kennedy was involved in, which involved your College and the Royal College of Pathologists and the national guidance that the Cabinet Office produced on the CDOP, Child Death Overview, doesn't make that presently clear either that children have to be investigated under JAR or SUDiC if they die in hospital or particularly neonates who suddenly die

unexpectedly.

Is that something that needs to be considered by the two Colleges and/or HMG?

A. Well the -- the joint, the Kennedy guidelines, as they are called, actually are out of date and --

Q. Yes.

A. -- in need of updating and if this sounds like a topic that would be perfect for a focused piece of work and collective thinking about -- about, you know, that would be something that could be undertaken in the -- in the update, although there isn't a plan or funding to do the update as things currently stand.

Q. If the SUDiC process doesn't apply and the benefits of the SUDiC process are obvious, it is a joint response?

A. Yes.

Q. It involves a degree of independence, it involves other organisations externally like the police or the Coroner, but if that doesn't apply how would the existing processes of death investigation that you apply say in your own hospital pick up concerns about foul play unless somebody stepped up and, as it were, whistleblew?

A. So I think it can be difficult and quite frustrating. So at the moment, the advent of the

Medical Examiners is definitely a step in the right direction because it's another clinician that one can speak to about a cause of death, but the world of neonatology is very specialised now and I think most of our Medical Examiners are adult trained clinicians. So to expect them to have the kind of degree of knowledge and for me as a neonatologist to be able to have the kind of detailed conversation, you know, when I am really troubled about what could have happened that triggered this child's death I think is expecting quite a lot of -- of clinicians who are dealing with all deaths in a busy, you know, general hospital.

So I think in a perfect world an advance on the current Medical Examiner system might be to have regional either Neonatal Medical Examiners or at least Paediatric Medical Examiners so people with specific training around death in childhood or death in the newborn period.

Q. Dr Fletcher, the Chief Medical Examiner --

A. Yes.

Q. -- this morning I asked him some questions about the need for a Paediatric or Neonatal Medical Examiner, a specialism on the basis that there are physiological differences with children which don't appear in adults and also there are safeguarding

vulnerability issues. Could you explain your own justifications for having a specialist Medical Examiner?

A. Well, I suppose it goes back to my -- you know, when you were speaking to me about sudden death on the neonatal unit. The signs that can lead up to a catastrophic collapse in a newborn can be very, very subtle. And so it -- one not infrequently can be in a situation where a baby has collapsed very unexpectedly, where you have got some suspicions about what might be might have led to that death, but you are really wanting to you are look at it in more detail. It might be that you actually want to get the Coroner involved but maybe the Coroner's threshold wherever you are working, the threshold to react and take on the case is not quite -- isn't aligned with yours.

So to be able to have a Medical Examiner who has got that degree of appreciation, I think it's quite a tall ask of somebody who's probably predominantly looking at death in frail elderly people and so on.

So I think there would be huge mileage to having people with particular expertise within child health.

In my own organisation we have one Medical Examiner who is a paediatrician but if it is a day that she is not rostered to work, we don't have access to that level of expertise.

Q. One of the counterarguments I think Dr Fletcher put was that there are lots of medical specialties, cardiology, neurology, orthopedics and all sorts and people die from all sorts of complex medical reasons which require specialist knowledge?

A. Yes.

Q. The generalist Medical Examiner will be well aware that there is a need for specialist input to their investigation. Why can't they obtain that input from a neonatologist or a paediatrician, why do they need to have a specialist knowledge themselves?

A. Because -- well, I would argue it is because I am talking about 20% of the population, I am not talking about cardiology, you know, which is a specialty, I am talking about the complexity of all diseases in children.

I mean, we train for eight years to become paediatricians. I think it's -- it -- it you have got to be able to understand everything from a, you know 22/23 week gestation preterm baby and all the complexities of that all the way up to a 17 year old. I think, with the greatest respect to the National Medical Examiner, that is a very tall ask of a Medical Examiner and I think we really, really want to understand child death and understand when it needs, for

instance, escalation to the Coroner, we do need to have resources that allow us to have those kind of conversations.

Q. You have mentioned escalation to the Coroner. What is, as far as you are concerned, the threshold when a neonate dies in a hospital setting for getting the Coroner involved?

A. Well, from the -- from the clinical perspective, the threshold is you can't explain you -- actually can't think of what the cause of death was. For me, that would be the trigger to have a conversation with the Coroner.

It depends on the Coroner you speak to. Some will -- you know, one you will end up having a conversation with, explain what your clinical question is and they will undertake to look at the case. But there will be others that are of the view: well, preterm babies die and put prematurity as the cause of death.

Q. Going back to the SUDiC criteria. I focused on the unexpected death but the death without medical explanation, would that also trigger a SUDiC process? Not only was it unexpected but immediate analysis doesn't provide an explanation for why the child has died medically?

A. Certainly in -- in the -- as things currently

in practice, it doesn't go down. We don't tend to go down the JAR/SUDiC approach. I think, you know, we recognise that sometimes we can't explain why small babies die, we have a suspicion. A lot of the investigations we do with small babies are problematical, so, you know, you might be considering sepsis as a cause for a baby's sudden collapse but actually, you know, when you have got a 600-gram baby, the volume of blood, you have sent the laboratory to look for signs of sepsis may have been inadequate so you are left with not the full picture of investigations.

I'm afraid it is -- it is not uncommon for there to be a degree of clinical uncertainty as to the precise reason why a particular baby collapsed and died.

Q. I understand that --

A. But it is usually in the context of a very at risk situation.

Q. I understand that. The difficulty is in the context of this Inquiry that that very uncertainty creates an opportunity for those that want to kill a child without it being spotted. Obviously some of the children were injected with air, some of them with insulin, and that was not picked up by any of the investigative processes while the babies were being looked at internally in the hospital or indeed in the

Coronial system.

So I am trying to understand how that can be stopped using the existing mechanisms, the Medical Examiner, the SUDiC process or the Coroner, and it does certainly require paediatricians such as yourself to engage those systems, doesn't it? So the criteria need to be satisfactory for that?

A. Yes. I -- I agree. And, I mean, it might be that we need to rethink with the Medical Examiners the Coroners, the SUDiC guidelines, how, you know, what the triggers would be for us to activate all three of those or where the Medical Examiner alone is, you know the single person that we discuss the case with.

Q. The second issue I would like to ask you about is just support for the paediatrician who has concerns. As you may know independently it appears several of the senior paediatricians and possibly some of the junior paediatricians started to suspect there was some form of harm taking place at the hospital but they were very isolated at least for a period of time and I wonder if there is a role for the Royal College supporting the paediatrician who finds themselves in that situation.

So someone that needs advice on what to do and the reason that support might be required is that it is now infamously known that the whistleblower may suffer huge

consequences personally and professionally for raising concerns and the Speak Out process is very valuable but hasn't necessarily provided the support that some doctors have needed in order to get themselves heard.

I wonder if there should be some advice given to your members on a helpline, what to do if you have concerns, who to contact, and the support that could be provided and associated with that?

A. As a membership organisation I -- I -- I can see that we would, could should have a role in this. I -- I would struggle to imagine how a Royal College would for instance offer a hotline that was available 24 hours a day. I don't think, well -- Royal Colleges don't have the resources for that kind of activity.

I do slightly beg to differ on -- I do think the Freedom to Speak Up Guardians and the Guardian of Safe Working, which is the member of -- every acute Trust has a Guardian of Safe Working for trainees, junior doctors, to escalate concerns to. Where they work effectively they are an incredibly valuable resource and they do provide confidential -- they are a confidential resource and certainly in organisations that take Speak Up seriously, the Freedom to Speak Up Guardians have direct reporting to board level.

My own sense is that these things are best dealt

with locally. But I am not saying that as a Royal College we couldn't be there to signpost people to resources, you know, because it is perfectly possible for an individual doctor to literally not know who to turn to for help and I think Royal Colleges do understand the landscape better.

Q. I think that's the issue, certainly it is clear the Speak Up policy will work if it is implemented effectively with robust internal governance, et cetera. It's just the advice to those who find themselves in a very isolated situation internally who are nevertheless in need of help?

A. Yes. Yes.

Q. Thank you. Lastly, an open question. You have been asked a lot about your thoughts on future changes and you have talked about data and you have talked about various other things. Are there any other aspects of other policies or governance relevant to this Inquiry that you would like to identify as being in need of change?

A. I think it probably comes back to a theme that we endlessly go on about at the Royal College of Paediatrics and Child Health which is around the importance of children and babies in the thinking and the priority setting of the NHS and each Trust. We

know, for instance, that when it comes to workforce planning, planning for expansion in the child health workforce is often on the back burner.

There are often assumptions made that because for instance our national birth rate is stable now that that means that actually attention focuses on the ever-increasing number of frail elderly in the population and that has meant that the degree of attention that I think needs to be paid on children and babies isn't there. Advances in medical care mean that we are looking after more and more vulnerable newborn babies, babies are surviving what were previously not survivable conditions so the complexity of the work and the care we deliver is rising exponentially and resources and focus hasn't kept up with that.

So -- and I think many of my responses around safety champions and reporting to the board directly come from a place of -- come from a place of sensing that actually -- Bliss, the baby charity, talk about "weigh less, worth less" and I am afraid on the ground it feels like that. Just because you have got a small baby in an incubator that somehow they don't need -- why would a critically ill baby need its own nurse in an intensive care unit, whereas on a children's intensive care unit or an adult intensive care unit it would be

entirely unacceptable not to have one-to-one nursing. Yet in neonatal intensive care units we almost never get one-to-one nursing and that is because it is simply not seen as a priority or they are just little. So of course a nurse could look after two critically ill newborn babies and their traumatised parents.

So in relation to -- this is an ongoing battle that we have around the importance of seeing these as human beings that are just as worthy of attention and resource as any other members of the population.

MR SKELTON: Thank you.

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton. Ms Scolding.

Questions by MS SCOLDING

MS SCOLDING: Dr Kingdon, you know who I am, so I have just got a couple of rounding up questions for you about some of the issues that have been raised by Mr Skelton and Mr Carr. The first one is about capital funding for neonatal units. One of the things that's come out very strongly in the evidence is that in effect the neonatal unit at the Countess of Chester was literally "out of sight, out of mind", both inadequate in terms of the accommodation it had, and also far away from the rest of the hospital, or so it was perceived.

Is that something which is uncommon or common in

respect of neonatal units and does that vary depending upon whether one is looking at a Level 3 unit, a Level 2 unit or a Level 1 unit?

A. It's not uncommon. It's a slight sort of quirk inasmuch as neonatal units have to be co-located with maternity services so they are not invariably not co-located with paediatric services.

Q. Yes.

A. And there's something about the fact that they are separate that means they are often forgotten. And I think that's particularly true out of hours, and I think, you know, as neonatal doctors and nurses, we are obsessed with hand washing and hygiene and we tend to restrict visiting, so I guess we don't exactly welcome people because our patients are very vulnerable so we -- so they are often these isolated little units with locked doors because you can't have access to just anybody and so they are "out of sight, out of mind".

Q. Right. In respect of capital funding, are there any current proposals? I know the RCPCH has made various proposals in needs of expanding cot numbers in the UK generally and/or aligning cot numbers with the regional units. Has there been any promise from NHS England or is there any prospect of any capital funding in order to expand units where appropriate

and/or upgrade units when they are old and in need of some better facilities and equipment?

A. There, there -- the caveat to that is that you haven't got staff to open more cots, it is pointless having any more cots. So because we have never achieved the British Association of Perinatal Nursing standards, I would have anxieties about brave ambitions to open many more cots because you can't put babies into them.

I have to say the advent of the neonatal ODNs -- Organisational Delivery Networks -- of which there are now ten across England, and there are similar structures in Scotland and Wales and Northern Ireland, has come with funding and so in the last less than five years there has been an injection of capital, this is since the Ockenden review and Kirkup review, so linked to maternity inquiries. And so there have been more resources made available and some attempt to think across networks and around where care is best delivered and sort of the streamlining of what we call, you know, Level 3 which is the intensive care Level 2, which is the local neonatal unit and Level 1, you know, the kind of the way the networks are structured. Attention has been -- more attention has been given to that.

Q. You have mentioned the BAPM standards in the answer to that question and we have heard a lot about

that during the course of this Inquiry, mainly that the Countess of Chester Hospital didn't need the BAPM standards, but that in reality no other hospital in the relevant locality met the BAPM standards. Is that still the picture across the picture, that very few versions meet the British Association of Perinatal Medicine standards for staffing?

A. Certainly if you are thinking -- depends what level you are talking about. For intensive care, yes, absolutely.

Q. None of them do?

A. I don't think any do.

Q. Right. Okay.

A. Which is -- that is one-to-one nursing for every intensive care baby, no.

Q. No.

Okay, can I ask in respect of the NHS published a Workforce Plan last year in 2023, did that include any enhanced roles either for paediatricians or for nursing staff with the paediatric or neonatal speciality?

A. No. There was 0% increase in children's nurses planned.

Q. Okay. Can I also ask: one of the more recent introductions has been introduction of Martha's Rule which I think the Royal College has welcomed in respect

of openness and candour.

Can you tell us what the Royal College's slight concern is about the operation of Martha's Rule? I mean, obviously Martha herself was a child, she I think was 12 or 13.

What the -- what the implications are for the implementation of Martha's Rule in respect of paediatric care?

LADY JUSTICE THIRLWALL: Neonatal care.

MS SCOLDING: And neonatal care in particular?

A. So Martha's Rule essentially is the opportunity for a concerned family member or patient, but in our world family member, to request a speedy second clinical opinion. So this is not a form of second opinion. It is: I am really worried about my child who isn't as well, nobody is listening to my concerns on the ward. I would like somebody to come in essentially with a fresh pair of eyes.

So in an adult setting, the way Trusts are delivering on Martha's Rule is essentially using their Critical Care Outreach Teams to visit the bedside and undertake that fresh pair of eyes review.

That's extremely difficult to deliver in both either a paediatric and certainly in a neonatal -- on the postnatal ward setting because you can't expect an

adult critical care nurse, for instance, to come to the bedside of a three-day old baby and deliver a clinical review. So there are major issues with delivering on Martha's Rule for children's services across the totality and particularly in a newborn setting.

Q. How could that particular problem be solved, in particular as obviously the rule was invented because of the death of a child in an acute setting?

A. So currently the three different approaches are being piloted for children's services. And actually the three models are quite interesting, I am sure you don't want to go into the details here. And they have been given an opportunity to report back as to whether they were effective or not.

But you are essentially dealing with, you know, significant workforce constraints. We have only got less than 20 paediatric intensive care units in the entire country so there is no way this can be delivered by Paediatric Critical Care Outreach Teams except potentially over a phone where you can phone your local paediatric intensive care and have a conversation over the phone and they potentially send a team round to assess the child, but that seems a -- that has major resource implications.

So I think in all my conversations with the Patient

Safety Commissioner and other senior people at NHS England, there is a recognition that this is extremely difficult to deliver in children. But we have to test out ways in which we can potentially make it work.

Q. Okay. There's been a number of discussions amongst the paediatricians who have come to give evidence in Part B about the fact that they were having to do the vast majority of their kind of worry time, thinking time, outside of their sessional time. In other words, they were doing it in their own time. Is that something which is common across the board in respect of paediatricians or is that something that was particularly unusual at the Countess of Chester, that the time that they were given for kind of oversight time, guidance time, thinking time, training time, was woefully insufficient for the work they actually had to undertake in those respects?

A. That is ubiquitous.

MS SCOLDING: Thank you I have no further questions my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Ms Scolding.

MS SCOLDING: Thank you.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Dr Kingdon, just if I can ask you about a couple of the matters you were being asked about by Mr Skelton, in particular.

You were describing the differing approaches of Coroners to the information that you might give them over the telephone as to whether there is to be a Coroner's investigation. I assume that is what you were describing?

A. Yes.

LADY JUSTICE THIRLWALL: I think you said it depends on the Coroner's threshold.

A. Yes.

LADY JUSTICE THIRLWALL: I think what you described, I want to make sure I have understood this correctly, would be a conversation between you or another doctor in your unit with the Coroner who was not really interested in how a very premature or how a premature baby had died and so it would end up being resolved as: premature baby died from being premature.

A. (Nods)

LADY JUSTICE THIRLWALL: Which seems quite unsatisfactory. But would that conclusion be come to without a postmortem or would there be a postmortem and then that discussion?

A. So it would be -- that conclusion would be

come to without a postmortem.

LADY JUSTICE THIRLWALL: Without, yes?

A. It's, it's -- we always counsel families about the value of a postmortem and in fact, you know, I am very fortunate where I work, sometimes the pathologists are happy to come and talk to families as well. But it is true that the uptake of hospital postmortems is very low in our practice.

And so if you then -- so if you can't encourage the parents to consent to a hospital postmortem, and the Coroner doesn't agree that it's met the threshold for a Coroner's postmortem, you are left in a situation where you actually don't have another means to formally explore, you know, the clinical questions you might have to really understand why a baby might have died.

LADY JUSTICE THIRLWALL: And I suppose -- perhaps I shouldn't suppose, but in that situation, I am assuming there is no even remote possibility that there may have been foul play in that situation?

A. Truthfully that isn't something that we typically think about inasmuch as the babies we look after have only ever been in hospital, so although as paediatricians we think a lot about safeguarding it's usually in the context of coming through the front door of A&E.

LADY JUSTICE THIRLWALL: Yes.
A. So, yes, you are right, the threshold to think about harm is not, you know, very high.
LADY JUSTICE THIRLWALL: Yes, understood. And you are at the Evelina I picked up from the various documents we have looked at?
A. Yes.
LADY JUSTICE THIRLWALL: I am assuming is that a Level 3 or a Level 4.
A. Level 3.
LADY JUSTICE THIRLWALL: So how many cots have you got?
A. We have 20 intensive care, 12 high dependency and 15 low dependency beds.
LADY JUSTICE THIRLWALL: Thank you. And I am assuming then that babies come from sort of all round --
A. Yes.
LADY JUSTICE THIRLWALL: -- London and wherever else?
A. Yes.
LADY JUSTICE THIRLWALL: Am I right to assume this has sort of been said, but since I have got you here and I wasn't expecting to, are the babies as a general rule overall more sick babies than those in a Level 2, than those in Level 1. Obviously it sort of rather depends

where the baby comes -- at what stage the baby comes into you but assuming it's in the very, very early stages of life, do you have the sicker babies than a Level 2 would have?
A. Oh, yes, there are very strict rules about what a Level 2 unit -- what kind of baby a Level 2 unit can look after and when they need to refer the baby out.
In a perfect world, we have -- the mother is identified as having a difficult pregnancy and the mother will deliver with us. But of course nature doesn't always work like that and so if a mother does end up delivering at a Level 2 unit or a Level 1 unit then we have a Regional Transport Service that brings the baby in to us.
LADY JUSTICE THIRLWALL: Yes. Thank you.
One question which you touched on without giving any numbers, but you mentioned that you deal a lot of death in your unit. So are you able to say, is there a sort of general level of the number of deaths that there might be in your unit over the course of a year?
A. Yes. It obviously varies.
LADY JUSTICE THIRLWALL: Of course.
A. Where I work we have a lot of babies with complex congenital cardiac disease, complex other congenital anomalies and so these are not just preterm

babies that are dying, I don't want to give you the idea that preterm babies die as frequently as -- so we on average will have between three and seven deaths a month but then we are seeing a subset of extremely ill babies. The numbers would be much lower in another Level 3 unit, for instance, that didn't have --
LADY JUSTICE THIRLWALL: That complexity.
A. -- cardiac or the other complexity.
LADY JUSTICE THIRLWALL: Then presumably lower in a Level 2 as a general rule?
A. It would be usual -- the less intensive care they are delivering, it should be more and more unusual to have maybe more than one death a month or even fewer than that.
LADY JUSTICE THIRLWALL: Yes. Thank you, that is very helpful.
Now, you were asked some questions about the regulation of senior managers and in your statement you suggested we might like to ask some other people what their views were about it but I understand from the evidence you have just given that the College is going to be making its submission in relation to the consultation.
A. (Nods)
LADY JUSTICE THIRLWALL: Now, without wanting to

tread on toes, it would be helpful if -- what is the deadline for the consultation? I have just forgotten it.
A. It is end of February.
LADY JUSTICE THIRLWALL: End of February. Thank you. That might work out quite well in terms of timing. I wonder whether consideration could be given to providing the Inquiry with the broad thrust of your views as they have been developed by that stage.
A. Yes.
LADY JUSTICE THIRLWALL: I don't want to take you by surprise but I am just flagging it and then obviously the legal team will have a look at it but I hope it is nothing too controversial to suggest that you might want to send that to the Inquiry.
A. Yes.
LADY JUSTICE THIRLWALL: Since you are obviously in the process of developing your thinking in a way that perhaps hadn't been anticipated.
A. Yes.
LADY JUSTICE THIRLWALL: Thank you. Those are all my questions, anybody want to ask anything else? No.
In that case, Dr Kingdon, thank you very much indeed for coming and you are free to go.
We will take a break now and start again at quarter

past 4.
(3.59 pm)
(A short break)
(4.15 pm)
LADY JUSTICE THIRLWALL: Mr Bershadski.
MR BERSHADSKI: Yes, if I could please call Mr Newman, my Lady.
LADY JUSTICE THIRLWALL: Mr Newman, do come forward.
MR TONY NEWMAN (sworn)
Questions by MR BERSHADSKI
LADY JUSTICE THIRLWALL: Do sit down, Mr Newman. I'm sorry you have had a longer wait than you were probably told to expect but I had assumed that you would rather give your evidence today.
A. Yes, please, if that is okay.
LADY JUSTICE THIRLWALL: Of course it is, yes, thank you. Now, Mr Bershadski.
Questions by MR BERSHADSKI
MR BERSHADSKI: Could you confirm your full name for the Inquiry please.
A. Tony Michael Newman.
Q. Mr Newman, is it right that you have made two statements for the Inquiry, the first dated 3 June 2024 and the second dated 1 November 2024?

A. That's correct.
Q. Are those statements true and accurate to the best of your knowledge and belief?
A. Yes, they are.
Q. If we could just start off with a bit of background, Mr Newman. Is it right that you worked for 33 years for the Post Office?
A. That's right.
Q. And that you have a Masters in Security and Risk Management?
A. That's right.
Q. You initially joined the NMC in April 2015; is that correct?
A. That's correct.
Q. You were first a senior project manager, but were then promoted to the position of adviser in the Employer Link Service, a regulation adviser in the Employer Link Service?
A. A regulation adviser, that's correct.
Q. That was in May 2016, is that correct?
A. Yes, that's correct.
Q. And is it right that you still hold that position today?
A. Yes, I do.
Q. Could you just briefly describe the purpose of

the Employer Link Service?
A. So the Employer Link Service was established from the Francis Inquiry into the Mid Staffs health failings and the primary purpose of the service is to develop relationships with employers, to do with anything to do with their professional regulator, but predominantly fitness to practise.
And one of the key functions of the service is that we offer an advice service to employers to call if they have got any emerging concerns, to have a discussion about what the regulator would like to see in terms of local action or whether it needs to be referred to the regulator or it doesn't meet the threshold for referral.
Q. And you explain in your first statement at paragraph 4 that when you receive a call, you speak to somebody who rings you up, there are three basic options you have at the conclusion of the call, and that's the first is to advise them to make a referral to the NMC, the second is to advise them not to make a referral and the third is to advise to investigate or manage locally, is that correct?
A. That's correct. That's how the advice service was initially established with those three outcomes.
Q. Broadly speaking, what are the criteria for giving somebody advice to refer?

A. So it would be based on the seriousness of the allegation, first and foremost, and then we would explore some information about the response of the individual, whether it's a nurse, a midwife or a nursing associate, to understand if they have developed or shown any insight, if they have reflected on the concern and whether if needed whether they strengthen their practice.
So we would consider all of those aspects in providing the advice as to whether it needs to be referred or not.
Q. Is it right that one of the important consequences of advising an organisation to make a referral to the NMC is that that triggers the power of the NMC to ensure that, for example, a nurse who poses a risk to patient safety isn't able to work?
A. Yes, we can restrict their practice initially at a very early stage while the investigation is ongoing. That's referred to as an interim order.
We could remove them from the register while the investigation continues or we could allow them to carry on practising but with some form of restriction.
Q. Is it correct that all of those powers that you have just outlined they are only available to you if they -- once there has been a referral, is that correct?

A. Absolutely, yes, that's correct.
Q. So it follows from that, does it, that if no referral is made then the NMC doesn't have any power to take any of those steps?
A. We don't have any statutory powers, that's correct.
Q. Is it correct that therefore the decisions that the NMC makes, including that initial decision about what advice to give, they are potentially hugely important in protecting patients?
A. Definitely, yes. I mean, there are some serious allegations that come through the advice line service and there are some really low-level calls that we receive where it doesn't meet the threshold.
Q. If we could just cover some background first to the call that you had with Alison Kelly.
Is it right that you received an email from Alison Kelly at the Countess of Chester Hospital on 4 July asking to have a call with you because she was aware that somebody else she knew had spoken to you and found a call very useful?
A. Yes. So part of the initial purpose of the service was to reach out to all of the directors and nursing across every single NHS Trust in England in the first year, so that we made contact with all of them to

make them aware of what the service was.
And I visited -- I can't remember the name of the Trust -- but I visited another Trust that operates on the same site and that particular Director of Nursing found the meeting so useful that she wrote to all the surrounding Trusts, which is where Alison Kelly picked up that email and made contact with us.
Q. Thank you. If we then go on to discuss the call that you had with Alison Kelly on 6 July. If we could just put up, please -- the best note that we have of that is an email that you wrote on the same day summarising the phone call to Alison Kelly and that's INQ0002965, and if we go straight to page 4.
Now, is it correct that this version that we see on the screen in front of us is a version of, firstly, an email that you typed up but then with some corrections that Alison Kelly made to it two days later?
A. That's right, she made some minor corrections.
Q. So where we see strikeouts and yellow, those are Alison Kelly's corrections, is that right?
A. That's right, yes.
Q. Now, if we just go through this note. We have essentially a series of bullet points which summarise the discussion, which, for some reason, appear as question marks in this version. You are told by her

that the Trust has seen a rise in mortality of babies on the neonatal unit, is that right?
A. That's right.
Q. Did you make any enquiry when told that as to the extent of the rise in the mortality?
A. I would have asked if there's any reason for that rise.
Q. So you would have only asked for the reason in the rise, but not the extent of the rise; so you didn't know, for example, what was a normal or average mortality rate and what the mortality rate had become?
A. No, no numbers were quoted.
Q. Just to understand that. Did you ask and not receive an answer, or did you not ask at all about how great the increase was?
A. It's probably unlikely I asked that question.
Q. Can you just explain why that would be. It would seem that if somebody's told you there's been an increase in deaths that one of the potential follow-up questions is, "Well, what do you mean?"
A. I would have asked what that meant, but I wouldn't have asked specifically for numbers or averages or what that meant in terms of what is normal and what is unusual. I probably wouldn't have gone into that level of detail at that time.

Q. Is this sort of issue, an increase in deaths, would it be fair to say that that's probably at the top end of the sort of spectrum of potential seriousness of the kinds of concerns that would come through to you on the Employer Link Service?
A. Potentially. It really does depend on the cause and the reasons. It could have been something that's completely innocent, it could be something obviously we now know is a lot more sinister.
It would depend on, really, the -- I mean we can only investigate individuals. So if there is a specific allegation or information that says an individual could have caused deliberate harm that would be at the highest level of concern for us.
Q. Yes. Well, let's carry on going through the list. So the second point is you are told that each death has been the subject of a clinical team case review, the third point is reviews have produced no evidence as to a lack of competence by individuals or the team and the fourth point is that further analysis has identified one registrant that has been present at nearly all these incidents and, fifthly, some clinicians are concerned that the registrant may present a serious risk to public safety, although no evidence is available at this time.

Now, taking those five points together, is that not precisely the sort of potential concern that you have just identified in your previous answer, which is that there may be a connection between deaths and an individual?

A. Yes, but the way it was positioned was that there was one person, the initial analysis had identified that there was one person, which is Lucy Letby, that was just present at all of these particular incidents.

Q. Yes.

A. Not all, but nearly all and that, as a result of that, her presence, some clinicians were concerned.

Q. Yes.

A. And that was the level of the information.

There wasn't -- there was never an allegation that she could be causing deliberate harm or that there was serious negligence. It was simply the facts that were presented in the first four bullet points.

Q. Well, if we just unpack that a little bit.

What you recorded in that fifth bullet point is that some clinicians are concerned that the registrant may present a serious risk to public safety and, at the same time, you are being told that there is no evidence as to a lack of competence.

So putting those two things together, isn't the obvious inference that in effect some clinicians think she may be killing babies?

A. Yes, which is why I took the time to actually record the conversation, which in the eight years I have been doing this job, I've never done since because I just really wanted to establish in writing exactly what I was told during that call.

Q. Had you ever taken that step prior to?

A. No.

Q. So it's the only time in your entire time with the Employer Link Service, which is around eight years --

A. That I have done that.

Q. -- eight and a half years, that you've ever done this?

A. Correct.

Q. Wouldn't that suggest that this is at the very top of the level of concern in terms of calls that you receive over your whole career in this service?

A. It crossed my mind, which is obviously why I followed it up in writing.

At the time, I think this was probably only the second call that I ever took on the advice line. So there is quite a intensive three-month induction and

then you are allowed to operate the advice line service on your own and I think this, this could even have been the first. It was definitely one of the first or second calls that I ever took.

So it was my uncertainty as to the level of risk at the time which probably caused me to follow up in writing.

Q. Do you think that you were affected in how you dealt with this call by the fact that it was so early on in your time in this role?

A. I think so. I did actually follow it up with a conversation with a colleague that had just joined the team at the same time that I knew was a very experienced lawyer in the Fitness to Practise directorate and I ran exactly the same information past him and he basically said that he agreed with the advice and that, at the moment, without any evidence or any further information to suggest that she does pose a risk the advice would be to manage locally or investigate further.

Q. So just to be clear. You had already come to the view that the appropriate response was to advise to manage locally --

A. (Nods)

Q. -- because that's the advice you gave straight away on that call and then you subsequently had the

correctness of that advice, as you saw it, confirmed by a colleague?

A. Yes, that's right.

Q. Okay. Can you just explain to us, given that this is at the top level of seriousness, why is it that you didn't take the most serious action, which would be: make a referral to us because that would trigger our powers to keep the public safe?

A. Because -- and it was confirmed at both the meeting and afterwards which we refer to as a peer review and benchmarking, which is another part of the governance process -- it would have just gone into our screening stage and just sat there because of the lack of information or evidence.

We wouldn't be able to take any action. We wouldn't be able to consider it for an interim order without further information or evidence of deliberate harm. So we were in a really difficult situation whereby if we advised to refer and there wasn't enough information or evidence to provide that advice, we would know full well that it would just sit in our screening section without any action having been taken.

Q. Is it really right that an allegation by -- well, the clinicians that you were told about that had these concerns, were you told that they were Consultants

because the Inquiry has heard evidence from people who were on this call that you were told that they were Consultants?

A. I wasn't told they were Consultants at the time.

Q. Are you sure you are able to recall a telephone call?

A. I probably would have put "consultants."

Q. Okay.

LADY JUSTICE THIRLWALL: I think you had put "the Trust", hadn't you?

A. Oh, I put "the Trust", yes.

LADY JUSTICE THIRLWALL: And that was corrected to "some clinicians".

A. It was corrected to "clinicians", yes.

I can't recall if it was specifically mentioned that they were Consultants. The suggestion is that I put "the Trust", it's managers in general.

MR BERSHADSKI: Yes. So surely a concern that's raised with you of such gravity isn't one that the NMC would or should allow to sit in a screening process without any action being taken?

A. Well, there wasn't an allegation. There was not an allegation that Lucy Letby caused deliberate harm or even through gross negligence caused the death of

these babies.

Looking back at it now, it seemed like it was an initial enquiry to maybe test the waters with the regulator because we'd just introduced this service where you could have this pre-referral discussion and obviously knowing Alison Kelly's evidence, you know, information was withheld at the call.

Q. Yes. But you have just agreed that the essence of what you have been told is that there is a concern that a nurse is killing babies and it's not due to incompetence. So, how does that square with the suggestion that there are no allegations being made? I mean, in fact, it's a very serious allegation that's being made, isn't it?

A. There was no allegation made on the call. Alison never said to me, "We suspect she could be deliberately harming babies." Had she said that, that would have set off all sorts of alarm bells and we probably would have said, even with a lack of evidence because we would recommend that they contact the police, we would recommend a referral at that time so that we could contact the police.

But there was never any suggestion that she caused deliberate harm in that call.

Q. Well, if we look at your last bullet point, it

reads, if we include Alison Kelly's corrections:

"The Executive Team are due to meet today 6 July 2016 to decide if this registrant will be reported to the police to investigate."

I mean, you have got one registrant who is present at nearly all deaths, some clinicians are concerned that she presents a serious risk to the public. Mortality has increased and they are considering referring that person to the police. What could all of that together be other than an allegation of deliberate harm?

A. The suggestion is there, but there was never any mention of that during the call.

Q. Well, isn't it an allegation from those clinicians who consider that she poses a serious risk of harm? It's a suggestion.

A. It's suggestion, yes, without any evidence to support it or additional information that would allow me to make a decision to refer.

Q. So is it the lack of what you see as additional evidence or of particular evidence that drew you to the feeling that it wasn't an allegation rather than the fact that the allegation is not made itself if you see what I mean?

A. It is both. There was no allegation and there was no evidence to support.

Q. What evidence would you expect at this stage of deliberate harm by a nurse before you would consider advising to refer?

A. Information or evidence that she could have caused harm that could have resulted in death, witnesses, that would be the type of information and evidence we would look for.

Q. Well, she clearly could have caused harm because she is present at nearly all deaths and there has been an increase in deaths and some clinicians think it is her and they are considering referring her to the police.

So clearly that first part of your test is met that it could be her, isn't it?

A. Yes.

Q. So are we then left with just the lack of eye witnesses?

A. The lack of evidence that will allow us to take action, yes.

Q. Well, how are you in a position to judge whether there is evidence against her or not if there hasn't been an investigation yet at this stage?

A. That was why the advice was to investigate first.

Q. But doesn't that mean that there isn't any

power to stop her in the interim period from continuing to practise and therefore possibly to harm more babies? If you don't make a referral at this stage and you just wait until a local investigation?

A. Sorry, can you repeat the question?

Q. Well, doesn't the approach of "investigate locally first" mean that there isn't an ability to stop the person from working whilst that investigation is going on and therefore potentially harming more babies?

A. With -- with most local investigations you would expect some sort of restriction on practice while the investigation is ongoing.

Q. But how would such a restriction on practice in a local Trust prevent that person from potentially working as a bank nurse, an additional shift at another Trust or leaving the Trust altogether and working elsewhere?

A. It would be a real trigger point if they left employment for that organisation. We would probably ask them to refer because they lose their ability to manage the situation locally to investigate without the registrant being present. There's opportunities to work bank or agency, we would expect the Trust to try and restrict that practice as well. There is a lot of emphasis on local resolution and local investigation.

Q. Is it not entirely misplaced to rely on a local investigation when you have got such hugely serious allegations being made because you don't know what kind of local investigation it would be, how well equipped people are at the Trust to undertake a local investigation, you have got no idea of those sort of matters, do you?

A. No and at the time, we didn't to be fair, no. We didn't have any idea about the quality of the local investigations.

Q. I think in opening statements to the Inquiry, counsel for the NMC suggested that the key priority of the NMC is the protection of patients?

A. (Nods)

Q. Is it not entirely contrary to that to not in such a serious situation advise to refer to the NMC so that it can immediately consider restricting that person from practising?

A. Well, the key aspects of the Nursing and Midwifery Council is to protect the public but in order to do that we need clear information and evidence to restrict someone's practice.

Q. Well, have you done anything here to go and obtain that evidence like saying: well, somebody needs to meet with you immediately to look at rotas, to go

through all the case records, et cetera?

A. So the emphasis was put on the Trust investigation.

Q. But I go back to that point. How is it adequate to put the emphasis on a local Trust investigation when you don't know how well equipped they are, how objective they are, how qualified they are to undertake investigation of that seriousness? How does it accord with patient safety to rely on such a huge unknown?

A. Even if we did recommend that a referral comes into the NMC we would wait until the Trust had concluded their investigation, without knowing the quality of the investigation, we would wait for them to provide us with information and evidence that was achieved through the local investigation and obtained through the local investigation.

So I understand what you are saying, how can we leave the burden or responsibility down to NHS Trusts? But that's simply the way it was then and it still is, to a certain extent, but we provide Trusts with a lot more advice and guidance about what we consider to be a really good robust local investigation and all the things you need to consider. But at the time that just simply wasn't there.

Q. Well, do you think if there is any possibility that this would still be the outcome today, is that a gap in the NMC's ability or processes to protect patient safety?

A. If we had a call like this today, the actions would be very different.

Q. Well, let's turn to that issue, if I may. I think you are aware that the Inquiry was provided with a document from the Employer Link Service team which suggested in essence that the actions today would not be any different. You are aware of that, aren't you?

A. Yes, I am, yes.

Q. You have looked at that document in preparation for giving your evidence today?

A. I did.

Q. That's right?

A. Yes.

Q. That document references you by name --

A. Yes.

Q. -- doesn't it?

A. Yes.

Q. Were you shown that document setting out concerns before it was circulated?

A. Yes, I was. But I didn't contribute towards it. I understood that when the initial statement by the

NMC was read out in the first week of the Inquiry the team had some concerns about some of the remarks in the statement suggesting a criticism of the team and how we reacted.

I think what we were trying to suggest in that statement -- and I didn't contribute towards the statement because it conflicted somewhat with my own personal statement, but obviously I was bound by the confidentiality of the Inquiry so I couldn't disclose that -- it was -- it was that the decision would still be the same, but what I am trying to suggest is the actions would be different.

Q. When you say the decision would be the same, that's the decision to advise investigate locally rather than advise to refer?

A. Yes.

Q. So that is what we are really concerned with, because as we discussed previously, it's the advice to refer which allows the NMC to protect the public?

A. Yes, that's right.

Q. So the very essence of the decision would still be the same today?

A. It would, because we didn't have the evidence to support any restriction of their practice or to even recommend a referral to the NMC?

Q. Again when you say "we didn't have the evidence", is it correct to say that what you mean is you didn't have eyewitness evidence?

A. Eyewitness evidence, or clinical notes that suggested that that individual was the person responsible for causing harm, whether it was deliberate, or accidental, or negligence. It's a combination, but essentially eyewitnesses is the most powerful evidence.

Q. Was the notion that you required eyewitness evidence before advising somebody to make a referral where there is a suspicion of killing babies, is that something that you were trained on, that particular types of evidence were required or was it contained in any particular guidance document that you were applying?

A. It would be in the screening seriousness guidance that we had available at the time.

Q. In the screening seriousness?

A. Yes. So it's what evidence does the screening team need to have available to consider it for an interim order which is an immediate restriction on someone's practice. So we would base our advice and decision using that as well.

Q. Was there any suggestion in this call by Alison Kelly or anybody else on the call because Sue Hodkinson says she was also on this call which you

can't recall, was there any suggestion by either Alison Kelly or Sue Hodkinson that these clinicians were -- didn't genuinely believe that there was a risk that this person was deliberately doing this?

A. So I wasn't made aware Sue Hodkinson was on the call. Had I been aware, I would have recorded it in the notes, because it's not unusual for someone else to be joining the call which we always allow.

Sorry, could you just repeat the question?

Q. Well, was it ever suggested to you -- let me put it this way: did Alison Kelly give any opinion of her own as to the motivations of the clinicians that were raising these serious concerns?

A. No.

Q. She simply said: there are clinicians who have serious concerns?

A. She said they had concerns.

Q. Okay. Do you think that it is a serious gap in the NMC's screening seriousness guidance that it requires specific evidence of an act before advising to refer in a situation like this because specific evidence might not be available until you conduct the investigation, do you see what I am saying?

A. I see what you are saying but equally we got a lot of allegations from employees and members of the

public that could be serious on face value and we can't restrict every nurse's practice based upon a straightforward allegation. We need evidence to do that.

LADY JUSTICE THIRLWALL: I think we have perhaps explored that sufficiently now.

MR BERSHADSKI: Yes.

LADY JUSTICE THIRLWALL: Can I just ask something before you leave it. You mentioned a number of times a local investigation and I just can't quite see where that's recorded here. There is reference to the police report and a subsequent action and then another advice call.

A. So it would have been provided verbally on the call and then when I record it on our system, I would record the outcome of that advice which was to investigate locally first.

LADY JUSTICE THIRLWALL: So it is not in the emails, it is not that I have missed it.

All right, thank you.

A. No, it doesn't appear so, no.

MR BERSHADSKI: Just to follow up on that if I may, my Lady.

Why would that not be included within your email summary?

A. I don't know. It's not something that, as I have said earlier, I have ever done in the eight and a half years I have been doing this job since -- and I suppose it would have been useful right at the bottom would be -- to summarise my advice would be to investigate locally. That would have been useful, yes.

Q. Now, you mentioned that you discussed this call with somebody in the Fitness to Practise Team. Was that on the same day as the call took place?

A. It was directly after the call.

Q. Is it right that your advice also went through a benchmarking process?

A. Yes. So first of all, it goes through what we call a peer review process which is other regulation advisers looking at the details of the call and either agreeing with the advice or challenging the advice.

So it went through peer review initially, which is with the team and they agreed with the advice. Then it goes as part of the governance process to what we call a benchmarking meeting, which also includes senior lawyers within the screening team and they again agreed with the advice.

Q. So would you have been present during that benchmarking process?

A. Present during both meetings, yes.

Q. Were any clinicians or people with a clinical background also present at the benchmarking process?

A. So in our team at the time there was an ex-NMC registrant, she may well actually have had NMC registration at the time and that was the only clinical person that was on the call at the time that I am aware of.

Q. So somebody probably who had a nursing background?

A. A nursing and midwifery background, if I recall.

Q. And midwifery, yes, thank you.

Is it right that you chase Alison Kelly for an update about this issue on 23 August?

A. That's right, yes, I think it was the day after the benchmarking meeting I took an action to follow up with Alison Kelly.

Q. Why did it take that period of time, so it's around a month and a half, why did it take that period of time before you chased for an update?

A. I think it is just the structure of our governance. So the peer review I think took place a week after the call and these are all scheduled well in advance for the whole year and then the benchmarking would have followed I think probably another two or

three weeks after that.

Q. You receive an answer -- if we can go to page 1 of the same document that is on the screen. You receive an answer from Alison Kelly on 31 August; is that right?

A. Yes.

Q. And she tells -- she says to you that we undertook a thorough internal review, nothing of significance was identified. You are told also that following discussion with our board and on receiving views from our clinicians the step was taken to place Lucy Letby on non-clinical duties working in a corporate team.

Is that the first time that you were told that some step had been taken to remove Lucy Letby from clinical duties?

A. From recollection, yes.

Q. Now, is it right that at the initial call on 6 July you didn't give any advice to Alison Kelly around removing Lucy Letby from clinical duties?

A. That's right.

Q. But you were told that she was on leave --

A. Yes.

Q. -- during that initial call but presumably you didn't know when she would be returning from leave?

A. No.

Q. Now, would it have been possible for you to give general advice of that nature in how to manage the concern at the time?

A. We probably would do now because of our strength and guidance on good local investigations, but at the time that wasn't available. So it would have been very unlikely I would have been allowed to give that type of advice.

Q. Well, you did advise her to inform you of any action that was taken regarding the police?

A. Yes.

Q. So there wasn't anything stopping you giving general sensible advice?

A. There's nothing stopping me, no.

Q. No. Is it just something that you didn't think about at the time?

A. I don't -- as I said, I don't think we had the guidance in place. I mean, about a year later we introduced the new Fitness to Practise Strategy which put a lot of emphasis on local resolution and it was at that point that employers were starting to contact us to say: well, what do you mean by a good local investigation, which prompted us to spend a couple of years on putting together some best practice guidance.

So it just wasn't something we considered at the time.

Q. So by 31 August, you now know that Lucy Letby has been placed on non-clinical duties as a result of these clinicians continuing to have their concerns and that further reviews were going to be conducted. Should that not have prompted at that stage a concern on your part: well, this issue hasn't been resolved, there is still a risk that she could go and be, if not doing shifts at this Trust, doing shifts at another Trust and therefore we need to get a referral in to prevent that risk from happening?

A. So it looked at the time as if the Trust were taking the right steps to protect any future risk by removing her from clinical duty and it's often a good thing to do to remove people from their role so it doesn't influence or affect a good local investigation. So that would seem quite a natural step to remove her from clinical duties while investigations are ongoing and manage the risk.

Q. But again that doesn't remove the risk in any other location, does it?

A. No. It -- I probably would expect the Trust to tell us if they thought this individual was working locally as an agency nurse or on another Trust Bank

service and if they knew that they probably would restrict her practice at the time as well.

Q. Okay, but you don't tell them to alert you?

A. No.

Q. As to any such development?

A. We ask the question now and it could be my inexperience at the time as to why I didn't ask it at that point.

Q. Now, the next conversation that you have is when you attend a meeting -- thank you, that document can come down off the screen now -- with Alison Kelly and Sue Hodkinson on 29 November; is that right?

A. That's correct.

Q. If we go to that, INQ0002447, page 6. We can see that's the second item in your note of the meeting. We discussed in detail the issues from the advice line call conversation in July. Were you given more detail at this point as to the nature of the allegations against Lucy Letby or why the clinicians had the concerns they did?

A. No. It looks as if I was told that the neonatal unit had been downgraded, obviously that would have restricted a number of children they were caring for because of the increase in mortality so that was new information.

They had commissioned a review, an independent review and following the initial feedback that there was no immediate risk to patient safety.

Q. So you can't recall being given any more detail than what's contained in that note, is that right?

A. It's very unlikely I was given any more detail. I probably would have tried to capture everything that was discussed even if it's a summary.

Q. As far as you were aware, the clinicians that had raised concerns still had those concerns?

A. Yes, they were still there.

Q. So did you at any point, whether on the previous occasions that we have discussed, 6 July, the email correspondence in August, did you ask for, "Well, why is it that the Consultants are saying this?"

A. I would have asked the question. But the information obviously wasn't forthcoming because I would have made a note of that either in the initial call or at the meeting that was held a few months later.

Now we would probably explore the context more, you know, the culture. Often maternity departments have a multi-disciplinary team cultural issue with doctors and nurses, the midwives. We probably would explore that now. But, no, I didn't at the time ask

specifically what their concern was other than ... But then there was no information to suggest anything at the time.

Q. Do you think looking back on it that you should have done?

A. Yes, and I would now given the same call.

Q. The reason you would now, is that because of updated guidance that is in place or is it because of your experience?

A. It's a combination of both. We've strengthened the service. There's a lot more detail taken on the calls now. Obviously I am a lot more experienced, I have had eight and a half years worth of advice line calls.

The relationship with the Trusts also has been strengthened significantly, which allows -- we have got a really good working relationship with all my Directors of Nursing, so if they have got concerns I know that they would be able to call me and talk about confidential matters, open and honestly, when looking for advice.

So it's a combination of all those factors.

Q. Is it right that fundamentally the process hasn't changed significantly from July 2016 to now? So for example you have given some examples that you can

now input more data and more coding regarding conversations that you have. I mean, that doesn't change the nature of the advice you give, does it?

A. No, but we explore a lot more detail. We ask a lot more information about the individual, their response to the concern. We explore context, you know, "What were the staffing levels? What's the equipment like? What's the culture like?"

And we would look for much more evidence of local resolution in terms of what did their investigator/investigation uncover? What action has been taken?

So the actual fundamental principles of the service remain the same, but we explore an awful lot more and probe for a lot more information on today's calls than we did at that time.

Q. Is there any different evidential threshold for allegations like this now compared to back then?

A. No.

Q. I'm going to ask you a few questions now about a different topic, about interim orders.

I appreciate that after the 29 November 2016 conversation you weren't involved because after that I think it's right that the adviser system was split by region such that this no longer fell within your remit?

A. That's right. So at the time there was just six regulations advisers. We were just reaching out to whoever came back with a response to our initial letter, inviting them to a meeting to explain the service.

And then when we -- as the team grew we were specifically assigned regional areas. So I moved to the Midlands.

Q. Yes.

A. And someone else took responsibility for that.

Q. Now, an interim order or the NMC didn't apply for an interim order in respect of Lucy Letby until after she'd been charged with an offence and in its opening statement on behalf of the NMC it was said that the arrest could have been sufficient to justify an interim order application.

What is your view about whether it's appropriate to wait until an arrest has been made of an individual in this sort of circumstance before applying for an interim order given that it might take a long time before, for example, the police reach that stage?

A. Yes. So this is not my area of speciality. There is a screening, Seriousness Screening team that look at the nature of the allegations, the seriousness of the allegations and if it's considered for an interim order it goes to an independent panel who will make the

decision as to whether in fact to impose an interim order.

So this is a little bit further through the process. This is actually when we get a referral into the NMC that that particular --

Q. Yes.

A. -- part of the process is invoked.

If you want my personal opinion, we have always said if the police are involved we would advise to refer because it allows us to open up our statutory powers and gain information from the police throughout the course of their investigation. If we didn't have a referral, we would have to wait for the conclusion of the police investigation and obviously any potential risks wouldn't be identified and we wouldn't be able to manage those risks.

So if there's police involvement, we would at the time and probably still to this day would recommend a referral comes in really quickly.

MR BERSHADSKI: My Lady, those are my questions for Mr Newman.

LADY JUSTICE THIRLWALL: And no one else wants to ask any questions, I don't think, and I have no questions for you, Mr Newman. So thank you very much for coming and you are now free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: Mr Bershadski, that concludes the evidence --

MR BERSHADSKI: It does.

LADY JUSTICE THIRLWALL: -- for this week.

So we are going to adjourn now and I think our next day of sitting is --

MR BERSHADSKI: I am told it's not until 7 January.

LADY JUSTICE THIRLWALL: 7 January, thank you very much indeed. And are we starting at 10 o'clock that day? Yes, so 10 o'clock on 7 January.

I hope you all have something of a break, thank you all very much and we will see you in the New Year.

(5.02 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 7 January 2025)

I N D E X