Witness Name: Dr Joanna Garstang
Statement No.: 01
Exhibits: [XXXX]
Dated: 20 March 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR JOANNA GARSTANG

I, Dr Joanna Garstang, will say as follows: -

Professional Background

1.0 My professional qualifications are MBChB, DCH, MRCPCH, MSc, PhD.

1.1 I am employed as a Clinical Associate Professor of Child Protection at the School of Nursing, University of Birmingham, appointed in June 2023. This is a clinical academic post; my clinical duties are as a Consultant Community Paediatrician at Birmingham Community Healthcare NHS Trust and as Designated Doctor for Child Death at Birmingham and Solihull Integrated Care Board.

1.2 I was employed as Consultant Community Paediatrician at Birmingham Community Healthcare NHS Trust and as Designated Doctor for Child Death at Birmingham and Solihull Integrated Care Board from June 2017 to May 2023. Prior to this I was a Consultant Community Paediatrician at Coventry and Warwickshire Partnership NHS Trust between July 2015 and June 2017, before this I was a Specialist Trainee in Community Paediatrics.

1.3 I was a Visiting Senior Clinical Lecturer in Child Protection, at the School of Nursing, University of Birmingham, from September 2021 to May 2023. I was an Honorary Clinical Research Fellow in the Institute of Applied Health Research, University of Birmingham from 2019-2021. I was an NIHR Doctoral Research Fellow at Warwick Medical School from 2010-2015 while I completed my PhD.

1.4 Much of my clinical work involves the investigation of unexpected child deaths, regularly working alongside police as part of the Joint Agency Response. I am the clinical lead for the Sudden Unexpected Death in Childhood in Birmingham

Community Healthcare NHS Trust. In my role as Designated Doctor, I am part of the Child Death Overview Panel, and review all unexpected child deaths.

1.5 I am a paid specialist Medical Advisor to the National Child Mortality Database, this role commenced in July 2023.

1.6 My PhD (2015) evaluated the joint agency investigation of unexpected infant deaths. Since then, my research has concerned improving child death investigation, prevention of Sudden Unexpected Death in Infancy (SUDI), recurrent SUDI within families, and child safeguarding. I have been part of the research team for the biennial/triennial analyses of Serious Case Reviews since 2015, and the annual analysis of Local Child Safeguarding Practice Reviews since 2020. I have published extensively on SUDI, child death investigation and safeguarding children.

1.7 I am a member of the scientific committee of the Lullaby Trust (UK support organisation for sudden infant death), medical advisor to SUDC-UK (UK support organisation for Sudden Unexplained Death in Childhood) and chair of the Association of Child Death Review Professionals.

1.8 My curriculum vitae is provided at appendix 1.

2. Current safeguarding procedures after sudden unexpected child death in hospital, Coroners' referrals, Joint Agency Response and Child Death Overview Panel.

2.0 The current process for managing all child deaths whether these occur in hospital or not is detailed in the 2018 Child Death Review Statutory and Operational Guidance(HM Government, 2018) and Working Together to Safeguard Children (HM Government, 2023). The determination and management of any safeguarding procedures is included in this process.

2.1 For most children who die in hospital, the death will not be unexpected, and doctors will be able to issue a Medical Certificate for Cause of Death (MCCD). However, if the cause or circumstances of death are not clear, it is from external causes, or there are concerns about care or service delivery further investigation is required.

2.2 Within 1-2 hours of the death, the senior paediatrician responsible for the child should have obtained enough information to decide (1) whether the death meets criteria for a Joint Agency Response (JAR) and if so contact the relevant multi-agency professionals to initiate it. (2) if a MCCD can be issued and if not to refer the death to the coroner. (3) whether an issue relating to healthcare or service delivery has occurred or is suspected and if so refer the death to the coroner and for NHS incident investigation. (4) determine whether any actions are necessary to ensure the

health and safety of others, including family or community members, healthcare patients and staff.

2.3 If the senior paediatrician is uncertain as to whether the death meets criteria for JAR, they should initiate multi-agency discussion so that all agencies can agree whether to proceed with a JAR or not. In practice, this usually means starting the JAR although if sufficient information becomes available all agencies may agree that the JAR can be stopped.

2.4 If there are safeguarding concerns relating to a child death, these would be managed by starting the JAR, this would notify the police and Local Authority and further multi-agency safeguarding enquiries would follow as needed.

2.5 If the safeguarding concerns related to a member of staff, the hospital should also follow their policy for 'People in positions of trust', which should require that the Local Authority Designated Officer (LADO) is informed within one working day (HM Government, 2023).

2.6 The following deaths should be referred to the coroner: deaths due to poisoning or exposure or contact with toxic substances, deaths due to medicinal products, controlled drugs or psychoactive substances, deaths due to violence trauma or injury, deaths due to self-harm, deaths due to neglect, deaths due to treatment or medical procedures, deaths due to injury or disease related to employment, deaths that are unnatural but not falling into previous categories, deaths where the cause is unknown, deaths that occur in custody, deaths where a doctor is unable to sign a death certificate, and deaths where the identity of the person is unknown. Full details are given in 'Guidance for registered medical practitioners on the Notification of Deaths Regulations' (Ministry of Justice, 2022).

2.7 An unexpected child death in hospital may therefore be referred to the coroner for a variety of different reasons.

2.8 The National Medical Examiner system is being rolled out but is not yet being used for child deaths in all areas of England. It is intended that this should happen by April 2024. The Medical Examiner will scrutinise all deaths that are not referred to the coroner; this will involve a review of the case notes and a telephone conversation with the family to identify if they had any concerns with their relative's treatment and care. All MCCDs will be scrutinised Medical Examiners and if necessary, deaths referred back to coroners (Department of Health and Social Care, 2023).

2.9 A JAR should be initiated if a child's death: is or could be due to external causes, is sudden and there is no immediately apparent cause, occurs in custody or if the child is detained under the Mental Health Act, where the initial circumstances raise suspicions that the death may not be natural, or for an unattended stillbirth.

2.10 A JAR should take place for all cases of Sudden Unexpected Death in Infancy or Childhood (SUDIC). SUDIC is defined as the death of an infant or child (or collapse leading to death), which would not have been reasonably expected to occur 24 hours previously, and in whom no pre-existing medical cause of death is apparent (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2016). SUDIC is a descriptive term used at the point of presentation, many SUDIC will subsequently have a cause for death determined.

2.11 A SUDIC investigation is the same as a JAR. There are nationally recognised guidelines for SUDIC investigation (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2016). These state on page 14: 'When a newborn infant suddenly collapses and dies on a neonatal unit, consideration should be given as to whether a joint agency response is required. In most situations this would not be appropriate.' The national SUDIC guidelines are also referred to as the 'Kennedy Guidelines' or 'Kennedy Protocol' as the working group was chaired by Baroness Helena Kennedy.

2.12 In practice, if an infant or child dies unexpectedly and with no explanation while an inpatient in hospital, the SUDIC process would now normally be initiated, and there would be discussions between senior paediatricians and police as to how best to investigate the death. These are however, rare events.

2.13 Our experience in Birmingham and Solihull is that when we are notified by consultant neonatologists or hospital paediatricians of sudden unexpected deaths on the neonatal unit or paediatric ward, we always have an immediate discussion with them and the on-call police about whether it is appropriate to start a JAR but often conclude it is not needed. However, we fully expect to have a discussion with the police about any case such as this.

2.14 The JAR/SUDIC investigation would vary somewhat from the national guidance for a death occurring in hospital as the guidelines are written from the perspective of deaths occurring in the community. The following should take place for a JAR/SUDIC investigation where a baby has died on a neonatal unit:

2.15 A lead health professional should be appointed to co-ordinate the health response to the death. For deaths occurring in the community this would be a Specialist SUDIC paediatrician (or the Designated Doctor for Child Deaths) but for a sudden death on a neonatal unit it may be more appropriate for a consultant paediatrician or neonatologist from the hospital to take this role, with advice and support from the Specialist SUDIC paediatrician.

2.16 The consultant paediatrician or neonatologist should attend the neonatal unit; if there is a specialist SUDIC paediatrician on-call they may be asked to attend or

give advice. Usually, for deaths occurring in neonatal units or other inpatient areas, the consultant paediatrician or neonatologist would lead the SUDIC investigation in the hospital with support from the specialist SUDIC paediatrician, as they would already know the baby and family.

2.17 The on-call police officer for SUDIC/JAR should be contacted immediately and asked to attend the neonatal unit. This is usually a Detective Inspector with specialist training in child death and child protection, and they should not be in uniform. There is no requirement or expectation that hospital management would be asked to consent to police being contacted; this is a standard part of the SUDIC/JAR process.

2.18 As SUDIC/JAR is a statutory process, parents should not be asked for consent nor are they able to decline the process. They should however be kept fully informed and supported throughout.

2.19 The police officer and consultant paediatrician or neonatologist should examine the baby together and document any injuries or marks, including those from medical interventions on a body map. If needed police may take photographs.

2.20 The baby should have post-mortem samples taken on the neonatal unit for infection, metabolic conditions and toxicology as detailed in national guidelines, these include skin biopsy, blood samples, lumbar puncture and swabs. This is because there are often delays of several days before formal post-mortem examination, and these samples are best taken soon after death.

2.21 The consultant paediatrician or neonatologist should take a detailed medical and family history from the parents, the police officer should be in attendance for this and ask any further questions as needed. The consultant paediatrician or neonatologist and police officer will also take a detailed account from the nursing staff caring for the baby in the hours before the death.

2.22 Social care should be notified, as standard practice for all SUDIC cases; this is often as a standard child protection referral to the Multi-Agency Safeguarding Hub (MASH). Police will carry out lateral checks on the family and home address.

2.23 There would be no reason to carry out a joint home visit by police and paediatrician or specialist nurse as the collapse did not occur at home. If the collapse occurred for example on the post-natal ward, or in parents' hospital accommodation (rooming-in prior to discharge from the neonatal unit) it would be very important the parents show the paediatrician/neonatologist and police officer the exact position the baby was in prior to the collapse, as well as the position they were found in. This is particularly relevant for sudden deaths when babies are in bed with parents.

2.24 The death should be reported to the coroner, who should arrange for a skeletal survey and a paediatric pathologist to conduct the post-mortem examination.

2.25 An initial case discussion should be arranged within a few days of the death, this should be chaired by the consultant paediatrician or neonatologist, SUDIC paediatrician or SUDIC specialist nurse. It should be attended by neonatal unit staff, including the baby's named consultant, police officer, social worker, coroner's officer, midwife and family GP; they are usually held online now. The meeting considers all the information currently available about the death, what further information is needed and how the family are going to be supported. Following the meeting, the consultant paediatrician or neonatologist, SUDIC paediatrician or specialist nurse should write a detailed clinical report for the coroner to share with the pathologist.

2.26 Once the post-mortem report is available, the coroner should share it with the SUDIC paediatrician or specialist nurse. A final case discussion (also referred to as a Child Death Review Meeting – CDRM) is convened; this should have the same attendees as the initial case discussion. All the information from the case is reconsidered, including the post-mortem report and any other investigations such as patient safety or clinical governance. The full causes for death and any contributory or modifiable factors are reviewed and there should be an explicit discussion of whether child abuse or neglect was a feature in any part of the death. A report from this meeting is shared with the coroner to inform any inquest which should not be held until after this final case discussion. The family should be offered a follow-up meeting with a paediatrician to discuss the cause of death.

2.27 A standardised Child Death Review analysis form is completed at the final case discussion and passed to the local Child Death Overview Panel (CDOP), along with all documents and information relating to the JAR.

2.28 Babies who received care on neonatal units and who die in the first 28 days of life will also be reviewed using the Perinatal Mortality Review Tool (PMRT)(National Perinatal Epidemiology Unit, 2022); this concerns the quality of obstetric and neonatal care received by the mother and baby. The findings from PMRT are fed into the Child Death Review process. PMRT is not designed to identify or manage safeguarding concerns.

2.29 All child deaths, whether there is a JAR or not, are reviewed by a local CDOP, currently based on the home address of the child. CDOP is a multi-agency, multi professional group who provide independent scrutiny and oversight of child deaths, identifying themes and learning across a local area. There are representatives from health, social care, education, public health and police. They use standard national

templates to guide their reviews. Individuals cannot be involved in the review of any child for whom they have had named responsibility for in life.

2.30 Detailed information from individual case reviews at CDOP is passed to the National Child Mortality Database for further national analysis and reporting.

2.31 I have not detailed the support that families should receive as part of this process; however it is expected that they are kept informed and all information shared with them unless there are criminal investigations underway.

2.32 A summary of the JAR and CDOP process is shown below in figure 1 taken from the 2018 Child Death Review Statutory and Operational Guidance.

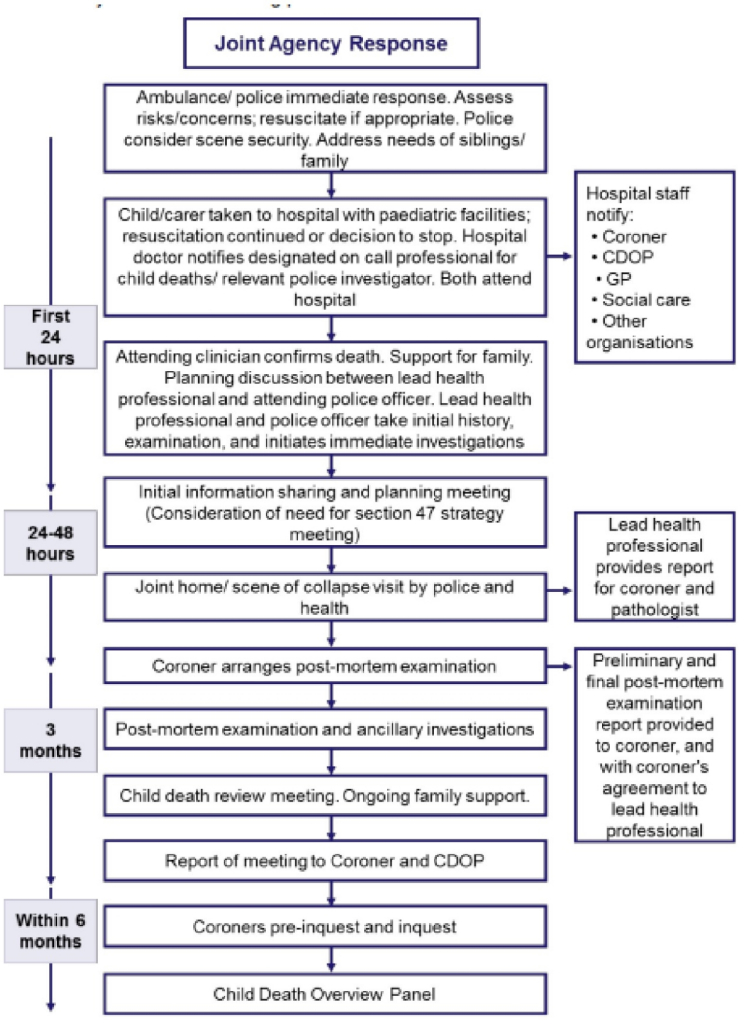

Figure 1 Joint Agency Response process.

3. Safeguarding procedures after sudden unexpected child deaths in hospital during 2015-2016

3.0 The term SUDI was first used in England with the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI SUDI) studies (Fleming et al., 2000); and the term has never made any reference to the place that the collapse or death occurs.

3.1 The SUDIC process and CDOP review of all child deaths became a statutory requirement in April 2008.

3.2 The current version of the SUDIC guidelines was published in November 2016, the original version (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2004) would have applied during 2015-16. The guideline is based on sudden unexpected infant deaths occurring in the community and there is no mention of sudden unexpected deaths occurring in hospital settings.

3.3 The 2004 guideline details the importance of NHS trusts having access to a consultant paediatrician with special responsibility for SUDI, and the importance of local coroners, police and NHS trusts agreeing protocols for managing SUDI.

3.4 The process of multi-agency investigation of SUDI described in the 2004 guidelines is very similar to that of 2016; with police being notified immediately, joint history and examination by police and paediatrician, initial and final case discussions.

3.5 Working Together to Safeguard Children, published in March 2015 (HM Government, 2015) details the processes to be followed for all child deaths in chapter 5. There is a section titled: Action by professionals when a child dies unexpectedly. This uses the same definition for unexpected child death as in the CESDI SUDI studies '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' with no mention of location of death or collapse.

3.6 It further details that '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.'

3.7 It also states in the section titled: Action by professionals when a child dies unexpectedly: 'In all cases when a child dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.' This would imply that unexpected child deaths in

hospital should be investigated the same as unexpected child deaths occurring in the community.

3.8 Working Together 2015 describes the process for investigating unexpected child deaths in a very similar way to the 2004 SUDIC guidelines and references these for further information.

3.9 The version of Working Together published in 2013(HM Government, 2013), describes the process for investigating unexpected child deaths in an identical manner to Working Together 2015.

3.10 This information suggests that SUDIC processes should have been followed for unexpected infant deaths in hospital during 2015-16.

3.11 I recall in Birmingham, my team undertaking SUDIC investigations for infants on neonatal units or paediatric wards in November 2017 and August 2018; this was prior to publication of the current statutory guidance.

4. Adequacy of current system of Child Death Overview Panels and Sudden Unexpected Infant Deaths processes where there is the possibility of malevolent actions by healthcare professionals.

4.0 I think the current system works well if SUDIC/JAR procedures are started; however, these rely on hospital paediatricians recognising that deaths are sudden and unexplained and not issuing MCCDs.

4.1 The SUDIC/JAR process is time consuming and the presence of police potentially upsetting to parents and staff; and hospital paediatricians may feel they are being kind to all by issuing a MCCD to avoid SUDIC/JAR and reduce distress.

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

4.3 Coroners are an important part of the SUDIC/JAR process. In the West Midlands, we have good working relationships with our coroners, and they would expect a SUDIC/JAR process for a sudden unexplained death in hospital and notify police and paediatricians if this did not occur. Other coroners have less knowledge of SUDIC/JAR so may not offer this degree of challenge.

4.4 The current CDOP system is based on a child's home address, this is a weakness for reviewing deaths of children who have been treated in hospital. Most children who die in hospital die in regional centres with neonatal or paediatric intensive care units. For example, Birmingham and Solihull CDOP only review approximately one-third of deaths from Birmingham Children's Hospital, the remaining two-thirds of children live out of area and are reviewed by many different CDOPs. This means it is difficult for

us at Birmingham and Solihull CDOP to identify themes relating to provision of healthcare at Birmingham Children's Hospital, it would similarly be difficult to identify malevolent actions.

4.5 Working Together 2023 states that 'Child death review partners for the local authority area where a child who has died was normally resident are responsible for ensuring the death is reviewed. However, they may also choose to review the death of a child, including a looked after child, that occurred in their local area even if the child in question was not normally resident there.' This could enable a CDOP to review deaths of all children who die in their local hospitals but there is no further guidance on how this could be achieved. NCMD held a webinar on 20 February 2024 (National Child Mortality Database, 2024) explaining how CDOPs could go about reviewing out of area deaths, but few CDOPs will have established processes for this yet. The webinar also detailed how CDOPs could have oversight of the numbers of children dying in their local area and hospitals, but again this is new to most CDOPs. It would require significant additional resource for CDOPs with a specialist children's hospital in their area; and the current electronic CDOP record system (eCDOP) does not support out of home area reviews.

4.6 Hospitals are responsible for holding Child Death Review Meetings for children whose deaths are expected; information from these reviews are then passed to CDOP for scrutiny. CDOP are reliant on the quality of hospital review as the basis for their review. If the hospital has not identified poor care or malevolent actions already it would be challenging for CDOP to identify these.

4.7 The 2016 SUDIC guidelines (pg10) explain the role of the Lead Health Professional and that this would normally be a specialist SUDIC paediatrician or Designated Doctor for Child Death. If the Lead Health Professional role is taken by a specialist nurse they must be supported by the Designated Doctor and have adequate case supervision.

4.8 In most areas of England, the Lead Health Professional role is now taken by Specialist Nurses, with varying degrees of supervision by Designated Doctors. There is no standard training for these Specialist Nurses. Although specialist nurses are excellent in providing support for families, they will not have similar clinical expertise and knowledge as a consultant paediatrician. Specialist nurses are less likely to understand the range of pathology that can present as sudden child death, it could

therefore be more difficult for them to recognise unusual clinical events and potential deliberate harm by medical or nursing staff.

4.9 It may also be more difficult for a specialist nurse to speak out if they have concerns of deliberate harm by staff in a sudden child death, due to professional hierarchies.

4.10 I am concerned that in some areas of the country, specialist nurses are in effect JAR Lead Health Professional with minimal support and supervision from Designated Doctors; this is not what was intended in the 2016 SUDIC guidelines. It potentially reduces the quality of SUDIC investigation and places children at risk.

5. Best practice for safeguarding concerns relating to staff members.

5.0 As a clinician, if I had safeguarding concerns about a member of staff, I would raise these with management. I would fully expect the management then to discuss these with the trust safeguarding team leading to a child protection referral for any child involved and a referral to the Local Authority Designated Officer (LADO) regarding the professional.

5.1 If my trust declined to make the relevant referrals, I would seek support from the Designated Doctor for Safeguarding either from my local area or elsewhere. If my trust continued to decline to make the referrals, I would make these myself, as my duty is always to act in the best interest of my patients. I note that I am making these comments with the benefit of hindsight.

6. Actions to be taken by managers if a professional raises safeguarding concerns relating to a medical professional.

6.0 I would expect managers to discuss with the trust safeguarding team and ensure that the appropriate referrals to social care were made, including LADO. If there was an immediate risk to child safety, I would expect them to contact the police urgently.

7. Gaps in hospital safeguarding relating to concerns about staff members

7.0 I think that current safeguarding policies are probably adequate, but staff may not know enough about them and how to use them. Many staff would not know what to do if they had a concern about another staff member. These issues should be included in safeguarding training.

8. Suggested improvements to safeguarding systems.

8.0 The Association of Child Death Review Professionals (ACDRP) role is primarily to improve quality of Child Death Reviews (CDR) rather than improve safeguarding

practice. However, good quality CDR should help identify safeguarding and patient safety concerns following a child death.

8.1 The 2018 Statutory and Operational CDR guidance requires NHS trusts to hold CDR meetings, where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death. These are generally much more detailed and resource intensive than previous mortality and morbidity meetings (M&M meetings) which typically considered only whether hospitals got their treatment correct during the final admission.

8.2 Parents should be asked if they have any questions, concerns or feedback to be discussed at the CDR meeting and these need to be addressed; this is an important safeguard.

8.3 Doing CDR well requires resources, there was no additional funding provided to NHS Trusts with the 2018 Statutory guidance. Funding for the JAR and to establish CDOPs was provided to Local Authorities in 2008, but this was only ring-fenced for three years. Some trusts have yet to start holding CDR meetings and are still holding traditional M&M meetings. Most trusts do not ask parents for feedback.

8.4 CDR does not have a high profile within paediatrics even though nearly all paediatricians will have to manage child deaths. Representatives from ACDRP attend the Child Protection Standing Committee of the Royal College of Paediatrics and Child Health, but there is no other representation within the college, such as the Policy, Training, or Quality and Standards committees. The ACDRP have been trying to address this with RCPCH for some time.

8.5 The current training syllabus for paediatricians has no mention of CDR, apart from the JAR, although this is due to be addressed in subsequent syllabus updates.

8.6 The low profile of CDR has meant than many paediatricians have limited knowledge of CDR, their roles or responsibilities in this.

8.7 In many areas, the SUDIC/JAR process is not well integrated with coronial investigations and some coroners have had very little training in SUDIC/JAR.

8.8 The 2016 SUDIC guidelines are in urgent need of updating. As explained before, they detail the processes to be followed for an unexpected infant death in the community. In practice they are used as the basis for investigating any death that requires a JAR, for example a child who dies by suicide or an unattended stillbirth.

This inevitably leads to confusion as to what elements of the guidelines are proportionate, and often conflict between police, coroners and health professionals.

8.9 The revised guidelines need to take account of the different situations in which a JAR is required, including the management of sudden unexpected deaths of children who are inpatients in hospital.

8.10 This is a considerable piece of work to undertake. The Royal College of Paediatrics and Child Health have agreed to lead the work but are currently seeking funding from NHS England so the work can be adequately resourced.

8.11 There is currently no national joint training for police, healthcare professionals and coroners relating to JAR/SUDIC processes, although some areas run local training. There was a course run at Warwick University although this stopped around 2015 and has not been replaced. There is an urgent need for more national multi-agency training.

8.12 The ACDRP are trying to address the lack of training in CDR; however they are a voluntary organisation of busy professionals trying to do this in addition to their paid employment. They have no dedicated time or budget to develop the training. This is a significant hindrance.

9. Suggested improvements for awareness of reporting safeguarding concerns.

9.0 I would suggest that safeguarding training for health professionals includes how they can raise safeguarding concerns about a staff member. This should be independent of clinical managers, with staff approaching NHS trust Safeguarding teams or advice.

10. NHS Culture potentially inhibiting staff from raising safeguarding concerns about staff members

10.0 I am answering this question from the perspective of a consultant paediatrician, as I am not an expert in safeguarding culture. I am not aware of culture that prevents staff speaking out with safeguarding concerns about other staff members. However, most staff members working with children do so with the best of intentions and it would be exceptionally rare for a staff member to suspect another

staff member of harming children. A staff member might be reluctant to speak out in case they falsely accused a colleague, given the rarity of staff inflicted harm.

11. CCTV in neonatal units

11.0 I do not consider my views expert in this area as I have not worked in a neonatal unit for at least 15 years.

12. Other comments in relation to terms of reference

12.0 The CDR process should be an effective safeguard, in that when done well it identifies failures in care, safeguarding concerns and potential improvements to practice. However, in many areas of England, CDR processes are not robust so do not provide this assurance.

12.1 There is a lack of accountability for CDR. Originally CDOPs were part of Local Safeguarding Children Boards, ultimately accountable to the Department for Education. As part of the 2018 CDR Statutory Guidance, CDR moved from the Department for Education to the Department of Health and Social Care, in recognition that most child deaths are not safeguarding matters but relate to underlying health issues. The Local Authority and Clinical Commissioning Groups (now Integrated Care Boards) as Child Death Review partners became responsible for CDR rather than Safeguarding partnerships.

12.2 In practice, CDR partnership arrangements are weak, and few hold NHS trusts to account for provision of CDR. A survey conducted by the Association of Child Death Review Professionals showed a wide variation in the provision of key statutory elements of CDR. **Exhibit JG/1** INQ0017973

12.3 NHS England Safeguarding oversees CDR; however it is difficult for them to hold CDR partners to account as most of the work does not involve safeguarding. There is no accountability for CDR partnerships if they do not resource CDR adequately.

12.4 The lack of visibility of CDR within the Royal College of Paediatrics and Child Health contributes to paediatricians and other health professionals not recognising its importance and not advocating for adequate resources. As a result, this limits CDR from being an effective safeguard for children as well as limiting learning from deaths.

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: _____ Personal Data _____

Dated: _____20 March 2024_____

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Appendix 1 Curriculum Vitae

Dr Joanna Jane Garstang

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Date of birth PD August 1971

GMC registration number PD

Qualifications

MBChB University of Bristol 1995

Membership of Royal College of Paediatrics and Child Health 2000

MSc Child Health University of Warwick 2009

PhD Health Sciences University of Warwick 2015

Current posts

Associate Clinical Professor of Child Protection, School of Nursing, University of Birmingham 1/6/23 onwards

Honorary Consultant community paediatrician, Designated Doctor for Child Death, Birmingham Community Healthcare NHS Trust, 12/6/17 onwards

Medical advisor to National Child Mortality Database 1/7/23 onwards

Previous posts

Visiting Senior Clinical Lecturer in Child Protection, School of Nursing, University of Birmingham 1/9/21 - 30/5/23

Clinical Trial Scholar, West Midlands Clinical Research Network/ Institute of Applied Health Research, University of Birmingham, 01/3/ 19 – 31/8/21

Consultant community paediatrician, Coventry and Warwickshire NHS Trust 1/8/2015 – 11/6/2017

Speciality Registrar in paediatrics, Coventry and Warwickshire NHS Trust 1/4/2015 – 31/7/15

NIHR Doctoral Research Fellow, University of Warwick, 1/9/10 – 31/3/2015

Specialist Registrar paediatric rotation, West Midlands NHS Deanery, 01/9/2002- 31/8/2010

Senior house officer posts in paediatrics, 1/8/99 -31/8/2002

Regimental medical officer, The Army, 1/2/1997-31/7/1999

House officer posts, 1/8/1995-31/1/1997

Non-stipendiary roles

Associate Editor of Child Abuse Review journal

Chair of Association of Child Death Review Professionals

Chair of Child Death Review Working Group of the International Society for the Study and Prevention of Perinatal and Infant Death (ISPID)

Scientific Advisor to the Lullaby Trust

Medical Advisor to Sudden Unexplained Death in Childhood UK

Research focus

My main areas of research are Child Death Review (CDR) and child safeguarding. Within CDR my work aims to improve learning from deaths, multi-agency working, support for families. My safeguarding research has involved child deaths related to abuse and neglect, children in kinship care and the impact of COVID.

Academic writing

I have 16 peer-reviewed publications of which I am lead author and have been co-author of over 40 more. I have contributed 4 chapters for textbooks. I regularly peer-review manuscripts for journals including Archives of Disease in Childhood, Child Abuse Review and BMJ Open, I have reviewed approximately 25 manuscripts in the last 3 years.

Doctoral Research Experience and Impact. I evaluated the new joint agency investigation of Sudden Unexpected Death in Infancy (SUDI) as detailed in 'Working Together to Safeguard Children' using a mixed methods approach. This study was the first to show the benefit of joint home visits by police and paediatricians after SUDI compared to police visiting homes alone, as this resulted in a more accurate understanding of the circumstances of death and parents greatly preferred this practice. Overall parents and professionals found all joint working practices beneficial, although parents wished for more information and emotional support. I submitted the findings from my PhD to the 2016 national review of SUDI guidelines, and as a result joint home visits have been strongly emphasised as best practice, and health professionals are advised to offer regular information and support to bereaved families. Commissioned by the government of New South Wales, Australia, I undertook an evidence review of alternative methods for SUDI investigation. My resulting recommendations were used to inform local SUDI policy. I have 7 peer review publications and 3 book chapters arising from my PhD research.

Post-Doctoral Research.

Current projects

Involving Parents and Staff in Learning from Child Deaths NIHR Research for Patient Benefit August 2022 – December April 2024

This project seeks to improve how parents are included in Child Death Reviews following expected child deaths in hospital, hospice or at home with palliative care. We interviewed bereaved families and staff about their experiences and have created together tools to support parental involvement. These are due for publication early summer 2024.

Improving Safeguarding Outcomes after Adoption or Special Guardianship, Sept 2023- Aug 2025

In this project, we will identify how safeguarding concerns arise after permanent placements and how they are best addressed. We will analyse social care files, and interview staff supporting these children and families and interview adoptive parents and guardians where children have had safeguarding concerns.

Previous projects

Serious Case Reviews (SCR)/ Child Safeguarding Practice Reviews (CSPR)

I was part of the team from the Universities of Warwick, Birmingham and East Anglia, conducting the triennial analysis of SCR in 2015 ,2018 and 2021; my remit was focusing on analysing recommendations for reviews, understanding the wider context of families subject to SCR and intra-familial Child Sexual Abuse.
The same team also analysed CSPRs for the National Safeguarding Panel in 2020 and 2021, my role was examining the quality and learning from these reviews.

Sudden Unexpected Death in Infancy

Following on from my SCR work, I conducted a thematic analysis of SCR of SUDI examining the parental backgrounds, behaviours and circumstances of death; this highlighted that most deaths were avoidable as these occurred when intoxicated parents shared sofas or beds with sleeping infants.
Working with colleagues from the Care of Next Infant Scheme, I led the analysis of sibling SUDI cases, these novel data have shown an approximate nine times risk of SUDI for siblings, the rarity of homicides but that safeguarding concerns are common.
I completed a national study comparing Child Death Overview Panels', and pathologists' and classification of cause of death for SUDI cases, showing the wide variation in practice and need for national consensus.
I worked with colleagues from the University of Bristol commissioned by the National Safeguarding Review Panel to conduct systematic reviews of the evidence for interventions to reduce the risk of SUDI in families at high risk. We produced three related reviews on effective interventions for high-risk families, interventions to improve engagement with professionals in families at risk of abuse, and parental decision making about sleep environments.

Reducing Infant Mortality in the West Midlands, West Midlands Clinical Research Network, June 2022- Dec 2023

This project co-designed a research proposal with bereaved ethnic minority parents, to help understand their experiences leading to infant death. We trained community researchers to undertake interviews and focus groups as part of any subsequent project.

Safeguarding

I led a team analysing data on child protection medical referrals in Birmingham during COVID compared to previous years; this project was completed and accepted for publication in BMJ Open within three months of initiation.

I conducted a service evaluation across Birmingham looking at the different referral rates for child protection medical examination for children living with birth families, children subject to child protection plans and children living with extended families under Special Guardianship Orders (SGO) highlighting that children subject to SGO are at high risk of further child abuse.

COVID response

I worked closely with the Research and Innovation team within Birmingham Community Healthcare to implement urgent Public Health projects. I was Principal Investigator for ISARIC (International Severe Acute Respiratory and Emerging Infection Consortium) and for sKIDS (COVID Surveillance in School Kids). The sKIDS study recruited 2000 participants from 18 local schools, with my team visiting schools weekly to obtain COVID swabs from children and staff.

Community Paediatric collaborations

I am a collaborator on several projects related to community paediatrics including challenging behaviour in children with learning disabilities and screening of school age children for Type 1 diabetes.

Selected recent publications

1. Garstang JJ, Menka MInfant death from accidental suffocation and strangulation in bed in England and Wales: rare or unrecognised events?BMJ Paediatrics Open 2024;8:e002419. doi: 10.1136/bmjpo-2023-002419
2. Garstang, J., Dickens, J., Menka, M., & Taylor, J. (2023). Improving professional practice in the investigation and management of intrafamilial child sexual abuse: Qualitative analysis of serious child protection reviews. Child abuse & neglect, 137, 106053. https://doi.org/10.1016/j.chiabu.2023.106053
3. Jonathan Dickens, Laura Cook, Jeanette Cossar, Cynthia Okpokiri, Julie Taylor, Joanna Garstang, Re-envisaging professional curiosity and challenge: Messages for child protection practice from reviews of serious cases in England, Children and Youth Services Review, 152, 2023, https://doi.org/10.1016/j.childyouth.2023.107081.
4. Taylor, J., Dickens, J., Garstang, J., Cook, L., Hallett, N. & Molloy, E. (2023) Tackling the 'normalisation of neglect': Messages from child protection reviews in England. Child Abuse Review, e2841. Available from: https://doi-org.bham-ezproxy.idm.oclc.org/10.1002/car.2841
5. Garstang J, Hallett N, Cropp G, Kenyon-Blair D, Morgans C, Taylor J. Service evaluation of child protection medical referrals for children subject to Special Guardianship Orders. BMJ Paediatrics Open ; 2021. 5, 1, e001103.

6. Garstang J, Eatwell D, Sidebotham P, Taylor J. Common factors in serious case reviews of child maltreatment where there is a medical cause of death: qualitative thematic analysis BMJ open. 2021 11, 8, e048689
7. Garstang JJ, Campbell MJ, Cohen MC, Coombs RC, Daman Willems C, McKenzie A, et al. Recurrent sudden unexpected death in infancy: a case series of sibling deaths. Arch Dis Child. 2020;105(10):945-50.
8. Garstang J, Debelle G, Anand I, Armstrong J, Botcher E, Chaplin H, et al. Effect of COVID-19 lockdown on child protection medical assessments: a retrospective observational study in Birmingham, UK. BMJ Open. 2020;10(9):e042867
9. Garstang J, Cohen M, Mitchell EA, Sidebotham P. Classification of sleep-related sudden unexpected death in infancy: A national survey. Acta Paediatr. 2020. Jul 12. doi: 10.1111/apa.15472.
10. Garstang J, Watson DL, S PA, Ellis C, Blair PS, Fleming P. Improving engagement with services to prevent Sudden Unexpected Death in Infancy (SUDI) in families with children at risk of significant harm: a systematic review of evidence. Child: Care Health and Development 2021-09 DOI: 10.1111/cch.12875
11. Pease A, Garstang JJ, Ellis C, Watson D, Ingram J, Cabral C, et al. Decision-making for the infant sleep environment among families with children considered to be at risk of sudden unexpected death in infancy: a systematic review and qualitative metasynthesis. BMJ Paediatrics Open. 2021;5(1):e000983.
12. Garstang J, Sidebotham P. Qualitative analysis of serious case reviews into unexpected infant deaths. Arch Dis Child. 2019;104(1):30-6.
13. Brandon M, Sidebotham P, Belderson P, Cleaver H, Dickens J, Garstang J, et al. Triennial review of serious case reviews 2014-2017 London: Department for Education; 2019.
14. Garstang J, Griffiths F. Working Together to Understand Why Infants Die: A Qualitative Study of Professionals' Experiences of Joint Agency Investigation of Sudden Unexpected Death in Infancy. Child Abuse Review. 2018;27(6):429-45.
15. Garstang J, Griffiths F, Sidebotham P. Rigour and Rapport: a qualitative study of parents' and professionals' experiences of joint agency infant death investigation. BMC pediatrics. 2017;17(1):48.
16. Garstang J, Griffiths F, Sidebotham P. Parental understanding and self-blame following sudden infant death: a mixed-methods study of bereaved parents' and professionals' experiences. BMJ Open. 2016;6(5):e011323.
17. Sidebotham P, Brandon M, Bailey S, Belderson P, Dodsworth J, Garstang J, et al. Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 London: Department for Education; 2016.
18. Garstang J, Ellis C, Griffiths F, Sidebotham P. Unintentional asphyxia, SIDS, and medically explained deaths: a descriptive study of outcomes of child death review (CDR) investigations following sudden unexpected death in infancy. Forensic Science, Medicine, and Pathology. 2016;12(4):407-15.

19. Garstang J, Ellis C, Sidebotham P. An evidence-based guide to the investigation of sudden unexpected death in infancy. Forensic Sci Med Pathol. 2015;11(3):345-57.
20. Garstang J, Griffiths F, Sidebotham P. What do bereaved parents want from professionals after the sudden death of their child: a systematic review of the literature. BMC pediatrics. 2014;14.