Witness Name: [Charles William Yoxall]
Statement No.: [1]
Exhibits: [CWY/a – CWY/v]
Dated: 03/06/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR CHARLES WILLIAM YOXALL

I, Dr Charles William Yoxall, will say as follows: -

Background and Experience

1. I qualified as a doctor (B.Med.Sc., BM, B.S.) from Nottingham University Medical School in 1986. I became a Member of the Royal College of Physicians (MRCP) in March 1990 and a Member, then a Fellow of the Royal College of Paediatrics and Child Health (RCPCH) in April 1997. I was awarded the degree of Doctor of Medicine (MD) from the University of Liverpool in 1999.

2. After completing medical school, I worked for one year as a pre-registration house officer in Derbyshire Royal Infirmary and Nottingham City Hospital, following which I spent 6 months practising adult medicine at Nottingham City Hospital as a senior house officer. Following this, I commenced my paediatric training and from August 1987 to September 1990 I was a Paediatric Senior House Officer, then Locum Paediatric Registrar in Derby and Nottingham Hospitals. In 1990 I commenced my paediatric registrar training in Mersey Deanery, working in Warrington District General Hospital, Alder Hey Children's Hospital and Liverpool Maternity Hospital between October 1990 and August 1993. I thereafter spent 2 years as a Clinical Research Fellow in the Department of Child Health at the University of Liverpool, doing neonatal research based at Liverpool Maternity Hospital. From September 1995 to March 1997, I was a Lecturer in Neonatal Medicine at the University of Liverpool. I worked clinically at Liverpool Maternity Hospital during this period, transferring to Liverpool Women's Hospital (LWH) when that opened in November 1995.

3. I was appointed as a Consultant in Neonatal Medicine at LWH in April 1997 and continued to work there until I retired in November 2020. I also worked as the Paediatric Training Programme Director for Mersey Deanery from July 2002 to September 2007. I had an honorary contract with University of Liverpool throughout my consultant career. I was actively involved in clinical research and contributed to medical and nurse education and training.

4. During my time as a Consultant at LWH I spent 9 years as the Clinical Director of the Neonatal Unit (NNU) from March 2010. I was therefore the Clinical Director of the NNU during 2015 and 2016. In this role I was a part of the NNU management team, responsible for day to day operational issues as well as longer term strategic development of the service. I was responsible for appointing and managing the consultant team and had responsibilities for the neonatal budget. I was responsible for overseeing the management of clinical incidents and monitoring the NNU's clinical standards.

5. I was a member of various committees in the hospital during my time at LWH and represented the Trust at various local and regional committees, including the Cheshire and Mersey Neonatal Network Steering Group. I was also a member of the British Association for Perinatal Medicine, The Neonatal Society and the British Medical Association.

6. I relinquished the role of Clinical Director in 2019 in preparation for my retirement. During the last couple of years of my work as a consultant, I had 2 main non-clinical responsibilities. The first was overseeing the development of the new neonatal unit at LWH. My second non-clinical responsibility during this period was as the Lead for Medical Appraisal in the Trust, ensuring that all consultants had an effective annual appraisal to inform their revalidation in line with GMC requirements.

7. I retired from clinical practise in November 2020. I am still on the Medical Register with the General Medical Council (GMC) but relinquished my license to practise in 2022. I still have an honorary contract as honorary lecturer with the University of Liverpool.

8. Since retirement, I have continued to act in various medical roles. I completed several research and clinical improvement projects that were ongoing at the time of my retirement and have had these published as peer reviewed articles. I have a medico-legal practice, producing reports for the court, mostly in relation to medical negligence claims, but also

for His Majesty's Coroner. In addition, I also did some paid work for Cheshire Constabulary, examining neonatal case notes from the Countess of Chester Hospital (COCH) to assist in the identification of any potential cases that should be investigated further in relation to Project Hummingbird; I performed this work between July 2021 and February 2023.

Cheshire and Mersey Neonatal Network

Background and working relationships

9. Cheshire and Mersey Neonatal Network (CMNN) is a network of 8 neonatal units (LWH, Arrowe Park, Ormskirk, Whiston, Warrington, COCH, Macclesfield and Leighton) with an additional surgical neonatal unit at Alder Hey Children's Hospital. Although Neonatal Networks were established in 2004, they were in a state of transition during 2015/2016. Neonatal Operational Delivery Networks (ODN) were being established in England in 2015. The North West ODN was established to cover the areas previously covered by 3 clinical neonatal networks (Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria).

10. The units at LWH and Arrowe Park were designated as Neonatal Intensive Care Units (NICU) for the CMNN during this period. The other units were designated as either Local Neonatal Units (LNU – Whiston, Warrington, Chester, Leighton) or Special Care Baby Units (SCBU – Ormskirk, Macclesfield).

11. The NICUs were responsible for the care of babies who needed intensive care. This included the most premature babies, babies with severe infections, life threatening malformations or severe birth asphyxia. Babies who were expected to require intensive care (including those below 27 weeks gestation at birth) were planned to be delivered at one of the NICUs. Obviously, this was not always possible, so all units had to have the capacity to resuscitate and stabilise babies who were sick, prior to transfer to a NICU for intensive care if required. LNUs could provide care for babies who unexpectedly required intensive care for less than 48 hours. All other babies were supposed to be cared for at LWH or Arrowe Park Hospital.

12. The NICU at LWH was the largest of the two NICUs and did the bulk of the intensive care for the CMNN, including all of the care for babies with life threatening malformation or surgical or cardiac problems (in collaboration with Alder Hey Children's Hospital).

13. The relationship between LWH and COCH at this time was generally very good. If a consultant at COCH was caring for a baby and needed more expert advice on the care of that baby, they could, and did, call the neonatology consultant on call at LWH. Sometimes the registrar on call at COCH would call the LWH consultant; this was always done at the request of, and with the knowledge of, the COCH consultant. It was not our practise in LWH prior to 2016 to make a record of the advice that we gave. We expected the doctors in COCH to record the advice in their case notes. In mid-2016, LWH introduced a system of making our own record of any advice given. This system required that we record the details of the call received and advice given using a standard proforma with an SBAR layout (Situation, Background, Assessment, Recommendation); these forms were then stored in a shared folder on the LWH computer network, accessible to all neonatal consultants.

14. If it was deemed that a baby required an 'uplift' to Intensive Care then, after this was agreed between the consultants, the Neonatal Transport Team would be contacted and a transfer would be instigated. The preferred NICU for COCH babies was Arrowe Park as this was closer than LWH and it was decided that this would be easier for the parents. Some babies were still transferred to LWH due to capacity problems at Arrowe Park or because of the nature of the medical condition (e.g. the need for cardiac or surgical intervention). Sometimes, if a consultant in COCH wanted to transfer a baby for intensive care, they would contact the on call consultant for the Neonatal Transport Team directly and that team would arrange the transfer, including the location that the baby was being moved to.

15. Subsequently, it was agreed that all transfers would be arranged by a telephone conference which included the referring consultant, the receiving consultant and the transport consultant. I cannot clearly recall when that process was introduced, but I believe it was after 2015/2016.

<u>CMNN Clinical Effectiveness Group and CMNN Steering Group</u>

16. In my role as a consultant and clinical director at LWH I attended various committee meetings in relation to the CMNN. I was a member of the CMNN Steering Group and attended meetings regularly. These meetings took place on a quarterly basis. The group included two representatives from each of the units in the CMNN, the Network Director, Network Clinical Lead and other officers and administrative support for the CMNN. There was also a parent representative. The aim was for members to attend at least 75% of meetings, but from recollection, attendance was generally inconsistent. I recollect that one of the specialist commissioners from NHS England (NHSE) also attended the Steering Group during the period prior to the development of the ODN. NHSE commissioners did not routinely attend the CMNN Steering Group meetings after that time, as I understand that they attended the ODN Board instead. Roz Jones, Senior Service Specialists at NHSE, is recorded as an attendee in the minutes from the meeting on 3 December 2015, but not subsequently.

17. I was not a member of the CMNN Clinical Effectiveness Group (CEG) and did not attend any of those meetings. I would therefore be unable to comment about any of the minutes formulated as a result of those particular meetings.

18. I was also not a member of the ODN Board and did not attend any of those meetings. I would therefore be unable to comment about any of the minutes formulated as a result of those particular meetings either.

19. As a member of the CMNN, I also participated in the Surgical Interest Group and participated in projects to develop the future configuration of the surgical and Intensive Care service across the CMNN. I do not consider that work or those committees to have any relevance to the Inquiry's Terms of Reference.

20. I became a member of the CMNN Steering Group when I became the Clinical Director of the NNU at LWH in March 2010 and continued as a member until 2019. After the creation of the ODN in 2015, the pre-existing steering groups of each of the preceding networks continued to manage local issues and their work was overseen by the ODN Board.

21. At the CMNN Steering Group, we did not discuss specific deaths or review adverse clinical incidents. Each unit within the network had a responsibility to review adverse clinical incidents and neonatal deaths internally. My recollection is that the results of each

mortality review, along with lessons learned were presented to the CEG. The CMNN Steering Group only sometimes received minutes from the CEG 'for information only' and these were not usually discussed by the Steering Group. There was no other formal contact between the CMNN Steering Group and the CEG, although the committees had some members in common and it was my understanding that issues identified at the CEG would be presented to the CMNN Steering Group and vice versa by these individuals.

CMNN Steering Group Meetings – 4 June 2015 and 29 January 2016

22. "Neonatal mortality" is referenced within the minutes from the CMNN Steering Group meeting for 4 June 2015 **[INQ0005526, pages 5-6]**, similarly this is referenced within the minutes from the CMNN Steering Group meeting of 29 January 2016 [**INQ0005560, page 6**]. This discussion related to the proposal to participate in the development and adoption of a standardised Perinatal Mortality Review Tool (PMRT) which was to be rolled out nationally. There was agreement by the Steering Group on both occasions that the CMNN should be involved in this.

23. Prior to this, there was no agreed, standardised method for conducting neonatal mortality reviews. At LWH, we had a standard method and reviewed all deaths. It was my understanding that a summary of each of the mortality reviews was presented to the CEG, but there was no other requirement for us to share the results of those reviews externally as a routine. If we considered that an individual death had occurred because of a Serious Unexpected Incident (SUI) we would report this to the local Clinical Commissioning Group (CCG) and share any subsequent investigation. I do not know what system was in use for conducting mortality reviews at COCH at that time, although the requirement to report all SUIs to their local CCG would have been the same.

24. A standardised system for performing and reporting neonatal mortality reviews was launched in 2018; this is known as the PMRT. This was produced in collaboration with and led by MBRRACE-UK, which was appointed by the Healthcare Quality Improvement Partnership (HQIP). The work under discussion at the CMNN Steering Group meetings referenced above eventually fed into the development and adoption of the PMRT.

25. There was no discussion about any individual deaths or any mortality data in relation to these CMNN Steering Group items. As indicated above, I understand that the summaries of mortality reviews were discussed at the CEG, of which I was not a member.

Mortality Rates

26. Mortality rates were never discussed in any detail at the CMNN Steering Group. There was often an item on the agenda entitled "Data Report" and there was on occasion an embedded file within the agenda called the "Quarterly Data Report". The Quarterly Data Report was a document that was usually about 15 pages long and contained activity information from the network (the number of admissions at each unit broken down by birthweight and gestation, the number of days of care at each level of dependency at each unit, the occupancy (proportion of cots occupied) at each unit, etc.). The report also included some data relating to the number of deaths in each unit within the network during each quarter; this generally made up 1 page of the document. The Quarterly Data Report was sometimes unavailable during 2015 and 2016, due to the absence of data analysts which I believe related to the transitional period during which the CMNN was becoming a part of the ODN.

27. To assist with my recollections, I have reviewed all the CMNN Steering Group agenda papers and minutes relating to the period 2015/2016. Generally, the agenda for the Steering Group meetings would be sent by email to all Steering Group members several weeks before the meeting. The agenda document contained a series of embedded papers; these included the minutes of the previous meeting and papers relevant to the items that were due to be discussed at the meeting. The Quarterly Data Report, when available, was also included as an embedded document. The expectation was that Steering Group members would read these papers before the meeting so that there could be an informed discussion. From comments made to me before and during many of these meetings, it was apparent that many members did not read the papers before attending. Some documents were included 'for information only' and there was no discussion timetabled in relation to these items.

28. I can see that the Quarterly Data Report reporting deaths occurring during the period quarter 4 of 2013/2014 to quarter 3 of 2014/2015 (i.e. from January 2014 to December 2014) [**Exhibit CWY/a -** **INQ0101121**] was available for the meeting held on 12 March 2015 [**Exhibit CWY/b -** **INQ0101122**]. This report showed that there had been 3 deaths in COCH during this period, all of which had occurred in January to March 2014. In the minutes from this meeting [**Exhibit CWY/c -** **INQ0101169**] there was no discussion with respect to the mortality data recorded.

29. The agenda for the meeting held on 4 June 2015 included an item entitled "Data Report" [**Exhibit CWY/d - INQ0101171**]. There was however no data file for the report embedded within the agenda. The minutes of this meeting record that the production of the Quarterly Data Report had temporarily ceased as there was no data analyst available [**Exhibit CWY/e - INQ0101186**].

30. The agenda for the meeting held on 16 September 2015 includes an item entitled "Data Report" [**Exhibit CWY/f - INQ0101189**] but again there was no embedded file. The minutes from that meeting record that there was no Quarterly Data Report available [**Exhibit CWY/g - INQ0101212**].

31. The agenda for the meeting of 3 December 2015 includes an item entitled "Data Report" [**Exhibit CWY/h - INQ0101217**] and the agenda contains an embedded file. The embedded report presents mortality data from quarter 1 of 2014/2015 to quarter 4 of 2014/2015, but from only 5 of the units in the CMNN. There is no data presented from COCH in this report [**Exhibit CWY/I - INQ0101248**]. The minutes from this meeting record that there was a discussion about the data report, but that this was 'work in progress' [**Exhibit CWY/j - INQ0101249**]. I was not present at this meeting as I was the consultant on duty for the NICU at LWH on that day.

32. There was no Quarterly Data Report embedded within the agenda for the CMNN Steering Group meeting of 29 January 2016, although there was an agenda item listed for the Quarterly Data Report to be discussed [**Exhibit CWY/k - INQ0101251**]. The minutes of that meeting state that the Quarterly Data Report was 'shared for information' [**Exhibit CWY/I - INQ0101269**] but there was no mention of any discussion of this report. I was present at that meeting and have no recollection of seeing the report or any discussion about it. The report was not present as an embedded paper within the agenda and I have no record of it being sent to me separately by email before or after the meeting. In preparation for producing this statement, I have obtained a copy of the Quarterly Data Report to the end of quarter 3 of 2015/2016 from North West ODN [**Exhibit CWY/m - INQ0101271**]; I obtained this report on 22 May 2024 and note that it was marked as a "draft" report. I assume that this was the report that is referenced within the minutes as having been 'shared for information' at the meeting on 29 January 2016. This report shows that there had been 8 deaths in COCH during the preceding 12 months, with 2 or 3 in each quarter.

33. There was no Quarterly Data Report embedded within the agenda for the CMNN Steering Group meeting of 12 May 2016 [**Exhibit CWY/n -** **INQ0101272**]. The minutes record that the Quarterly Data Report would be provided for the next meeting [**Exhibit CWY/o -** **INQ0101286**].

34. The agenda from the CMNN Steering Group meeting of 13 July 2016 does contain a Quarterly Data Report embedded within it [**Exhibit CWY/p -** **INQ0101287**]. This report [**Exhibit CWY/q -** **INQ0101303**]. showed that there had been 10 deaths at COCH between the period quarter 2 of 2015/2016 to quarter 1 of 2016/2017 (i.e. from July 2015 to March 2016) with 2 or 3 deaths in each quarter. The minutes from that meeting record that this was the meeting when the 'voluntary redesignation' of the NNU at COCH was announced and they stopped looking after babies born below 32 weeks gestation or those needing any intensive care [**Exhibit CWY/r -** **INQ0101304**]. These minutes do not record any specific discussion about the deaths reported in the report, but I remember that the reason that was given for the redesignation was the unexpectedly high number of deaths at COCH.

35. I have summarised the information contained within the Quarterly Data Reports that were available to the CMNN Steering Groups in the following chart:

Year	**2013-2014**			**2014-2015**				**2015-2016**				**2016-2017**			
Quarter	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Deaths at COCH			**3**	0	0	0	0	**3**	**3**	**2**	**3**	**2**			

This data was available at the Steering Group Meeting of 12 March 2015

This data was available at the Steering Group Meeting of 13 July 2016

This data was available at the Steering Group Meeting of 29 January 2016

Figure 1.0 – Summary of the COCH mortality data contained within Quarterly Data Reports available to the CMNN Steering Group.

36. Figure 1.0 illustrates that there was an increase in the number of deaths at COCH from quarter 1 of 2015/2016. This data would have been available within the Quarterly Data Report presented to the Steering Group meeting of 16 September 2015 if a report had been available. It is unlikely that any action would have been taken at that time, had the report been available and data reviewed. When a unit has a small number of deaths per year (as in COCH) then we would not necessarily expect them to be distributed evenly through the year. For example, there was no concerns raised by the 3 deaths seen in quarter 4 of 2013/2014.

37. There was no COCH mortality data contained within the Quarterly Data Report available to the CMNN Steering Group for the meeting held on 3 December 2015. If there had been COCH data presented it would have contained data up to quarter 2 of 2015/2016 and this would have shown 2 consecutive quarters with 3 deaths at COCH.

38. One of the challenges in analysing this data would have been that there was no 'expected' number of deaths or 'previous' number of deaths contained within the Quarterly Data Report for the purposes of comparison and members of the CMNN Steering Group may not therefore have recognised that this was a significant rise in the number of deaths at COCH. If the increase in the number of deaths had been recognised, this should have prompted a discussion with the COCH team who would most likely have been asked to provide an explanation. I would be unable to comment on what may have happened had these discussions taken place.

39. When the Quarterly Data Report was made available for the CMNN Steering Group meeting of 29 January 2016, it showed that there had been 8 deaths over the previous 3 quarters at COCH. Again, there was no data presented about the historic number of deaths at COCH or the expected number of deaths, so members of the Steering Group may not have identified that this was an increased number of deaths. Although, this may have been apparent to the senior members of the CMNN Steering Group, who had a better understanding of the 'normal' numbers of deaths at COCH. The Quarterly Data Report shows that the number of deaths at COCH was lower than the numbers at the 2 NICUs, as would be expected, but was much higher than the number of deaths at the 3 other non-NICU units with data reported (Ormskirk, Warrington, Whiston). On balance, I think that had this data been properly considered, this would have prompted a discussion and an explanation from COCH would have been requested. Unfortunately, it appears that the

Quarterly Data Report was not discussed in any detail at the meeting on 29 January 2016. It was not presented to the Steering Group with the agenda prior to the meeting so that they could read it and consider it in advance; it was provided at the meeting 'for information'. I would be unable to comment on what may have happened had discussions with COCH about their mortality rates taken place at this time.

40. There was no Quarterly Data Report available for the CMNN Steering Group meeting on 12 May 2016. If a report had been available it would have shown that there had been 11 deaths at COCH during the preceding 12 months. Again, there would have been no data presented about the historic number of deaths at COCH or the expected number of deaths within the report, so members of the Steering Group may not have identified that this was an increased number of deaths. Although, this may have been apparent to the senior members of the CMNN Steering Group, who had a better understanding of the 'normal' numbers of deaths at COCH. If a Data Report had been available to the Steering Group at this meeting, I would have expected the Steering Group to have raised concerns and to have asked COCH for an explanation and some reassurance as to what was being done with respect to these mortality rates. As before, I would be unable to comment on what may have happened had discussions with COCH about their mortality rates taken place at this time.

41. I do not think that the Steering Group had access to the MBRRACE-UK database or National Neonatal Research Database. The annual MBRRACE reports were discussed, but not in great detail. I do not remember focussing on the MBRRACE mortality data from specific hospitals in the CMNN and this is not reflected in the minutes of the meetings either. We did, of course, review these reports in relation to LWH internally as a Trust.

42. In terms of being able to monitor patterns or rates of neonatal death or other adverse incidents within the CMNN, the Steering Group was not an effective forum in this respect. As outlined above, mortality data was not provided on a regular or timely basis to the CMNN Steering Group during this period to allow for patterns or rates to be identified. The Data Report formed only a small part of the agenda for the Steering Group meeting, and focussed predominantly on cot occupancy and activity at each site.

43. I am of course hugely disappointed that patterns or rates of mortality at COCH were not identified by the CMNN Steering Group during this period. If an individual or group had been aware of an increased mortality rate, then it would have been their duty to raise those

concerns. I am not aware that any such concerns were raised at any time. The CMNN Steering Group received information about the numbers of deaths in COCH during this period on 2 occasions: 29 January 2016 (for the period covering January to December 2015) and 13 July 2016 (for the period covering July 2015 to June 2016). As per the meeting minutes outlined above, there was no discussion about the data on 29 January 2016, the Quarterly Data Report was only shared at the meeting 'for information' and by the time the data was seen again in July 2016, the decision to redesignate the COCH NNU and reduce the risk level of the babies cared for there had already been made.

44. The CMNN Steering Group was not made aware of any concerns about the number or nature of deaths occurring in COCH during this period by the CEG. If mortality reviews had all been performed in a timely and robust manner and thereafter discussed by the CEG, as would be their function, then it may have been possible for concerns to have been raised via that forum. As previously mentioned, I was not a member of the CEG.

My involvement in the care of babies named on the indictment

Baby A and Baby B

45. I can confirm that I was the consultant on duty for the NICU at LWH on 10 June 2015. Any requests for advice from the COCH Neonatal Team on that date would have been answered by me. I have no recollection, however, of any discussion that day and as referenced above it was not my practise at that time to make a contemporaneous record of advice given.

46. I have no reason to doubt that what Dr Ogden and Dr Salaadi have written is an accurate reflection of their understanding of our conversations. My comments below are based solely on the entries made in the case notes by Dr Ogden and Dr Salaadi and the comments made within their respective witness statements.

47. Dr Salaadi has noted a management plan in the medical records on 10 June 2015 [**INQ 0000698, page 31**] "*D/W (discuss with) specialists at Alder Hey and NNU at Liverpool regards events overnight*". He also reiterates this in his witness statements [**INQ0013865, page 6 and INQ0000721, page 5**]. It appears that Dr Salaadi delegated this task to Dr Ogden, his junior colleague, as he does not record the outcome of the discussion. In his

further statement [**INQ0000721, page 5**] he also implies that the communication with other specialists was delegated to Dr Ogden.

48. Dr Saladi has stated [**INQ0000721, page 5**] that the consultant at LWH felt that the death was not linked to I&S as "*he had not seen it before*". The reason for not believing that the death was caused by I&S is taken from the case note entry made by Dr Ogden. I believe that this entry is an oversimplification of my opinion. My reason for not thinking that maternal I&S was the cause of the problems was not just because "I had not seen it before" but would have been based on the description of the clinical events that I was given and my knowledge of the presentation of the clinical manifestations of maternal I&S.

49. Dr Salaadi has also stated that "*one of the treatments [for I&S] is intravenous haemoglobins...*" I assume that this is a typographic error and he means intravenous immunoglobulins. Maternal intravenous immunoglobulin infusion has been used to decrease the risk of pregnancy loss in women with I&S. I am not aware of any references to intravenous immunoglobulin being used to treat a newborn baby affected by maternal I&S. If it had been used in this case it would have been a purely experimental treatment. If I had been asked about its advisability, I would have discouraged it on the basis of:

    a. The absence of a diagnosis of I&S in the mother;
    b. The lack of any experience or literature known to me supporting maternal I&S as the explanation of the clinical problems being experienced by the baby; and
    c. The lack of any evidence of effectiveness or safety of this treatment in this situation.

50. At 10:30 hours on 10 June 2015, Dr Ogden has written a case note entry [**INQ0000698, page 31**] "*D/W Dr Yoxall at LWH…*". It appears from this entry, that I have provided my opinion that this is unlikely to be due to maternal I&S, albeit my reasoning has been oversimplified, as outlined above. Dr Ogden has noted that I recommended that the team at COCH consider sepsis or a metabolic disorder as an explanation for what was happening. These are common causes of unexpected collapse or death in pre-term babies, so this appears to have been a reasonable suggestion. Dr Ogden also noted that I recommended that they consider whether the cyanotic spells could be due to a Fallot's tetralogy (a common cardiac abnormality).

51. It appears that I did not have enough information to offer a diagnosis or meaningful change in treatment, but suggested that they perform a cranial ultrasound and await the results of the post mortem examination. I also offered further opinion "*if anything changes*", and presumably if the information from the ultrasound scan or post mortem required further expert interpretation. It does not appear that I was contacted subsequently about these babies.

Baby C

52. I can confirm that I was the consultant on duty for the NICU at LWH on PD June 2015. Any requests for advice from COCH Neonatal Team on that date would have been answered by me. I have no recollection, however, of any discussion that day and as referenced above it was not my practise at that time to make a contemporaneous record of any advice given.

53. I have no reason to doubt that what Dr Brunton, Dr Ogden or Dr Salaadi have written is an accurate reflection of their understanding of our conversations. My comments below are based solely on the entries made in the case notes and witness statements of Dr Brunton, Dr Ogden and Dr Salaadi.

54. Dr Ogden has made a note entry at 17:00 hours on PD June 2015 [**INQ0000108, page 11**] shortly after Baby C was admitted to the NNU at COCH, saying that baby was to be discussed with LWH due to his weight. I assume that Dr Ogden meant that Baby C should be discussed in case a transfer to LWH was required for ongoing care. Dr Ogden has also said within her witness statement [**INQ0013957, page 4**] that she recommended that this baby be discussed with LWH as his birth weight was only just over 800g which, she thought, was the threshold for transfer to a NICU.

55. Dr Brunton has made a case note entry at 18:00 hours on PD June 2015 [**INQ0000108, page 11**] which states "*D/W [discussed with] Dr Yoxall re ? transfer as <800g*". He has recorded that my advice was that I was happy for the baby to remain at COCH at that time, but to rediscuss if there was any deterioration.

56. Dr Salaadi has also described these discussions in his witness statement [**INQ0013959, page 5**], although he did not take part in them. He has also stated that babies at 27 weeks

gestation and below or with a birth weight of 800g and below would be transferred to the "regional centre", by which he means a NICU. From my recollection, there was no agreed weight limit below which babies had to be transferred to a NICU.

57. At the time of the telephone conversation with me, based on what is in the case notes, the baby was not ventilated and, although the birth weight was low at 800g, the baby did not meet the gestation criteria mandating immediate transfer. The fact that the baby was not ventilated suggests that prolonged intensive care was unlikely, so it seems reasonable to have not transferred the baby at that time. If a need for ongoing intensive care had become apparent over the subsequent hours or days, we would have transferred this baby at that point.

Baby I

58. Baby I had 2 brief episodes of admission to LWH and I participated in her care on each occasion. I have no clear recollection of these events but have examined the Neonatal Electronic Patient Record (Badger 3 system) to review the admissions and the following information is based on my review of those clinical notes.

59. Baby I was born at LWH on PD August 2015. Her mother had initially booked for antenatal care at COCH. There was known poor fetal growth and she was being monitored for that. The fetal membranes ruptured prematurely at 26 weeks. Her mother was given steroids; this is standard treatment to improve lung maturity when a pre-term delivery is anticipated. Mum was subsequently transferred to LWH because of anticipated pre-term delivery before 27 weeks gestation. It is not clear in the case notes at which point that transfer occurred. Mum went on to have spontaneous onset of labour and delivered Baby I at 27 weeks gestation with a birth weight of 970g.

60. I was not present on the unit when Baby I was born or over the I&S. I was the consultant on call at LWH from the I&S morning and over all of the weekend, so I led the team looking after her during that period.

61. Baby I had been ventilated after birth and given surfactant to improve her lung function. Her ventilation requirements were minimal and she had been extubated at 07:00 hours on I&S August 2015, 2 hours before I first reviewed her on the morning ward round. At that

time, she was stable on nasal CPAP [Continuous Positive Airway Pressure – a commonly used non-invasive method of breathing support used in pre-term babies] and was only needing minimal supplemental oxygen. Her blood gases were excellent and she did not require any blood pressure support. She was on antibiotics because of the history of pre-term labour and prolonged rupture of the fetal membranes. Although the blood cultures were not available, the c-reactive protein (CRP) concentration was elevated to 42.5mg/L, so I made the decision to give her a full 5-day course of antibiotics even if the blood cultures were negative (which they subsequently proved to be). I requested that the team should chase up the result of the lumbar puncture, to check whether or not there was any sign of meningitis (there was no meningitis). I asked that a cranial ultrasound be performed to check for any evidence of bleeding in the brain, which is relatively common in pre-term babies (this test was also normal). Baby I was being fed intravenously with Parenteral Nutrition (PN) via a long line. I requested that we obtain expressed maternal breast milk (EBM) so that we could commence milk feeds.

62. I performed an echocardiogram on Baby I at 12:59 hours on [redacted] August 2015. I did this to assess whether or not the baby had a patent ductus arteriosus (PDA). I detected a PDA, but it was tiny and was showing signs of spontaneous closure, so no intervention was needed.

63. During the rest of the weekend when I was looking after her, she remained stable on CPAP, although she required a slightly greater concentration of oxygen, up to 50%. We continued the antibiotics. She developed mild jaundice and started treatment with phototherapy. It appears that there was not enough EBM to allow the commencement of regular milk feeds, but on the ward round on [redacted] August 2015, I decided that the small amounts of milk that were available could be used 'for mouth care' to coat her mouth.

64. I was not involved in Baby I's care during the rest of that admission. I have read the case notes and it appears that she remained stable and her condition improved. She was able to breathe with no CPAP support from 12 August 2015. She needed minimal supplemental oxygen after that point only. She started on regular small volume EBM feeds, which were tolerated and the volume was increased slowly whilst the PN was decreased. She completed a full course of antibiotics and was transferred to COCH on 18 August 2015. At that time she was stable, breathing independently on low amounts of supplemental oxygen and was tolerating over half of her nutrition as EBM feeds.

65. Baby I was readmitted to LWH from COCH 19 days later at 15:41 hours on 6 September 2015. I was not the consultant on duty when she was readmitted, she was seen and assessed by my consultant colleague, Dr Dewhurst. She had reportedly been stable at COCH until the day before the readmission when she had deteriorated with desaturations and bradycardias and had required reintubation and ventilation. There was a suspicion that she may have developed a condition called necrotising enterocolitis (NEC). Dr Dewhurst reviewed the x-ray and described it as showing dilated bowel loops with bowel wall thickening; he did not think that Baby I had severe NEC requiring surgical intervention. He commenced treatment for mild NEC (intravenous antibiotics, intravenous nutrition, bowel rest, analgesia, support and observation).

66. I came on duty at 20:00 hours on 6 September 2015 and was responsible for the supervision of Baby I's care throughout the night and into the morning of 7 September 2015. It was not our practise to document a written handover report between consultants at that time, but I would have had a verbal handover from Dr Dewhurst about Baby I and the other babies in the NICU at that time; I cannot however remember what I was told.

67. I have not made any note entries during the shift and there was no reason for me to change or review any of Dr Dewhurst's decisions or management. I would have been present on the unit until at least 23:00 hours that evening. After that time, I would have been able to go home and be 'on-call' and available for the unit if required. If any of the babies on the unit had been unstable, then I would have remained on the unit after 23:00 hours, or would have returned to the unit if a new problem had occurred. I do not remember whether or not I was present on the unit after 23:00 hours on that particular shift.

68. Baby I remained stable throughout the shift until 06:35 hours when she had an acute deterioration because her endotracheal tube had become blocked; this was removed and replaced very promptly by the team on site and she recovered rapidly. I cannot remember whether or not I was informed about this episode. Her ventilation requirements were minimal and she was extubated the following day on 8 September at 10:00 hours.

69. I had no other involvement in Baby I's care, but I have read the case notes and it appears that she did not have NEC. She had minimal gastric aspirates and her abdominal examination findings were normal, so feeds were recommenced at 14:00 hours on 7

September 2015; these were tolerated and increased successfully whilst she remained at LWH. Although several case note entries subsequently record a diagnosis of 'suspected NEC', presumably because this was the admission diagnosis, this was not true at that time. If there had been any suspicion of NEC she would not have been allowed to have milk feeds. She also did not have the typical laboratory findings of a baby with NEC; her blood lactate concentration was not elevated, her white cell count was within normal limits and her platelet count was also not reduced.

70. The differential diagnosis of mild NEC is a 'septic ileus'. This is when a baby has an infection elsewhere (i.e. not in the gut) which causes the gut to stop functioning temporarily. The bowel function returns to normal in this condition once the infection is treated. It is possible that Baby I had an infection with a septic ileus when she became unwell at COCH, but this is not certain. The concentration of CRP in her blood was normal at 5.9mg/L on readmission to LWH. I would normally expect the CRP to be higher if there was a significant infection before she came back to LWH from COCH, so it is not clear that she had a septic ileus either.

71. The cause of her deterioration at COCH prior to returning to LWH on 6 September 2015 cannot therefore be explained based on the content of the LWH case notes.

72. The concentration of CRP within her blood increased following her readmission to LWH to a peak of 34.4 on 9 September 2015. A long line had been sited when she was admitted to LWH and this was noted to be 'tracking' so it was removed and replaced. It seems most likely to me that she developed a line infection after admission to LWH and that this was the cause of the CRP elevation that occurred during the admission.

73. The case notes show that Baby I's condition continued to improve and that she was well enough to return to COCH on 13 September 2015 having completed a full course of antibiotics. At that point she was tolerating feeds of 6mls of EBM every 2 hours and was tolerating regular increases in the feed volume. She was also not requiring any breathing support other than a small amount of supplemental oxygen.

74. Baby I did not return to LWH again and I had no further contact with her.

<u>Baby N</u>

75. Dr Salaadi has stated in his witness statement [**INQ0000645, pages 4 - 5**] that he discussed the problems he was encountering in the management of this baby with me. He has also recorded in his contemporaneously recorded case notes [**INQ0000579, page 40**] that he discussed this matter with me at 16:30 hours on 15 June 2015.

76. I can confirm that I was the consultant on duty for the NICU at LWH on 15 June 2015. Any requests for advice from COCH Neonatal Team on that date would have been answered by me. I have no recollection however of any discussion that day and as referenced above it was not my practise at that time to make a contemporaneous record of any advice given.

77. I have no reason to doubt that what Dr Salaadi has written is an accurate reflection of his understanding of our conversation. My comments below are based solely on the entries made in the case notes and witness statements of Dr Salaadi.

78. It appears that the clinical problem that Dr Salaadi was encountering at that time was the inability to intubate Baby N, who required intubation and was experiencing significant airway bleeding. There had been failed attempts to intubate this baby by two registrars and two consultants and Dr Brearey had inserted a laryngeal airway as a temporising measure.

79. Faced with this clinical scenario, I would not have advised transfer of the patient whilst there was no safe airway. I could not have attended COCH myself as I was the consultant on duty for the NICU at LWH. I could have considered trying to arrange for another neonatal consultant from LWH to attend to attempt intubation but given the lack of success by the consultants at COCH already, this was unlikely to be successful and would have wasted time.

80. Contacting the Neonatal Transport Team to provide airway support was not something that I would have advised as it is unlikely that the airway management skills of the Neonatal Transport Team were any better, and were possibly worse than, the clinicians on site at COCH.

81. On the extremely rare occasions that we were unable to intubate a baby at LWH (these were always babies with very severe congenital upper airway malformations), it was our practise to involve the paediatric anaesthetists and ENT surgeons from Alder Hey. Both

of these teams have expertise in the management of severe airway difficulties, including the formation of a tracheostomy if required.

82. I therefore advised that the COCH team sought advice and support from the paediatric anaesthetists and the paediatric ENT team at Alder Hey to see whether they could provide some on-site support. There was no Neonatal Network Policy in place for management of a difficult airway at that time, although one was developed later. Seeking advice from the Paediatric Transport Team seems a reasonable piece of advice as, unlike the Neonatal Transport Team, this team may have encountered similar problems previously and may have had a policy in place to deal with it, which could have been used in this case.

Other babies named on the indictment

83. To the best of my knowledge, I did not have any involvement with any of the other children named in the indictment.

Involvement in reviewing the care of babies named on the indictment

Baby I

84. I was invited to take part in a Table Top review of this baby's care by an email from Laura Hughes on 2 February 2016 [**INQ0005961, page 1**]. The invitation contained a "query" from the CMNN, using a standard form [**INQ0004528, page 1**]. It was not clear to me what the nature of the query was, so I didn't provide a written response, preferring to discuss the queries that arose in person at the meeting. The date selected for the review was 26 February 2016. I was unable to attend on the planned date as I was away on pre-arranged annual leave and holiday abroad. With the agreement of Laura Hughes, I asked Dr Yajamanyam to deputise for me [**Exhibit CWY/s - INQ0101306 and Exhibit CWY/t - INQ0101307**]. Dr Yajamanyam did attend as recorded in the summary of the review meeting [**INQ0012107**]. I do not remember receiving any feedback from the review meeting.

85. Based on what was known and understood by me as a consultant neonatologist at LWH, I do not remember having any clinical concerns about the care provided to Baby I at the time.

Other babies

86. I received an email from Dr Brearey on 25 June 2018 asking me to review a medical report produced by him in relation to Baby F, prior to this being submitted to the police and we had some subsequent email correspondence in this regard [**Exhibit CWY/u - INQ0101308 and Exhibit CWY/v - INQ0101309**. Dr Brearey asked me to do this, as a senior colleague, to check that the conclusions that he reached on reviewing this matter were reasonable.

87. I did not have any involvement in the investigation or review of the other children named on the indictment to my knowledge or recollection.

88. I was not involved in the Royal College of Paediatrics and Child Health (RCPCH) invited review at the COCH in 2016.

Response to the increased deaths at COCH NNU

89. As referenced above, it was announced at the CMNN Steering Group meeting on 13 July 2016 that the NNU at COCH was effectively being redesignated as a SCBU having previously been a LNU, with removal of all intensive care and they were not to provide care for babies with a gestation of less than 32 weeks. Whilst it does not appear in the minutes, I remember that it was discussed that the reason for this was because of a higher than expected number of deaths over the preceding period. My recollection is that I was not surprised by this announcement because I had had prior notice of it in the days beforehand, I cannot remember who informed me of this.

90. The decision was presented as a voluntary one, made by the staff of COCH NNU and was not one externally imposed on them. I remember stating to the meeting that I thought the decision to reduce the risk profile of the babies cared for at COCH was the correct one if the level of concern about the ability to provide safe care by the COCH team was so high. I commended them for making such a brave and open decision, this was also not recorded in the minutes.

91. Dr Subhedar, Consultant Neonatologist at LWH sent an email 20 July 2016 [**INQ0012086, page 962**] to all of the consultants at the NICUs in LWH and Arrowe Park Hospital outlining

the changes in COCH designation, although the reasons for the changes were not described. As confirmed above, I was aware that by then the reason for this was the increased number of deaths in babies cared for at COCH.

92. I think by this time many people in the CMNN were aware of the increase in the number of deaths at COCH. I am not however aware that anybody knew what the clinicians at COCH thought the cause of the increased number of deaths was. I certainly did not know what the cause of the increased number of deaths was at that time. I thought that it was most likely explained by either; an infection outbreak, an increase in the number of vulnerable babies that they were caring for at COCH, or due to some deficiency in staffing numbers or clinical practise that would become apparent when the RCPCH invited review (which I knew was about to happen) had concluded.

93. I remember offering support to Dr Brearey and his colleagues at COCH during this difficult time when I met them and also in a couple of emails. One of these emails, dated 8 July 2016 [**INQ0012086, page 950**] refers to a doctor named Doctor ZA; I am fairly certain that this would be reference to Doctor ZA, a consultant paediatrician at COCH. I cannot remember any of the specifics of the conversation that I had with Doctor ZA as referred to within this email. At that time I was unaware of the nature of the concerns that the clinicians at COCH had in relation to the cause of the increased number of deaths.

94. It was sometime later that I became aware of the nature of the concerns. I remember a telephone conversation with Dr Brearey at some point in 2017, I cannot remember the exact date. He was unhappy and frustrated that the RCPCH invited review had not got to the bottom of the problem and that the Executive Team at COCH were not taking the concerns that he had seriously enough. There was a discussion about the COCH Executive Team's refusal to involve the police with the investigation despite Dr Brearey thinking that this was necessary. I remember asking him the question "Do you think you have a 'Beverley Allitt' working on the unit?" to which he replied "yes". I was completely shocked. He did not disclose any names or details of the person about whom he had concerns. I believe that the police investigation commenced shortly before or shortly after that conversation. I did not discuss this conversation with anybody else at the time.

95. As referenced above, on 25 June 2018, I received an email from Dr Brearey asking me to review a statement he was about to send to the police in relation to the twin of a baby that had died at COCH. I now know that this report related to Baby F. Dr Brearey had concerns

about the case, but stated within his email that the COCH Executive Team "have always tried to portray us as having made totally unreasonable allegations". I reviewed Dr Brearey's statement and I thought it was very reasonable and well written. It was apparent to me that Baby F had had exogenous insulin administered. The only explanations for this were a medical error or a deliberate poisoning. This led me to believe that Dr Brearey's concerns about deliberate attacks on babies were justified, although I had no idea who he thought the perpetrator was at that time.

The culture and atmosphere of the NNU at COCH in 2015/2016

96. It is not possible for me to have an accurate or fair view of the culture or atmosphere on the NNU at COCH in 2015/2016 as I had no direct involvement there. I had occasional contact with the clinicians on the unit in relation to specific patients whose care we shared and I had contact with a couple of senior clinicians at the CMNN Steering Group meetings. I would also have heard comments from junior medical staff who were rotating through the training programme, including at COCH and LWH.

97. The impression I formed from this limited contact was that the NNU at COCH was an effective, happy unit that people enjoyed working at. I am unable to comment on relationships between the various people working at COCH at that time, or to compare those relationships as against those within my own unit.

98. I am also unable to comment on whether or not there was any change in the quality of the culture or relationships at COCH after 2016.

Review of care provided by Letby whilst at LWH in 2012 and 2015

99. I was informed on 3 July 2018 that the police were about to arrest a neonatal nurse from COCH in relation to some suspicious deaths. I was told that her name was Lucy Letby. The reason I was informed of her name was because the police were aware that she had spent two periods working on the NICU at LWH and they wanted us to tell them whether we had any concerns about the care that the babies on our unit had received during those periods.

100. I am aware that Lucy Letby worked on the NICU at LWH during 2 periods, in 2012 and then in 2015. I am also aware, after reviewing the case notes of the babies that she had

contact with during that time, that I came into contact with her on several occasions; I have no recollection of those occasions. At that time I had no concerns or suspicions about Lucy Letby.

101. When the police contacted LWH to inform us of Lucy Letby's arrest in 2018 and informed us that she had worked in the NICU at LWH, I was tasked with reviewing all of the neonatal deaths that had occurred at LWH during those periods as well as the case notes for all of the babies who had been cared for in our intensive care nurseries. Following those reviews, I developed some suspicions and concerns about the care that the babies in Lucy Letby's care had received. I have made those concerns known to the police and made a series of statements in relation to those incidents. I understand that those matters are still under police investigation.

102. By the time that I was aware of the name of Lucy Letby, she had already been arrested and was no longer working at COCH, so there was no need for me to report my concerns to them or anybody else other than the police.

Concluding comments

Interviews pertaining to Lucy Letby and her crimes

103. I have participated in numerous interviews with the Cheshire Constabulary in relation to the incidents I have identified at LWH and have made a series of police statements about these.

104. I was also interviewed by a reporter from the Daily Telegraph about the apparent failure of the Executive Team at COCH to support the clinicians there. This article titled "Letby hospital chairman said 'final measure' of its delivery is 'financial performance'" was published on 26 August 2023, containing a quote from me which read: "*The role of the NHS is to look after patients. You can't do that in isolation from the money (but) my Trust was very clear that they'd rather be sacked for being financially incompetent than for being dangerous*".

105. I also participated in an informal, confidential interview with a BBC TV reporter who was making a film about the Lucy Letby investigation which has since been shown on TV. He already knew that Lucy Letby had worked at LWH and that I had been asked to identify any potential further incidents there. I confirmed this but refused to provide any details of

what I had found. Nothing about LWH appeared in the film. The reporter knows that there is an ongoing police investigation and I am unable to discuss these matters. I agreed that in the future when the police investigation and any potential court case was resolved, then I would be willing to discuss these matters further with him if there was still public interest in the story.

106. I have conducted no other interviews and made no other public comments.

Safeguarding of babies in hospital

107. I always maintained my training in safeguarding at level 3 as part of my Continuous Professional Development up until my retirement from clinical practise in December 2020. I do not recollect that this training ever specifically covered what to do if abuse on the part of a member of the hospital staff was suspected. I would have thought that the same approach should be taken regardless of the suspected perpetrator.

108. I have not been given any specific advice from RCPCH or the GMC about safeguarding in the context of suspicion of abuse by a member of staff towards babies.

Raising concerns

109. Where concerns are raised about the conduct of clinician, be that a nurse or a doctor, if that concern relates to the professional or clinical performance of an individual, concerns could be reported to their line manager or to the Chief Nursing Officer or Medical Director at their Trust. If necessary concerns could be raised with the appropriate statutory body (GMC or NMC as appropriate). If there was any concern about a criminal act, I would have always have informed the police.

110. In relation to the performance of an organisation, it was possible to raise concerns via the ODN (and through them to NHSE) or directly to the CCG.

Reflections and recommendations

111. I have been asked whether the monitoring of babies by CCTV would have prevented the crimes committed by Lucy Letby. It would be impossible for me to answer this

question. The presence of CCTV in the intensive care area could have acted as a deterrent if Lucy Letby believed that the crime was likely to have been recorded and suspected. Some actions, such as interfering with endotracheal tubes would be detected by CCTV, but not necessarily if she had been able to mask the handling of the baby at that time as being part of the routine care provision. Similarly, injection of air could have been detected by CCTV, but not necessarily if it was timed to coincide with the administration of other intravenous medications. Addition of insulin to infusion fluids could have been detected by CCTV if it was performed in the monitored area, but if this was performed in an area where IV fluids were stored and this area was not monitored, it would not be detected. I do not know enough about the specific details of the crimes committed by Lucy Letby to know whether or not her crimes would have been detected by CCTV.

112. CCTV recording of an ITU would provide many hours of recording and I cannot see how it would not be possible to review all of this footage. A NNU with 10 cots being monitored by one camera each continuously would generate 1680 hours of CCTV per week. It would be possible to look back at a specific event, instead there would have to be a suspicion that the CCTV might show something or to shed light on an adverse incident or death. It appears from the information as I understand it, that there were suspicions about Lucy Letby for a period of time before action was taken, so had there been CCTV there may have been a reason to review the footage at that stage, although it is possible, for the reasons described in my previous paragraph, that this would not have identified what was going on.

113. In considering whether security systems that monitor access to drugs and babies in NNUs would have prevented deliberate harm being caused to the babies named on the indictment, again I do not know enough about the specifics of the incidents to say for certain whether or not this would help. As a generality, I think such systems could contribute to the protection of other children in hospitals in the future. The details of the systems would need to be developed and could include video surveillance, biometric access to clinical areas or drug stores and proximity monitoring to detect which people were present at the time or immediately prior to such incidents.

114. I would suggest that a range of recommendations could be considered by the Inquiry to ensure that babies in NNUs are kept safe from the criminal actions of staff in the future, these include:

a. More robust and complete adverse incident reviews must be performed. These should include a list of "who was present" including people in the vicinity at the time and immediately beforehand. Whilst the focus of clinical incident reporting and review in the NHS has been on organisational learning, it is important to detect individuals with poor performance or malicious intent. The "who was present" data should be stored in a database and analysed regularly, including at the time of annual appraisal, to identify patterns.

b. There is a need for a much more robust clinical incident reporting system across the neonatal community which approaches the standards adopted by the airline industry. All units have an incident reporting system but these vary in quality and there is still a culture common in many areas that this is about blame rather than about learning, resulting in a hesitancy to report. There is also a poor understanding about what an adverse incident is. Intensive care is an area of clinical practise where things can go wrong and the consequences can be severe. There may be a culture of accepting that "things go wrong, it's nobody's fault, there is no value in reporting it". For example, none of the incidents that I detected in my review of the case notes at LWH were reported in the clinical incident reporting system, even though the unit has a more robust incident reporting culture than many other units.

c. There is a need for systematic, robust and timely neonatal mortality reviews with oversight from an external body, such as the ODN. My impression is that implementation of the PMRT has gone a long way in achieving this.

d. Regular, timely, review of mortality rates, in comparison to expected mortality rates in each neonatal unit should be performed by each unit and by the Clinical Network.

e. There may have been opportunities to detect the exogenous insulin administration incidents at COCH sooner if the relevance of the very low c-peptide results had been appreciated. This should have been an immediate red flag for the clinical team. Systems for the laboratory highlighting and appropriately escalating such results should be in place. Arrangements for the grade of person reviewing laboratory results may need to be considered.

f. Better monitoring of students and learners in the clinical area should be implemented to ensure that their work is overseen by the same individual in order to detect the repeated occurrence of similar incidents.

g. Some of the technological systems referenced above may be considered useful.

h. Clinicians should be provided better support and should be empowered to escalate concerns about potentially criminal matters directly to the police, without requiring 'permission' from the executive team of their employing Trust.

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: 3rd June 2024