Witness Name: Karen Milne
Statement
Exhibits: **KM/1 - KM/2**
Dated: 29 May 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF KAREN MILNE

I, Karen Milne, will say as follows: -

1. There have been significant changes in my life both personally and professionally since the events at the Countess of Chester Hospital (COCH). in addition, for personal reasons, the years 2015-2018 were significantly distressing times for me and my family. For these reasons my recollection of certain events will be difficult.

Midwifery career and employment at the Countess of Chester Hospital (COCH)

2. I have set out below my employment history.

- 1993-1995: Health Care Assistant at COCH
- 1995-1998: Student Midwife, University of Chester
- 1998- 2005: Midwife at COCH
- 2005-2021: Named Midwife/Professional Safeguarding Children/Lead Domestic Abuse at the COCH
- June 2021 September 2021: Early Support Officer with Cheshire West & Chester Local Authority Childrens Social Care
- September 2021-May 2023: Bank Staff Member (Midwifery & Quality Team COCH)
- July 2023 (Fixed Term Contract until August 2024): Specialist Safeguarding Children Practitioner with Cheshire & Wirral NHS Partnership Trust

From Substantive Midwife to Safeguarding role / Training

3. I completed my university course with a diploma in higher education and qualification as a midwife and I secured a job at the COCH in August 1998.

4. Whilst working as a midwife at the COCH, I went back to Chester University and gained a BA Honours in Midwifery Studies in November 2003.

5. My work as a midwife frequently brought me into contact with those living with domestic abuse. At that time, the Head of Midwifery put out an expression of interest asking for staff to become members of a multi-agency working party to write the Trust's first Domestic Abuse policy. I took this on as an add to my substantive midwife post. In addition, I frequently encountered vulnerable families where there were *"child protection"* concerns and both child protection and domestic abuse became key issues in everyday midwifery practice. My dissertation for my degree looked at the role of the midwife in child protection. Legislation around child protection was changing following the death of Victoria Climbie and the Lord Laming Public Inquiry, which led to the 2004 Children Act and the Section 11 duty to cooperate with the Local Safeguarding Children Board (LSCB) requirement. The terminology changed from *"child protection"* to *"safeguarding".*

6. Those of us working in a safeguarding capacity were doing so as an add on to our substantive roles. It became increasingly clear that paid substantive roles were required to be able to comply with the new legislation and a business case led to my first substantive role (as a Band 6) in safeguarding. However, with an ever-increasing safeguarding caseload at the COCH, mainly in midwifery but also increasingly across the organisation, I was asked to put a business case together and I was then re-banded to a Band 7 and we recruited a Band 6 deputy to my role, which was a Nurse and Health Visitor around 2009. There was an expectation that I would work across the organisation (as opposed to just in Midwifery), my title changed with my role to Named Midwife/Professional Safeguarding Children/Lead Domestic Abuse. I cannot remember timelines but, supported by the requirements stated in the Intercollegiate Document, another business case resulted in my role being re-banded to an 8a (Band 8) range, and my deputy to Band 7. I cannot remember exactly when that happened. The Band 7 post changed title to *"Specialist Safeguarding Children Practitioner" (SSCP).*

7. During the time above and through to June 2021 when I left my substantive post at the COCH, I completed a whole range of regular training in all aspects of safeguarding. These included a Safeguarding Children Clinical Supervision course and a NHS England Leadership in Safeguarding training course.

Duties and responsibilities as the COCH's Named Midwife/Professional Safeguarding Children and Lead for Domestic Abuse 2015 and 2016

8. The *"safeguarding team"* consisted of myself and the SSCP in substantive paid roles. I worked 30 hours per week and the SSCP was a fulltime post. The team also had link nurses from the Accident & Emergency Department (ED) and the Children's unit, working 7.5 hours every other week.

9. During 2015 – 2016, my role consisted of being a source of advice, supervision, and support for staff (Nursing and Midwifery) in all matters related to safeguarding children and domestic abuse. We were a Monday to Friday 0830-1630 service. Staff would come to the team if they had identified a potential safeguarding issue for a child, or an unborn child, or concerns about an adult that could impact on their ability to care safely and effectively for their children. Most notifications came via Midwifery and the ED and would relate to a whole range of safeguarding issues including adult mental health issues, domestic abuse issues, substance misuse issues (that were impacting on the safe and effective care of children) children attending the ED with self-harm, mental health issues, potential signs of exploitation, concerns around other social and family circumstances. We had an open-door policy. Staff would knock on the office door, telephone, or use the notification system via the ED. Once a concern was raised with the team, we would liaise with other agencies and gather information to inform the next steps decision. This process would include liaising with the Local Authority Children's Services (LACS) health partners, police, and other relevant agencies as appropriate. Next steps could include no further action, information sharing with relevant health colleagues, partner health organisations, or referral to the Local Authority Children's Social Care (LACSC). The COCH's safeguarding processes were aligned with the Cheshire West Local Safeguarding Children Board (LSCB - now known as the Safeguarding Children's Partnership) processes as required by Section 11 of the 2004 Children Act. We delivered regular safeguarding children supervision sessions to community staff members, who were working with families in the community, for example, community midwives or community paediatric nurses. Supervision enabled regular review and reflection of individual cases to ensure that the multi-agency actions around each child were appropriate and at the right threshold of intervention. We would support staff (and would attend ourselves where required) with the initial and review Child Protection Case Conference, strategy meetings (where there was concern of

actual or potential for significant harm) and it was our role to contribute to the decision-making around these cases. We attended monthly Multi-Agency Risk Assessment Conferences (MARAC) led by the police, where we had a responsibility in decision-making about high-risk (at risk of serious or fatal injury) victims of domestic abuse, monthly multi-agency contextual safeguarding meetings to review children at risk of Child Criminal (CCE) and/or Child Sexual Exploitation (CSE), and other relevant multi-agency meetings such as multi-agency PREVENT meetings (reviewing children who could be at risk of radicalisation).

10. Whilst most of our work came via Midwifery and the ED, we would also deal with cases that arose on the Children's unit. These cases would usually relate to children with mental health issues, where there were concerns about family circumstances and safe discharge of children, potential cases of Non-Accidental Injury (NAI) or unexplained injury, which would always be led by a Consultant Paediatrician with support by the Named Doctor for Safeguarding Children, and cases where we would have input into a multi-agency Discharge Planning Meeting (DPM) to ensure safe discharge of a vulnerable child.

11. We would also on occasion be contacted by the Neonatal Unit (NNU) staff in relation to concerns for a new-born arising on the NNU, for example concerns about parental presentation or interaction, neonatal abstinence (drug withdrawal) or to attend DPMs as outlined above. We would also use the NNU (Nursery 4) as a place of safety if we had a new-born, where the child protection concerns had led to a local authority decision that parental contact had to be supervised. The NNU was utilised in these circumstances only if it was necessary and for a short a time as possible as it was recognised that a healthy baby should not be taking up a bed on the NNU. These incidences would be planned and managed within the Local Authority Child Protection Planning Process (Section 47 of 1989 Children's Act) and in line with local authority legal planning. Contacts from adult wards related to adult issues (that could impact on safe and effective care for children) were also increasing in numbers in 2015-2016.

12. As well as operational responsibilities as discussed above, the team was responsible for:

    - The preparation and delivery of safeguarding children training to staff across the organisation

- Supporting staff to write court reports and reports for child protection case conferences
- Supporting staff with report writing for the Section 47 Core Group meetings and Section 17 Child in Need meetings
- Supporting staff in early intervention processes, such as leading on a Team Around the Family (TAF)
- Members of LSCB multi-agency training team
- Completion of annual Trust safeguarding children audits and other relevant multi-agency safeguarding audits related to safeguarding children
- Completion of chronologies and Individual Agency Management Review for any relevant Serious Case Reviews or Child Safeguarding Practice reviews
- Completion of relevant actions following attendance to a monthly MARAC and Child Exploitation meetings

13. All our work reflected the statutory requirements as set out by the LSCB and Working Together to Safeguarding Children 2015. The Executive Lead for Safeguarding Children was the Director of Nursing & Quality, Alison Kelly, who also had the below responsibilities in relation safeguarding and domestic abuse:

- The COCH's board representative on the LSCB
- The Chair of the Local Multi-Agency Domestic Abuse Steering Group
- The Chair of the COCH's Safeguarding Strategy Board

14. I met with the Executive Lead for my 1:1s. I cannot recall if the meetings were monthly or bi-monthly. The aim of the meetings was to touch base in relation to what was happening within safeguarding and to discuss the progress in relation to the annual submission of the Commissioning Standards to the Clinical Commissioning Group (CCG) and others such as:

- The Quarterly Safeguarding Assurance Framework to the CCG
- Trust safeguarding children training compliance
- The Annual safeguarding Children Report - I had responsibility for gathering the information for the report from relevant data drawn from the safeguarding children team's work and by asking for updates from relevant colleagues across the Trust. The report was given in first draft for the Executive Lead to approve before the Executive Lead would present it to the Trust Board. The reports were retrospective for the previous financial year.

15. I was required to have regular meetings with the Designated Nurse for safeguarding children in the CCG. We would discuss the same issues as I would discuss with the COCH's Executive Lead, but these discussions were in relation to the CCG expectations of the COCH as a provider in relation to the Commissioning Standards.

16. It is difficult to reflect on the nature and amount of work that was covered, the figures shown in the annual safeguarding reports year-on-year evidenced an ongoing increase in the cases dealt with by the team and consequentially, an increase in the daily workload. I have previously mentioned that we were essentially a team of two and the workload was relentless and often difficult to manage. However, we were a dedicated team and gave every case the utmost attention.

Concerns or suspicions at the hospital

17. In 2015 - 2016 I worked within the hospital, but my work involved many multi-agency meetings external to the hospital.

18. I cannot remember when or how I became aware of increased infant mortality on the hospital NNU, but I was made aware that the Royal College of Paediatrics and Child Health (RCPCH) came into the hospital to review the situation. I vaguely recall myself and the Named Doctor for safeguarding children having a meeting with the RCPCH.

19. I never participated in or overheard any discussions about an unexpected death of a baby at the hospital.

20. I cannot remember dates, but during a routine 1-1 meeting with the Executive Lead for safeguarding, I noted that they appeared very preoccupied. I think I recall they may have stepped out of the office briefly and then returned. The Executive Lead said something about the police being called in relation to a member of staff from the NNU. I cannot remember the exact words used, but I can remember that I responded by stating that, if there was any suspicion whatsoever that a member of staff was causing harm, the police had to be called. The Executive Lead was not asking for my advice or my opinion, they were telling me something that had happened or was happening. I remember feeling very anxious and very shocked. I left that meeting and returned immediately to my office and was in a state shock. I told the Specialist Nurse Safeguarding Children about what had happened in confidence. I knew how serious

and awful a situation it was, and I never discussed this with anyone else. Sometime after this, the media was set up in the car park. I only became aware of the name of the staff member when the name came into the public domain.

21. In addition, at some point prior to the above, the Executive Lead on one occasion had shared with me that a member of staff from the NNU had been re-deployed to a non-patient role due to their practice concerns. My advice was not being sought, and I would have been told at the end of the 1:1 when out of care and courtesy, I would always ask the Executive Lead how they were. I knew they carried enormous responsibilities and sometimes they would share some of their current workload with me. I was not given any other specific details related to the name of the staff member or the re-deployment area. I cannot recall if this was before or after the RCPCH were at the Trust regarding the excess deaths. I know that when this information was given to me, I would have linked the situation to competency in practice and that something about their practice had been raised and to ensure that there was no risk to patients the staff member had been re-deployed. In my NHS career, I have known situations where staff members have been re-deployed to non-patient facing roles either because of their own wellbeing or because of concerns around their practice, or because they have made a mistake. Re-deployment would be in place until matters were investigated and resolved. This could also include referral to the relevant professional body. Previously in midwifery for example, the individual would be on a period of supervised practice before returning to normal practice and I have also known of cases where staff members were dismissed. In my safeguarding role if advice had been sought from me in relation to an issue such as re-deployment because of concerns about practice, I would have advised re-deployment until investigations were concluded and a return to normal practice only if there were assurances of the staff members competence. Safeguarding would not however have been involved in the investigative process. It would have been for the relevant managers and professional body to resolve. However, if information was shared with safeguarding pertaining to a staff member potentially deliberately or potentially knowingly causing harm or deliberately and knowingly withholding care, the advice given would be that the police would need to be involved in any investigation and that the staff member could not be in a patient-facing role until all investigations were completed. If safeguarding were made aware of a case in this context in 2015-2016, another step would have been to refer the staff member to the Local Area Designated Officer at the LSCB. which in 2015 was a relatively new requirement.

22. Nothing was reported to me directly about concerns regarding Letby deliberately harming babies and with the benefit of hindsight, I would have expected the safeguarding team to be contacted by any member of staff who thought someone was deliberately harming babies. I was very shocked, saddened, and distressed when the crimes came to light, and I always will be. What has taken place at the COCH will live with me for the rest of my life, and I will always feel extremely sad that babies were being harmed whilst I worked there. My small team and I worked tirelessly to reduce risk to babies and children, we had an open-door policy, and no question was a silly question, so I am deeply disappointed. I feel that what has happened has completely undermined all the hard work we did. My small team worked with sincere commitment, including working long hours over and above what we were contracted to do, which was often commented on in my annual individual performance reviews. Given what has happened and the trauma that the families involved have had to face and will have to face for the rest of their lives, it makes me personally feel that the safeguarding work we did has paled into insignificance. I used to feel proud of all that our very small team achieved in protecting and reducing risk to hundreds, possibly thousands of children and adults, proud to work at the COCH and proud of what I had achieved in my career, but I do not feel like that now, I only feel a deep sadness about what has happened.

Safeguarding Policies and Roles

23. I was responsible for the below policies:

    - Safeguarding and Promoting the Welfare of Children policy
    - Domestic Abuse Policy
    - Safeguarding Children Clinical Supervision Policy

24. There might have been a safeguarding adult policy (although I am not certain). It was the responsibility of another individual.

25. The other policies listed in **KM/1 [INQ0004505] page 3]** were linked policies, but I was not responsible for them.

26. I confirm and have listed below the professional responsibilities of the following individuals as below.

- Executive Lead for safeguarding – Alison Kelly Director of Nursing
- Named Midwife/ Professional Safeguarding Children Lead for Domestic Abuse/ Lead for CSE – Karen Milne (myself)
- Specialist Safeguarding Children Practitioner – Paula Lewis (responsible for daily safeguarding children work as discussed above)
- Link ED Nurse – Vivian Beswick (she was an Advanced Nurse Practitioner in the ED and worked two days a month with the safeguarding children team).
- Named Doctor for Safeguarding Children – Dr Howyada Isaac (Consultant Community Paediatrician, who supported paediatricians with safeguarding. For Example, in relation to NAI)
- Designated Doctor Safeguarding Children – Dr Rajeev Mittal (Consultant Community Paediatrician, Child Death Overview Panel lead, SUDIC Lead).

Annual Safeguarding Report from the Countess of Chester

27. The document Safeguarding Children Annual Report 2015 – 2016 KM/1 [INQ0004505] was the annual report covering the period end of March 2015 to the beginning of April 2016. This report would have been written around May – June 2016. The report was for the Trust Board and its purpose was to give an annual safeguarding children update. The contents in the report were a combination of the figures relating to the work carried out in the period covered, and information requested from other sources. The comments from hospital staff at Appendix 1 of the report from Karen Rees (Head of Nursing Urgent Care), Julie Fogarty (Head of Midwifery), Dr Ravi Jayaram (Consultant Paediatrician and Lead Clinician for Children's Services) came about because when collating the annual report, I would contact random members of staff for comments to include in the report. This was done by email and all comments came back to me via email. My request would usually be along the lines of *"I am completing the annual report and would appreciate a brief summary of your view of the work of the safeguarding team".* I did this to try and demonstrate to the Trust Board, the visibility, and staff opinion of the safeguarding team. When I wrote the report, I was not aware of any suspicions or concerns about Lucy (Letby), and I cannot recall if I was aware of increased mortality on the NNU at that time. I collated the report and drew on information provided to me from other sources. The report would be written in draft and then approved by the Executive Lead for safeguarding, Alison Kelly, who would then

present the report to the Quality, Safety and Patient Experience Committee and then to the Board.

Local Safeguarding Children Board

28. The hospital was represented on the LSCB board by the Executive Lead for safeguarding.

29. In 2015-2016, I represented the hospital on the LSCB multi-agency performance management and quality assurance subgroup. I think at this time myself and the SSCP were also members of the LSCB training subgroup and the LSCB multi-agency audit subgroup. I was not aware of any suspicions about a staff member and so did not pass on any information to the LSCB or any Police representatives at the LSCB.

30. There was an LSCB Local Area Designated Officer (LADO) process in place for when agencies had potential concerns about an adult and their suitability to work with children. I cannot recall any specific case involving a staff member who worked with children at the COCH, but I was involved in a case with a staff member where there were concerns about them being a perpetrator of high-risk domestic abuse against their own elderly parent and they were caring for elderly vulnerable patients at the hospital. We dealt with this case through the adult safeguarding Persons in Position of Trust (PIPOT).

31. The quarterly data being submitted to the LSCB Performance Management and Quality Assurance subgroup that is mentioned in the 2015-2016 Annual Report refers to the Safeguarding Assurance Framework (SAF) that was a quarterly return to the CCG. This included much of the data that was included in the COCH's annual safeguarding report such as numbers of safeguarding notifications to the hospital safeguarding team, numbers of referral to Children's Social Care, numbers of safeguarding supervision sessions delivered and levels of compliance with safeguarding children training. The SAF was overseen and monitored by the CCG Designated Nurse, who in turn used it for assurances to the LSCB regarding the hospital safeguarding processes and work. The SAF data was also used to populate and comply with the CCG annual commissioning standards for safeguarding.

32. I cannot remember, but I am not aware of any information pertaining to the increased mortality rates at the hospital NNU being shared with the LSCB performance management and quality assurance subgroup. If the LSCB had asked me about that sort of information, I would have referred them to the Executive Lead for safeguarding or to the Named Doctor / or the Designated Doctor for safeguarding and I do not recall doing this. Increased mortality on the NNU was not in my area of expertise, I would not have been able to answer any queries about this or potential reasons for increased mortality rates.

33. If I recall correctly, the Local Area Designated Officer (LADO) process was beginning to be implemented in 2015-2016. If a person working in an identifiable profession was thought to be a risk to children, then a referral to the LADO in the LSCB would be required and this would be alongside whatever other actions were taking place.

34. During 2015-2016 on a quarterly basis the COCH submitted data to this LSCB subgroup pertaining to the child self-harm attendance to the COCH's Emergency Department. This will have been required so that the LSCB and the multi-agency partners could try to gain an understanding of the level of child self-harm at that time. In the 2015-2016 reporting period, the quarter four data included 11 children, who were already inpatient due to mental health issues in local adolescent mental health units. This information was highlighted as a significant concern at the Performance Management & Quality Assurance meeting on the 12th of May 2016. Whilst it was recognised that very sadly children and Young People in the frame of mind of wishing to self-harm will use any means at their disposal to do so, it was concerning that they were still managing to self-harm whilst inpatient in a mental health inpatient setting, and this needed to be explored further. The information above related to self-harm attendances was part of the data submitted to the CCG via the Safeguarding Assurance Framework, which was a quarterly submission and included data in relation to for example, Trust compliance with safeguarding training, numbers of safeguarding supervision sessions delivered to staff, numbers of referrals to children's social care, numbers of child protection medicals completed by paediatricians where concerns about unexplained or non-accidental injuries had been raised. Some of the data submitted came from records of work within the safeguarding team, some of the data for example, numbers of child protection medicals came from the Designated or named Doctors for safeguarding. There were no reports from me through these conduits to the LSCB regarding excess deaths on the NNU.

35. The Annual Safeguarding Report from the Countess of Chester 2016-2017 report **KM/2 [INQ0004715]** would have been written around May-June 2017. The information for the report was collated as discussed above for the 2015-2016 report and overseen by the Executive Lead for safeguarding before being presented to the Trust Board by the Executive Lead for safeguarding, just as outlined above for the 2015-2016 report. I note that extract from the report which states:

> *"There were a cluster of neonatal deaths identified between June 2015 and June 2015 at the Countess of Chester Hospital which are being investigated by the Cheshire Police. As a result of this inquiry, some changes have been made to the Pan Cheshire CDOP process called SUDIC protocol. The new protocol will be applicable to any baby who dies in the neonatal unit or unexpected collapse in the neonatal unit or any neonatal death >24 weeks gestation for the next 6 months (till 2017 end). It has also been identified the importance of understanding the CDOP process within North Wales and in maintaining effective communication with colleagues across the border."*

36. The wording and information above about the cluster of deaths being investigated by Cheshire Police will have been given to me to include in the report. I would not have been able to write this myself as I did not have any role in what was happening in that regard. This information will have been given to me to include either by the Executive Lead for safeguarding or by the CDOP Lead. I collated the report and drew on information provided to me from other sources. The report would be written in draft and then approved by the Executive lead for safeguarding, Alison Kelly, who would then present the report to the Quality, Safety and Patient Experience Committee and then to the Board. I was not permitted to share the report with any other party until it had been approved at the Trust Board.

37. As I have mentioned above, the one conversation I had with the Executive Lead for safeguarding when they shared with me that the police were being called was the first and only time any discussion was had with me about the suspicions of deliberate harm related to a staff member. I cannot remember the date of this conversation, only that it had a profound effect on me, and I recall being in a state of shock. I shared what I had been told confidentially, on the day that I was told, with the Specialist Safeguarding Children Practitioner when I got back to my office. Given what is written in

KM/2 [INQ0004715] that one conversation with the Executive Lead must have been before June 2017 or otherwise the information pertaining to Cheshire Police involvement could not have been in that report.

38. I do not recall what changes were made to the Sudden Death in Infancy (SUDIC) protocol. The SUDIC protocol was led by the Designated Doctor for Safeguarding Children. I could only do so much and the remit I already had was huge. The Child Death Overview Panel (CDOP), SUDIC and leading on for example, NAI's and fabricated illness was the responsibility of the Named and Designated Doctors for safeguarding and the paediatricians. The role of the CDOP was to review the death of every child 0-18 years whose death was not expected in the 24 hours prior to death. The CDOP process was a multi-agency process, led by the Designated Doctor. There was also a CDOP Nurse in post (employed by a partner agency). I had no direct involvement in this CDOP process and would not have had the capacity to do so at that time. In line with safeguarding colleagues nationally, learning from deaths that came from the CDOP processes would be shared more widely as appropriate and included in training updates. I by no means have the expertise to question the CDOP process, but I do think about why the CDOP process did not identify that something untoward could have been taking place.

The Culture and atmosphere on the neonatal unit at the hospital in 2015-2016

39. I did not work on the NNU and only attended there occasionally if we had a baby resident there that, for example, had been made subject to a child protection plan, or was residing there as a place of safety due to parents only being permitted supervised contact, or if we were having a safeguarding Discharge Planning Meeting for a baby who was ready for discharge from the NNU. In all contacts with the staff on the NNU as mentioned above, the NNU staff were always professional and fully engaged with the safeguarding requirements. I am unable to say what the relationships between different disciplines of staff were like or make any comments on whether the quality of relationships on the NNU affected the quality of the care being given to babies on the unit.

40. I was not involved in any governance boards or meetings, and I am unable to comment on professional relationships affecting the management and governance at the hospital in 2015-2016.

Reflections

41. The Lucy Letby crimes have had a profound effect on everyone involved and this should not be underestimated. My very small team and I worked tirelessly and in the face of adversity at the hospital to reduce risk to babies and children and I am sure that our work saved the lives of many, as well as our work in relation to domestic abuse that reduced risk and saved the lives of many adults. We spent most of our working hours firefighting and exhausted but in the face of austerity and the Trust having huge financial deficits, my repeated requests for more resource to the team went unresolved. We were proud of the work we did; no query to our team was unanswered. On reflection, I do not believe the Executive team had any real understanding of the work that we did or the pressures we were under, and of the work we did every day to ensure the Trust was compliant with all its safeguarding children and domestic abuse requirements. The work was distressing and unrelenting, and regularly brought us into conflict with parents and carers, but we saw it as our duty to our service users. We were respectful and kind, but I do not feel that was always replicated back to us as it should have been by the Executive team. It is deeply saddening and will remain with me forever that despite all the work my small team was doing in 2015-2016 this terrible event took place, and I cannot begin to imagine the pain and suffering caused for the families involved. I no longer work at the hospital having taken early retirement in June 2021. When I reflect on the small team that I had and what the hospital now invests in safeguarding, I feel let down by the hospital. It is right that the investment is now there, but this should have happened many years ago. I was not party to what was going on behind the scenes regarding the NNU in 2015-2016 and therefore, I do not know if what happened could have been stopped or if the police should have been called sooner. However, I wonder now if there had been greater investment and a more senior presence/recognition from the Executive team towards safeguarding, could things have been different? The Paediatricians could seek advice from the Named or Designated Doctors for safeguarding, and were more likely to do so, given the Named and Designated Doctors for safeguarding were also Consultant Paediatricians and so the Paediatricians may have valued their opinion more than that of a midwife or nurse. I do not know if the Paediatricians spoke to the Named or Designated Doctors for safeguarding about their concerns about the NNU. If a comparison is made in what was invested in safeguarding children at the hospital in 2015-2016 and what is invested now, and of the seniority of the safeguarding team within the Trust structure now, there is no comparison to 2015-2016; perhaps this had a bearing on what happened. The

annual safeguarding children reports for 2015-2016 and 2016-2017 used to support this statement go some way to illustrate the amount and nature of the work we did year on year. We were absolutely committed to our work. In our training, we frequently spoke about having to sometimes believe the unbelievable in terms of information sharing, and in relation to safeguarding, we also told staff it is better to be held to account for sharing information than to be held to account for not sharing information. We always supported staff when they and we were trying to think both the best and worst of parents and carers. It is all this that makes knowing what has happened difficult to comprehend. The two reports mentioned above also contain a paragraph related to the challenges and the pressures that the safeguarding team were working with.

42. I only know what the public knows about Letby's actions on the NNU. I did my best not to spend time with the details of the trial as it is so distressing to know that was taking place in the hospital NNU and thinking about the families this has affected. However, I do think CCTV should be in all NNUs and in all hospital areas where staff are caring for vulnerable service users who do not have their own voice.

43. There should be more familiarity between senior management and Executive teams and frontline operational staff. The hierarchy of them and us model is uncomfortable and demeaning to frontline operational staff. This can mean the staff will not stand up for themselves or to the hierarchy. Trusts must not put financial savings above ensuring that all staff groups are properly resourced so that they can do their jobs properly. In my opinion, the NHS cannot continue to operate as it has been with a top-down approach. I left the hospital in 2021 because of the way I felt I was treated by some members of the senior staff in place at that point; these sorts of behaviours must stop. Respect from the top to all members of staff should be the golden thread that runs through every decision made by the Executives so that staff do feel valued, respected and that they know they do have a voice and can speak up without fear of what could happen to them if they do.

Any other matters

44. I have been asked about the role and purpose of the LSCB performance management and Quality Assurance subgroup. The Inquiry could ask the current safeguarding Children Partnership if they have an archived terms of reference for the Performance Management & Quality Assurance subgroup in 2015-2016 and 2016-2017.

45. I have not and would not ever give any interviews or any public comment to anyone about this case. I would see this as distasteful and hurtful to the families involved.

Request for documents

46. I do not have any documents that are relevant to the Inquiry's Terms of Reference.

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 in its truth.

Signed: **Personal Data**

Dated: 29.05.2024 | 16:09:01 BST