Witness Name: Tom Luce
Statement No.: 01
Exhibits: TL/1 – TL/3
Dated: 12/04/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF TOM LUCE

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1. I, Tom Luce, cover firstly the relevance of the probable absence of Medical Examiners in the area and times of the neonatal murders and attempted murders the Inquiry is assessing, and subsequently the timing and purposes of the legislation which has led to a slow introduction of the Medical Examiner system.
2. After retirement in 1999 for 27 years as a Civil Servant in the England Department of Health, I was appointed Chair of the *Fundamental Review of Death Certification in England, Wales and Northern Ireland* (Exhibit TL/1 [**INQ0015454**]) of which the report by all its members was submitted to and published by the Government in 2003 *(Cm 5831)* and included a support of the Medical Examiner system previously invented by the Home Office:-"*There should be a common certification process for all deaths not reported to a coroner, whether the body is to be buried or cremated, and that process should bring two professional opinions to bear before disposal of the body is authorised*".
3. Similarly relevant was the report in the same year of the separate and judicial Shipman Inquiry (*Cm 5854)* set up to assess the murders of his 15 patients by the convicted NHS GP Dr Shipman. The Inquiry did find "*Shipman had killed at least 215 of his patients over a period of 24 years"* (Exhibit TL/2 [**INQ0017834**]). The Inquiry also supported the additional and independent medical assessment of deaths.
4. I have not subsequently had any relevant management or policy responsibilities so my statement covers only the relevance of the post-Fundamental Review and Shipman Inquiry reform legislations, and the serious issue of delays in real service introduction and reformation.

RELEVANCE OF THE PROBABLE ABSENCE OF MEDICAL EXAMINERS OF DEATHS IN THE COUNTESS OF CHESHIRE HOSPITAL

5. The Medical Examiner system was intended to introduce for each death certified by the deceased's treating doctor an independent medical check of the certification as correct and uninfluenced by improper motivation (including, for example, to conceal the patient's murder or improper treatment). The general introduction of the system did not start until 2019. For some previous years, some experimental appointments were made to work on its functional details. If, as is likely, no Medical Examiners were available for Countess Cheshire Hospital deaths at the time of the Nurse Letby murders and attempted murders, the consequential absence of an independent assessment of the deaths is clearly relevant to Item B(i) of the Thirlwall Inquiry's Terms of Reference: -

> *"Whether suspicions should have been raised earlier, whether Letby should have been suspended earlier, and whether the police or other external bodies should have been informed sooner of suspicions about her".*

6. Had there been a Medical Examiner to check the certifications of the children Letby murdered, it's very likely that the first such would have raised a suspicion preventing most or all of the later deaths.
7. Some similar relevance is in the likelihood that one or more of the Countess Cheshire Hospital Consultants must actually have prepared the death certifications of the neonatal deaths of which Letby was much later convicted for murdering, since death certification was to be done by doctor responsible for the deceased's treatment. No doubt the Inquiry will assess such certification processes in the Letby murder cases.
8. Also of interest is that Medical Examiners are required to make themselves accessible to the bereaved family of the deceased whose certificate they are independently assessing.

CIRCUMSTANCES AND TIMING OF THE LEGISLATION INTRODUCING MEDICAL EXAMINERS

9. The Government of the time having considered and generally accepted the recommendations of the Fundamental Review and Shipman Inquiry introduced legislation to introduce them which was The Coroners and Justice Act 2009, of which Sections 18-21 contained provisions for the Medical Examiner reform system. The relevant provision in the Act was changed in the Health and Social Care Act 2012, which gave central Government an explicit responsibility and timing flexibility for introducing the system. Some important experimental and educational work on the system started soon afterwards, though the formal system was not started until 2019

but not soon thereafter fully set up. In April 2023 it was announced to Parliament by a Health Minister that the Medical Examiner system would be fully introduced in April 2024: -

> "*I wish to update the House on the Government's plan to introduce secondary legislation to reform death certification in England and Wales, from April 2024. Under the reforms, all deaths will become legally subject to either a medical examiner's scrutiny or a coroner's investigation.*"

10. Some details of the new scheme were published in December 2023. The conception of the Medical Examiner system was originated by the Home Office very soon after the 1999 conviction of Dr Shipman for murdering his 15 patients, so the system's full implementation will occur about a quarter century after its initial governmental invention. The Fundamental Review's terms of reference required it to consider the system proposal which it did endorse and recommend, as did the Shipman Inquiry.
11. There had historically been failures as well as the recent delays in reforming death certification and investigation systems after relevant and troubling cases:
    a. The Brodrick Review 1971 advocated comprehensive death certification and coroner reforms, but they were not done.
    b. The Allitt Inquiry, following the conviction of a hospital nurse for the murder of 4 children in her care: "*Inquiry into Deaths and Injuries in the Children's Ward at Grantham and in Kesteven General Hospital in 1991",* by Sir Cecil Clothier, published in 1994. The recommendations were not acted on.

It's distressingly relevant that following these and the Shipman Inquiry the Thirlwall Inquiry is by no means the first into murders of their own patients by professional health carers.

12. In sending its 2003 Report to the Government, the Fundamental Review ended its introductory letter thus, referring to earlier failures of reform: -

> "*During the last three-quarters of a century, the Government has twice commissioned reviews of these subjects, in 1936 and 1965. Very little happened in response to their reports. The services are showing the consequences of this neglect. We, and those whom we have consulted, hope that the inaction will not continue*" (Exhibit TL/1 **[INQ0015454]**).

13. Equally relevant is that in sending to Ministers the Shipman Inquiry Report which she had chaired, Dame Janet Smith concluded her letter: -

"*Policy decisions will be required before change can be effected. In Chapter Three, I have set out the history of events following the publication of the Brodrick Report in 1971, in which the issues of death certification and the coroner system were*

comprehensively reviewed. The recommendations were not implemented because the conflicting views of interested parties were never resolved by the making of a clear decision on policy. I urge you now to ensure that the work of the [Fundamental] Review and this Inquiry do not meet the same fate" (Exhibit TL/3 **INQ0017835**).

Statement of Truth

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

Signed: _____Tom Luce._____

Dated: ___12 April 2024_____