Witness Name: M. Leaf
Statement No.: 1
Exhibits: 1
Dated: 26.1.24

THIRLWALL INQUIRY

WITNESS STATEMENT OF MIKE LEAF

I, Mike Leaf, make this statement believing the contents to be true to the best of my knowledge and belief. I will say as follows: -

1. I am a public health professional by background and have been involved in the child death review process since 2013 when I was Director of Health Improvement at Lancashire County Council. This included chairing the Lancashire Child Death Overview Panel following the reorganisation of the public health function which transferred from the NHS to local government. After leaving Lancashire County Council at the end of March 2016 under a voluntary redundancy arrangement following an internal reorganisation, I was appointed through a formal selection process as Independent Chair of Merseyside and Pan-Cheshire Child Death Overview Panels on 1st January, 2017 and 20th October 2017 respectively. I was appointed Independent Chair to the Blackburn with Darwen, Blackpool, and Lancashire Child Death Overview Panel on 16th October, 2017.
2. It is important to clarify the limitations of my evidence. The only baby death reviewed under my chairmanship was the Lancashire case when I was chair of the pan-Lancashire Child Death Overview Panel in my role as Director of Health Improvement with Lancashire County Council, which hosted the Child Death Overview Panel function, and which was then a sub-group of the Local Children's Safeguarding Board.
3. In general terms my role as Chair includes:
    - Ensuring the Child Death Overview Panel operates effectively and within the statutory guidance.

- Facilitating discussion at panel meetings, encouraging all members to participate appropriately, ensuring that all statutory requirements are met, and maintaining a focus on preventive work.
- Facilitating resolution of agency disputes.
- Escalating issues to the statutory partners and any other networks where appropriate.
- Ensuring that any actions recommended by the panel are implemented.
- Ensuring that there is effective guidance in place for all partner agencies and front-line practitioners.

4. This statement is written from my perspective as Independent Chair of the three NW Child Death Overview Panels described in the opening paragraph above. In preparing this statement, I have not sought the views of colleagues except to clarify any points I have made, nor the agencies represented at the three Child Death Overview Panels, and represents my views and understandings at the time of writing, and not those of anyone else. This statement has been shared with the statutory agencies involved in the 3 NW Panels.

5. For clarity, when I use the term "Panel", I am referring to the Child Death Overview Panel, and will clarify which Panel I am referring to where necessary.

6. In order to explain the process of Child Death Review and Child Death Overview Panels (CDOPs) I have summarised briefly below.

7. Chapter 1 of the Child Death Review Statutory and Operational Guidance (England) 2018[1] (INQ0012367) provides an overview of the key stages of the child death review processes. Figure 1 which is taken from this guidance, provides a pictorial representation of these stages.

Chapter 1
Overview

This chapter briefly describes the whole child death review process. The flow chart below (fig. 1) sets out the main stages of the child death review process. To help readers navigate the guidance, it appears at the start of chapters 2-6 with the relevant stage highlighted.

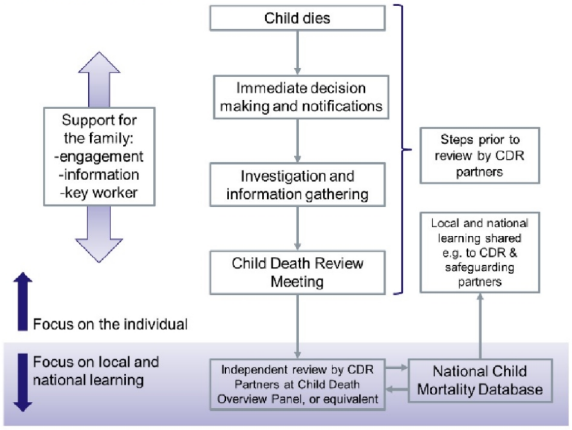

Figure 1 Chart illustrating the full process of a child death review. This includes both the statutory responsibilities of CDR partners to review the deaths of children at an independent multi-agency panel (described here, and throughout, as review at CDOP or equivalent), and the processes that precede or follow this independent review. Further explanation is below.

8. The Panel is the final stage of the Child Death Review process, and is concerned with the death of any child below the age of 18 years old. This includes babies who die on neonatal wards. Panels have the benefit of having access to all documentation relating to the child and any outputs from any review of the death prior to the Panel meeting. This includes the child death review meeting which is a meeting held some time before the Panel, which should involve all agencies/ professionals who have had some involvement with the child or family prior to death. Within the hospital setting, where the child death review meeting is usually organised for those dying in hospital, there is generally more of a focus on clinical elements of care, rather than wider social elements. Because the Child Death Overview Panel is the final stage, it may be several months, and sometimes even years after the death has occurred, that the death is considered, as the Panel cannot review any deaths until after all other investigations have been completed, and relevant paperwork submitted to the Panel administrator.

9. The broad purpose of the child death overview panel is to identify any themes or modifiable factors that may be addressed either local or nationally, that might reduce future deaths or risks to children, and identify any additional learning or

actions, that previous reviews have missed. Section 5.2.1 of the Child Death Review Statutory and Operational Guidance (England) 2018[1] (INQ0012367) clarifies the functions of the Panel:

• *to collect and collate information about each child death, seeking relevant information from professionals and, where appropriate, family members;*

• *to analyse the information obtained, including the report from the child death review meeting, in order to confirm or clarify the cause of death, to determine any contributory factors, and to identify learning arising from the child death review process that may prevent future child deaths;*

• *to make recommendations to all relevant organisations where actions have been identified which may prevent future child deaths or promote the health, safety and wellbeing of children;*

• *to notify the Child Safeguarding Practice Review Panel and local Safeguarding Partners when it suspects that a child may have been abused or neglected;*

• *to notify the Medical Examiner (once introduced) and the doctor who certified the cause of death, if it identifies any errors or deficiencies in an individual child's registered cause of death. Any correction to the child's cause of death would only be made following an application for a formal correction;*

• *to provide specified data to NHS Digital and then, once established, to the National Child Mortality Database;*

• *to produce an annual report for Child Death Review partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process; and*

• *to contribute to local, regional and national initiatives to improve learning from child death reviews, including, where appropriate, approved research carried out within the requirements of data protection.*

10. Panels are made-up of a variety of professionals who should, where possible, have had no involvement with the child or the child's family prior to the child's death, and who provide a professional perspective to inform the multi-professional and multi-agency final Panel review. In accordance with 5.3.1 Child Death Review Statutory and Operational Guidance (England) 2018[1] (INQ0012367) the multi-professional panel whose core membership should include *senior representatives from the following agencies or roles:*

• *public health;*

• *Designated Doctor for child deaths (and a hospital clinician if the Designated Doctor is a community doctor or vice versa);*

• *social services;*

• *police;*

• *safeguarding (designated doctor or nurse);*

• *primary care (GP or health visitor);*

• *nursing and/or midwifery;*

• *lay representation; and*

• *additional professionals should be considered on a case-by-case basis, for example from: coroner's office, education, housing, council services, health and wellbeing board, ambulance services, or hospices.*

11. Child Death Overview Panels will occur at pre-determined times throughout the year, depending on the average number of child deaths the geographical area might expect. Some meet monthly and others every two months. Deaths for review at panel will only be brought for consideration after all other reviews have taken place, and when the Panel Administrator has received all the paperwork from the various agencies. The panel may make referrals to the local safeguarding partnerships to consider instigating child safeguarding practice reviews in cases where a child may have died through neglect or abuse. This could include deaths on neonatal wards, where neglect or abuse was evident or suspected. Whilst I am fairly familiar with the Safeguarding process in relation to child deaths, detailed understanding of wider safeguarding processes is outside my professional expertise.

12. Panels should follow a process that covers all the key lines of enquiry included in the "Panel Analysis Form" which consider various "Domains" relating to the child including: *Factors intrinsic to the child; Factors in the Social environment including parental capacity; Factors in the Physical environment, and Factors in service provision.* (See Panel Analysis form.) The factors will be scored 0-2 depending on the perceived relevance to the death of the child according to the following scores:
0 – Information not available

1 – no factors identified, or factors identified but are unlikely to have contributed to the death

2 – Factors identified that **may** have contributed to vulnerability, ill health or death. (At the time when the reviews of the deaths which are the subject of this Inquiry took place, a score of 3 would be given to factors which gave a full explanation of the death.)

13. The panel does not need to establish a cause and effect relationship between factors and the child's vulnerability, ill-health or death, only agree on the factors which **may** have contributed to any of them. This process applies to all child deaths, including neonates, which include additional sub-categories including immaturity, prematurity, perinatal asphyxiate, perinatally acquired infection or any other cause related to neonates.

14. After identifying any modifiable factors, that is, any factor across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths, the panel will then categorise the death in accordance with at least one of 10 categories:
    1. Deliberately inflicted injury, abuse or neglect
    2. Suicide or deliberate self-inflicted harm
    3. Trauma and other external factors
    4. Malignancy
    5. Acute medical or surgical condition
    6. Chronic medical condition
    7. Chromosomal, genetic and congenital anomalies
    8. Perinatal/neonatal event
    9. Infection
    10. Sudden unexpected, unexplained death

15. The panel will note any additional learning and actions supplementary to those already identified through previous reviews, and ensure that the respective agencies are all made aware of these, and where necessary seek assurance that learning and other actions have been implemented.

16. I am not directly involved in the initial review of deaths within a neonatal unit, but from my experience of chairing Panel meetings and from reading the various reports we receive at Panel, reviews are mainly undertaken by clinicians involved in the care of the child prior to death. This follows the national guidance available and considers the information requirements contained in the sections included within the Child Death Reporting Form (Form B) exhibited as **ML/01**

17. The clinician completing the Child Death Reporting Form/ Form B **ML/01**, should provide as many details as possible, and returned to the Panel Administrator. The details/ information, outcomes/ learning and conclusions from any internal review would be later sent to the Panel Administrator, which would then form part of the paperwork available for discussion at the Child Death Overview Panel. There is also a supplementary set of queries for neonatal and unexpected deaths. I am not involved in any of the processes prior to the panel itself, so this falls outside my professional experience. The responsibility for who completes the Form would be determined by the Trust/Unit.

18. The same scoring system described above is used for all child deaths, including those occurring on a neonatal unit.

19. Panels do not directly work with neonatal units, but Panel Administrators are likely to request information from them, to support the operation of the Panel. Similarly, the police, and any other agency that has information concerning the child or the child's family, will be contacted for information that would be relevant for the Panel review. Panel members may also make links with other child death review agencies including regional neonatal operational delivery networks (i.e. North West Neonatal Operational Delivery Network for the NW Panels) which undertake peer reviews of perinatal deaths, and the National Child Mortality Database, to which all information concluded in the Panel Child Death Analysis Form (appended hereto as **ML/02**) is sent automatically, as soon as an individual review is concluded at Panel and processed by the administrator.

20. According to the "Child Death Review Statutory and Operational Guidelines" (2018)[1] (INQ0012367), Panels are expected *"to produce an annual report for CDR partners on local patterns and trends in child deaths, any lessons learnt and actions*

taken, and the effectiveness of the wider child death review process". The NW Panels I Chair have produced annual reports each year, including trends of all child deaths occurring in each planning year. The Annual Reports are circulated to all child death review partners and to the Local Children's Safeguarding Boards (pre-2018 Guidance) and Children's Safeguarding Partnerships (post-2018 Guidance); Local Public Health networks; and Health and Wellbeing Boards. All annual reports are available on request. The annual numbers of child deaths for each panel are relatively small (see Table 1 below).

21. As previously mentioned, Panels constitute the concluding phase of the child death review process, following other comprehensive assessments, which could include coronial inquests, criminal investigations, perinatal mortality reviews, and hospital mortality reviews. Much of the learning is captured and appropriate actions taken before the cases get to Panel for this final review. From my perspective, the Panel acts as a "safety net" for learning, providing a final opportunity to identify any learning or actions that might have been missed through the other review processes.

22. Learning identified at the panel in relation to service provision can be relevant to individual services, similar services in the locality covered by the Panel, and on occasions have national relevance. Frequently learning might be relevant to local commissioners of services where there may be inconsistent levels or standards of service provision for example out-of-hours palliative care.

23. From my perspective, the processes are broadly similar today as they were back in June 2016, although there are greater expectations in relation to the information being requested. In 2018, the most significant change was that Panels were no longer considered sub-groups of Local Children's Safeguarding Boards, as per a national review of Safeguarding governance arrangements. This change created a lack of clarity as to where accountability and oversight for child deaths reviews should be best placed. Panel and child death review professionals come from numerous organisations for a particular geography, including numerous local authorities and NHS bodies. Whilst it is clear who has the statutory responsibility for ensuring that there is an effective child death review system in place (Local Authorities and NHS

Commissioners), it was not made clear where the function should be accommodated if not part of the new Children's Safeguarding Partnerships.

24. Several other processes have been introduced since June 2016, which provide greater scrutiny of deaths occurring in neonatal and maternity units, although I am less familiar about the exact procedures involved, as these fall outside my professional expertise. These processes provide additional information that is made available to Panels to consider. The following provides a brief overview of some of the improvements, the descriptions of which have been taken from a Northwest Neonatal Operational Delivery Network report[4] (pages 2-3):

MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK undertakes reviews on:

• *Early neonatal deaths including live born babies (born at 20+ 0 weeks gestational age or later or with a birthweight of 400g or more where an accurate estimate of gestation is not available) who died before 7 completed days after birth.*

• *Late neonatal death including live born babies (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) who died from 7 completed days after birth but before 28 completed days after birth.*

PMRT - Perinatal Mortality Review Tool undertakes reviews on:

• *All perinatal deaths from 22+0 days gestation until 28 days after birth excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known.* (This was, I understand, introduced in 2018.)

HSIB - Healthcare Safety Investigation Branch undertakes reviews on:

• *Term deliveries (≥37+0 completed weeks of gestation) following labour that resulted in early neonatal death: when the baby died within the first week of life (i.e. days 0–6) of any cause.*

NHS-R – NHS Resolution

• *Term deliveries (≥37+0 completed weeks of gestation) following labour that resulted in early neonatal death: when the baby died within the first week of life (i.e. days 0–6) of any cause.*

25. All the outcome reports emanating from these perinatal mortality reviews are made available and considered at Panel. In all the NW CDOP areas that I chair, I have introduced a Child Death Review and CDOP Business group that produce quarterly reports for local governance systems highlighting any key learning or issues.

26. I consider the Child Death Review process and Child Death Review Panels to be effective in: identifying modifiable factors that can reinforce and complement local public health intelligence; improving policy/practice at a local level; contributing to national surveillance to provide opportunities for detailed research; influencing local partners to take action; identifying safeguarding issues.

27. In my view, there appear to be some areas where information provided by clinicians is being duplicated. The child death review process could be improved by rationalising some of the reviews that the NHS currently undertake prior to Panel.

28. All Child Death Review Partners should have been aware of and guided by "Working Together to Safeguard Children" (March 2015) (INQ0013235) [5] between June 2015 to June 2016. There were and still are different processes for dealing with *Unexpected* and *Expected* deaths in children and infants. From my perspective, the quality of information provided by hospitals, GPs and other partners which informs the child death review process and Panels has been variable over the time I have been involved, but this has improved since the 2018 Child Death Review Statutory and Operational Guidance was published (INQ0012367). The Guidance (INQ0012367) makes it very clear that reviews, frequently within hospitals should include other professionals who have been directly involved in the care of the child during his or her life prior to death, and should not be limited to medical staff. In my experience, most child death review meetings in hospital mainly involve hospital clinical staff, and this needs to be improved.

29. For **Unexpected deaths**, there was and is, clear national guidance, but it is not always followed by all professionals. For the period June 2015 to June 2016, unexpected deaths were covered by Chapter 5 of "Working Together to Safeguard Children[5]" (March 2015) (INQ0013235) on pages 85-86, where it states:

> *12. In this guidance an unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24*

hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

13. The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

14. As set out the Local Safeguarding Children Boards Regulations 2006, LSCBs (Local Safeguarding Childrens Boards) are responsible for putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

15. When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the local designated paediatrician with responsibility for unexpected child deaths at the same time as informing the coroner and the police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. The paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it. The joint responsibilities of the professionals involved with the child include:

- *responding quickly to the child's death in accordance with the locally agreed procedures; maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the Association of Chief Police Officers;*
- *making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;*
- *liaising with the coroner and the pathologist;*

• *undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;*

• *collecting information about the death;*

• *providing support to the bereaved family, involving them in meetings as appropriate, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and*

• *gaining consent early from the family for the examination of their medical notes.*

30. In addition, the Pan-Cheshire Sudden Unexpected Deaths in Infants (SUDI) Guidelines 2015[6] (which staff at the Countess of Chester Hospital should also have been working to) state:

> *9.28.8* ***Where the death of a child is explained but occurs unexpectedly****, the Duty Consultant Paediatrician will discuss with parents and the Coroner to decide if there is an explanation for the child's unexpected death for issue of the death certificate. For example: a child with cerebral palsy with reflux and gastrostomy who develops a pulmonary aspiration with a fatal ALTE (Apparent life-threatening events): there is little benefit in undertaking a post mortem. The Duty Consultant Paediatrician can sign the death certificate.*
>
> *9.28.9 However, if the parents or staff have any concerns about the child's management, then the case needs a thorough investigation. The Police will be involved if it is considered that there were suspicious circumstances around the child's death or concerns have been raised about neglect or inappropriate medical or nursing care.*

31. "Working Together to Safeguard Children" (2015)[5] (INQ0013235) makes it clear that any suspicions by any of the clinical staff should be discussed with the Designated Paediatrician responsible for child deaths in the first instance, with the police and coroner being informed. I am aware that some of the deaths forming part of this Inquiry were discussed with the coroner, but I am not clear whether the police were consulted at the time. If the clinicians had any suspicions about the nature of any of the deaths,

then the processes outlined above should have been initiated. I am again unclear whether these processes were followed for all cases at the time.

32. Child deaths, particularly unexpected ones are relatively rare, so the processes involved are not routine for most professionals. Non-adherence to the process is usually quickly identified and flagged, and the Panel will re-enforce these issues or learning with the relevant organisation/ professional group, if and where required.

33. Having reviewed the Panel paperwork in relation to the cases requested by Cheshire Constabulary, I can find no reasons for any of the NW Panels to have had any suspicions regarding any of the deaths from the information supplied. From my experience, the CDOP process was conducted as one would have expected, although I was not present at the time, and have based my assessment purely on the paperwork I have reviewed.

34. I am not aware of any particular increase in infant mortality in the NW during this period so have focussed on deaths in Cheshire. I was not Chair at the time, so must rely on the records made available to me. I have reviewed all the Panel's annual reports 2014-2017 for Cheshire, to determine whether there were any unusual spikes in data that might have indicated unusual patterns of mortality, especially in neonates.

35. It is my understanding that, because some of the deaths occurred in babies that resided outside the Cheshire footprint, for example in Wales, and adjoining areas, some may not have been notified to the Cheshire Panel. In addition, the deaths forming part of the criminal investigation were spread over two reporting years (2015/16 and 2016/17) and the individual cases are likely to have come to panel at different times, sometimes months after the death, so it would have been difficult for the panel to notice any spikes or trends. In addition, Panels are reliant on the quality of the information provided by professionals contained within the Form Bs (ML1) when reviewing cases. Having reviewed all the Form Bs requested by Cheshire Constabulary, I can find no reasons for the panel to have had any suspicions regarding any of the deaths from the information supplied.

36. The number of deaths notified to the Cheshire panel between April 2013 and March 2017 can be seen in Table 1.

Year (April-March)	2013-14	2014-15	2015-16	2016-17
No. of deaths	59	46	64	51

From the table above, there was an increase in all child deaths in 2015-16. As there were no comparative data in any of the annual reports I reviewed in relation to perinatal/ neonatal deaths by area or trust, it would have been difficult to determine spikes or trends in numbers of perinatal/ neonatal deaths by Trust.

37. The Panel neonatal/ perinatal death notifications for the Countess of Chester Hospital (CoCH) provided to me (all less than 11 months at time of death) between April 2013 and March 2017 highlighted that:

a. During 2013/14 there were 4 deaths (April – March)

b. During 2014/15 there were 4 deaths (April – March)

c. During 2015/16 there were 7 deaths (April – March)

d. During 2016/17 there was 1 death (April – March)

38. It can be seen that there was an increase in deaths from CoCH in 2015/16, but because regular monitoring of timely data was not in place at the time and only included those babies resident in Cheshire, the spike in numbers would have been difficult to identify. The two English babies who featured in the criminal trial who were not Cheshire babies were reviewed by their respective Child Death Overview Panels (Merseyside and Lancashire). I am not clear whether the babies from Wales were reviewed.

39. All child deaths should be reported to the Panel Administrator. The numbers of neonatal deaths per year in a typical Panel geography are relatively small, and do not occur evenly over the course of a year. In order to make improvements to the current system, it may be possible to make it a requirement for Panels, Neonatal Operational Delivery Networks or Integrated Care Boards to facilitate a more timely process of record keeping and reporting on the numbers of deaths occurring by Trust or neonatal/maternity Units, to identify any unusual patterns or concerns. In addition, an

individual unit/ Trust might be better placed to monitor unusual patterns, through an agreed clinical governance process, as this could also include sudden unexpected collapses that might not necessarily result in death. Other professionals involved in the child death review process may be better placed to comment or offer alternatives for improvement, and what is an acceptable threshold of deaths/ unexpected collapses.

40. As described above, numerous additional processes have been introduced since 2016, which would help identify issues, although I would suggest some rationalisation of the current NHS review process to reduced potential duplication. I believe there is scope to significantly improve the awareness of the current processes and ensure that child death review processes are adequately resourced.

41. I am not aware of any public comments made by any NW Panels about any matters relevant to the Inquiries Terms of Reference, and I would have expected to have been notified if there had been.

Statement of Truth

I believe that the facts stated in this witness statement are true to the best of my knowledge and belief. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Mike Leaf, Chair of Pan-Cheshire, Merseyside and Blackburn with Darwen, Blackpool and Lancashire Child Death Overview Panels

Signed: Personal Data

Dated: 19/3/24