Witness Name: M. Leaf

Statement No.: Leaf/2

Exhibits: None

Dated: 3/6/24

THIRLWALL INQUIRY

WITNESS STATEMENT OF MIKE LEAF

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

1. I am a public health professional by background and have been involved in the child death review process since 2013, when I was Director of Health Improvement at Lancashire County Council. This included chairing the Lancashire Child Death Overview Panel following the reorganisation of the public health function, which transferred from the NHS to Local Government. After leaving Lancashire County Council at the end of March 2016, under a voluntary redundancy arrangement following an internal reorganisation, I was appointed through a formal selection process as Independent Chair of Merseyside and Pan-Cheshire Child Death Overview Panels on 1st January, 2017 and 20th October 2017 respectively. I was appointed Independent Chair to the Blackburn with Darwen, Blackpool, and Lancashire Child Death Overview Panel on 16th October, 2017. Prior to taking over as Chair of the Lancashire Child Death Overview Panel in March 2013, I had no previous involvement in the child death review processes. I have only ever been a Chair, so child death reviews were a completely new field for me.

2. This statement is written from my perspective as Independent Chair of the three NW Child Death Overview Panels described in the opening paragraph above. This statement represents my views and understandings at the time of writing, and not those of anyone else.

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

4. Prior to taking over the Chairing role of the Lancashire Panel in 2013, I had received no specific training in relation to the child death review processes, nor the relevant legal framework context at the time. I did, however, have considerable senior leadership and public health experience from previous roles within the NHS, including Director of Public Health in Hyndburn and Ribble Valley Primary Care Trust and Blackburn with Darwen Primary Care Trust, and senior public health roles in the North Lancashire Primary Care Trust, before moving to Lancashire County Council in 2013. I was familiar with numerous governance structures within the public sector, and was a very experienced chair, particularly in multi-agency/ professional meetings and networks. I subsequently familiarised myself with relevant legislation and guidance.

5. The Child Death Review process and the Panel relies on the input and engagement of various professionals who provide a wide variety of perspectives, and I continue to learn from them, even though I have been involved for over 11 years. I have participated in numerous professional development opportunities, including a national child death review training programme at Warwick University, which has since been decommissioned.

6. Whilst there may be training for specific professional roles, it is recognised that there is no standardised training for child death review professionals on the overall process. The newly established Association of Child Death Review Professionals (ACDRP) is exploring

opportunities for continuing professional development, including formal training at a national level. I sit on the ACDRP Executive.

7. The Association of Child Death Review Professionals is in the process of developing a set of quality standards for Chairs. The Chair of a Child Death Overview Panel (CDOP) plays a crucial leadership role in facilitating the panel's activities, ensuring effective collaboration among members, and overseeing the review process of child deaths. My current contract with Lancashire County Council highlights the following requirements which I would endorse:

Knowledge:

- *Thorough understanding of statutory child death review processes and how these are discharged in practice.*
- *In depth knowledge of infant and child mortality, including its contributory factors and measures that can be taken to reduce its frequency.*
- *Knowledge of local factors and service provision within the local area.*

Competencies:

- *The ability to chair multi-agency meetings, assimilating information from a range to sources to draw conclusions and agree actions.*
- *The ability to analyse complex information, identify trends and draw evidence-based conclusions in order to inform future activity.*
- *The ability to form effective working relationships with senior managers in a multi-agency partnership, to build confidence and resolve conflict within a statutory process.*
- *The ability to clearly present information orally and in writing in a manner that is appropriate to the audience.*
- *The ability to lead and develop a partnership.*

- *The ability to effectively manage own workload, to ensure that a service is provided in a timely and consistent manner.*

8. CDOP members are not there to represent their own organisations, but to provide professional perspectives and insights. From my point of view, they should be credible professionals in their own right but have the following skills and qualities:
    - Have a solid understanding of child safeguarding principles, policies, relevant legislation, and procedures.
    - Remain impartial and highlight any conflicts of interest.
    - Focus on the child's best interests and learning outcomes.
    - Be an effective communicator within the panel and with external agencies.
    - Work collaboratively with other panel members, professionals, and where relevant, families.
    - Share insights and contribute to discussions.
    - Come prepared and dedicate appropriate time for case reviews and learning discussions.
    - Handle sensitive information with discretion and abide by information governance regulations.
    - Uphold professional standards and ethics.
    - Attend panel meetings regularly.
    - Commit to cascading learning.

9. During the period 2015-17 in Lancashire, I liaised predominantly with the 3 Children's Safeguarding Board Chairs/ Lead Officers on reporting matters, and in particular Designated Doctors of Child Death, Designated Nurses and the Coordinator on operational issues. I was not required to liaise with hospitals unless the panel determined that it would be useful to expedite actions through a formal letter from the Chair. I would

not normally liaise directly with other CDOPs, as the coordinator would do this, particularly when there is an out of area death.

10. Frequently the coordinator receives Reporting Forms (Form B) with some information missing. Usually, if it is highlighted that there is pertinent information missing whilst reviewing a case at Panel, it may decide to defer the case, or leave it open and seek the necessary information before the review can be concluded. Having examined the information provided to the Pan Lancashire CDOP in respect of one of the babies named on the indictment I cannot see any relevant missing information that would have prevented the review from being completed or which raised concerns. I do not recall any professionals raising concerns about the level of information at the time. As far as I am aware, we did not request any further information, as the review was concluded.

11. From the combined reporting Form B [INQ0012016_0004], whilst the death was initially considered as unexpected, it met the exclusion criteria i.e. where a child dies within 24 hours of birth or shortly thereafter and has never left hospital and there is a clear medical explanation for the death. The forms clarified that the death was discussed with and accepted by the coroner, there was no inquest, and a cause of death had been established. The information provided at the time highlighted that this was a high-risk baby, and there were no reasons to consider this as a suspicious death. In my experience, there was nothing unusual about the information provided regarding this case.

12. I have no reason to doubt that the CDOP Pan Lancashire Child Death Overview Panel Rolling Log – I&S **[INQ0012189]** does not represent the minutes of the meeting on I&S, so far as consideration of this baby is concerned. The notes do not, however, make any reference to the discussion which concluded that the death be recorded as "expected," when the death had been originally considered as "unexpected". I suspect that because there was an agreed cause of death with the coroner and no

inquest, this is likely to have been the rationale for recording it as "expected." The rationale should have been recorded in the Rolling Log, which is the only formal record. I am convinced that there was no additional discussion at that meeting of any other matter relevant to the inquiry.

13. At the meeting on I&S the Panel were not aware that this baby was the I&S of the babies to have died since the start of June 2015, or that a further baby had died on the neo-natal unit at the hospital since the death of this baby. In accordance with Working Together to Safeguard Children (March 2015) **(INQ0013235)**, *"the Local Children's Safeguarding Board (LSCB) is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP"* (Child Death Overview Panel). As Panels' primary focus was on deaths who reside in their own areas, it might not have been considered relevant at the time for the Cheshire Panel to inform other neighbouring Panels of the deaths within the Countess of Chester.

14. Panels would not normally have the relevant expertise to determine what is an unusual pattern or number of deaths in a hospital unit. The Panel would not routinely consider the mortality rates in a particular hospital, unless it was aware of any concerns raised by one of the partners, or that some form of inquiry was being undertaken. In these circumstances, cases would normally be deferred until any conclusions were reached. The mortality rates of the Countess of Chester Hospital were not requested prior to this baby being reviewed.

15. The panel would not normally ask about neo-natal mortality rates at a hospital when reviewing a death, unless there was a particular reason, for example if members were aware that there was some form of review being undertaken. As far as I am aware, Lancashire were unaware of any review being undertaken, and therefore had no reason to ask in the case of this baby.

16. As highlighted in my first statement, the Panel is the final stage of the Child Death Review process, and takes place following the conclusion of other comprehensive assessments, which can include coronial inquests, criminal investigations, perinatal mortality reviews, and hospital mortality reviews. Much of the learning is captured and appropriate actions taken before the cases get to Panel for the final review. This includes deaths on a neonatal unit. There may therefore be numerous "reviews" prior to the case coming to panel. The Panel Administrator should be made aware of any such reviews as partner agencies should be aware of the Child Death Review process, and the need to share this information. On occasions the panel discovers that such reviews have been undertaken or not concluded, which would normally lead to the case being deferred to a future Panel meeting.

17. The level of inter-agency co-operation in advance of a Panel meeting will depend on the type of death and the circumstances leading up to the death. There were and continue to be clear procedures for unexpected deaths as has been previously cited. At the time of this baby's death, if a child or infant died unexpectedly, it would have been anticipated that an initial discussion would have been initiated between the lead agencies (i.e. health, police and local authority children's social care) to share information and decide what should happen next and who would action. (Working Together to Safeguard Children" (March 2015) (INQ0013235))

18. Changes brought in and described in NHS and Children's Safeguarding The Child Death Review Statutory and Operational Guidance (England) 2018 (INQ0012367) states that there should be a Child Death Review Meeting that precedes the Panel meeting which: "…*should be a multi-professional meeting where all matters relating to an individual child's death are discussed. The Child Death Review Meeting (CDRM) should be attended by professionals who were directly involved in the care of the child during his or her life, and any professionals involved in the investigation into his or her death. The nature of this*

meeting will vary according to the circumstances of the child's death and the practitioners involved, and should not be limited to medical staff." This includes expected deaths.

19. In my experience, the Guidance (INQ0012367) makes it very clear that reviews, frequently within hospitals, should include other professionals who have been directly involved in the care of the child during his or her life prior to death, and should not be limited to medical staff. In my experience, most child death review meetings in hospital mainly involve hospital clinical staff, and this needs to be improved.

20. I am not aware of any inter-agency discussion with or without any other CDOP that took place in this baby's case, although there was sharing of information. From the records I have seen, Lancashire CDOP received information from Southport & Ormskirk Hospitals, Countess of Chester Hospital, and Lancashire's Sudden Unexpected Death in Children Nurse.

21. There were no issues, learning or recommendations highlighted by the Panel at the meeting of I&S. This was attended by myself [INQ0012189_0001], a former Director of Public Health (Chair), Designated Doctor for Safeguarding, Panel Coordinator, Lancashire Constabulary, Lancashire SUDC Nurse; Blackpool NHS, Named Midwife Blackpool Victoria Hospital, Blackpool Early Years, Named Nurse Southport and Ormskirk Hospitals, and a Lancashire Public Health consultant. There were no further actions taken, or any external reviews initiated by the Pan Lancashire CDOP in relation to its review of this baby, as there were no grounds from the information provided. No issues had been identified prior to the Panel meeting, there was a cause of death, and the coroner had been satisfied with all information discussed.

22. I was not aware of the specific details or scale of the investigation at the Countess of Chester Hospital relating to an increased mortality rate on the neonatal unit. After I chaired

my first Panel meetings, I was made aware by Panel members through informal and general discussions. Many of them had been present at previous meetings where it had been discussed. I recall no direct discussions with anyone in relation to suspicions and concerns of deliberate harm being caused, nor any possible underlying reasons/causes. The first time the increased mortality rate on the neonatal unit at the Countess of Chester Hospital was discussed formally with me present, was at the Panel meeting of 6th July 2018. The notes of the meeting provided by the Panel Administrator state: *2) As part of the Countess of Chester Hospital investigation, CDOP has been asked to clarify its processes in relation to child death notification, in particular those children who die within Cheshire, but who reside elsewhere. CDOP should receive a Form A for children who die within the Cheshire footprint but do not live within the Cheshire footprint. It was agreed that a named officer would be contacted once a quarter to clarify that there have been no deaths of children who reside outside of the Cheshire footprint.* **Action:** *Hospitals to be contacted, and thereafter, quarterly to clarify the number of deaths for children outside of Cheshire. The communication will remind Trusts of their responsibility to notify CDOP Admin of any child deaths occurring on site.*

23. I was aware that there was an investigation involving the police but was unaware of the key lines of enquiry or that it had a focus on potential suspicious deaths. I had no discussions with anyone in relation to suspicions and concerns of deliberate harm being caused.

24. I do not consider that the CDOPs should have spotted any rise in neo-natal mortality rate at the Countess of Chester hospital, because at the time, we were not monitoring neonatal deaths by Unit or Hospital Trust. In addition, because some of the deaths occurred in babies whose parents resided outside the Cheshire footprint, for example in Wales, and adjoining areas, I understand that some of the deaths may not have been notified to the Cheshire CDOP.

25. As mentioned in my previous statement, I was appointed to the Merseyside CDOP on 1st January 2017, so was not involved in the Panel that reviewed another baby's case, and therefore cannot comment on the process.

26. In the light of Letby's convictions and with the benefit of hindsight, my reflections about the role of CDOPs include:

    i. CDOPs to continue to play an important role in the child death review process, albeit having to rely heavily on the quality of the information provided by agencies and professionals. If there are concerns from any agency or professional concerning the death of a child, they should make this clear on the reporting forms so that the Panel can determine whether or not to postpone a Panel review.

    ii. CDOPs should have an overview of all deaths of children who die within their geographical patch, irrespective of place of residence, and flag any issues to partners where appropriate.

    iii. Panels need to delay reviews of a hospital neonatal death where there is an ongoing investigation that might impact involve the death of a child or children. For out of area cases, CDOPs of place of residence would need to be informed from the CDOP of place of death, whether the hospital involved was under any such a review.

    iv. Child death review partners should ensure that all relevant professionals are aware of the existing child death review and safeguarding processes, so that concerns can be escalated as appropriate.

    v. The importance of CDOPs having a minimum standard for recording minutes/ actions/ conclusions, to ensure that pertinent discussions within the Panels are summarised. The Association of Child Death Review Professionals would be able to support this.

vi. Professionals should use existing processes to engage the police if they have any safeguarding concerns/ suspicions without the need to seek permission from the Executives.

27. These may have resource implications, and in my experience, there is already a wide variation in terms of the level of funding apportioned for the child death review process, of which CDOP is a part.

28. In relation to the review of another baby in Lancashire when I was the Chair, the level of information requested from the hospital and provided to the CDOP at the time was sufficient to enable the Panel to conclude the case, and it would not have been possible from the information provided to indicate whether deliberate harm had been caused or highlight anything untoward. The Panel relies almost entirely on the combined information and intelligence of the agencies and professionals provided. If there were any ongoing concerns relating to the death of this baby, these were not communicated at the time, otherwise the case would not have scheduled for the Panel.

29. There is an established mechanism for hospitals to share information with CDOPs to include broader relevant concerns, themes or trends. The Reporting Form (Form B) exhibited as ML/01 (pages 2-3) contains several prompts, including:

- Was there any cause for concern about any element in the child's environment or circumstances of death where action is required for urgent learning?
- Concerns about the functioning of medical equipment e.g. pumps, syringe drivers, wheelchairs, sleep systems, orthotics
- Concerns about any product e.g. nappy sacks, blind cords, apnoea monitors, car seats, sleep positioning devices, swaddling devices, play equipment
- Concerns about specific medications
- Concerns regarding clusters of similar deaths known to you

30. Responses to these prompts may indicate a need to postpone a review of the death at CDOP, until all investigations have been completed. However, there is no formal framework for the hospitals to share relevant data such as near misses or still births with CDOP. These would be valuable. There are informal, ad hoc pathways as the child death health professionals may work in the safeguarding/quality teams of the hospital or Integrated Care Board. In addition, CDOP is reliant upon on notifications or information from hospitals, that a review might be taking place. Often, we do not hear of such a review until the case is presented at Panel. It would be useful for Medical Examiners within hospitals to be mandated to keep CDOPs informed of any reviews and investigations that are due to take place.

31. As previously mentioned in my first statement there have been numerous improvements in child death review processes, including reporting to CDOPs. Since the submission of my first statement, the National Child Mortality Database (NCMD) has held a webinar for CDOP members, stressing the importance of recording the details of all deaths of children, in and out of area, and hospitals where babies have died. NCMD is exploring how it can support local CDOPs in identifying deaths by hospital. It is unclear whether there is consistency in the way CDOPs monitor deaths within their hospitals.

32. In addition, Pan-Cheshire CDOP has established a quarterly meeting with Public Health Wales which oversees child death reviews in Wales to share intelligence. This has now extended to include all CDOPs along the national border.

33. Based on my knowledge and experience as a CDOP Chair, I would recommend improvements including:

    i. Introducing a standard for CDOPs to follow, in terms of the monitoring of deaths within their local neonatal/ maternity units, irrespective of parent's place of residence.

ii. Rationalising some of the existing child death review processes e.g. perinatal mortality reviews and software platforms to reduce duplication and improve information sharing.

iii. Amalgamating the learning from reviews on stillbirths and near misses with those from the child death review process.

iv. Making explicit the role of Medical Examiners in monitoring deaths within neonatal/ maternity units within their hospitals and ensuring that local CDOPs are notified of any other relevant reviews within the hospital.

v. Mandating the Neonatal Operational Delivery Networks to monitor deaths within local maternity and neonatal units, to support Integrated Care Boards (ICBs) in their performance management role of Trusts in relation to deaths on maternity/ neonatal units. The ICBs, as commissioners of hospital care, are accountable for the quality of that care, and should also monitor any "near misses" and clinical incidents. CDOPs and/or Neonatal Operational Delivery Networks could flag and report any unusual patterns and fluctuations in deaths. CDOPs would not normally have the relevant expertise to determine what is an unusual pattern or number of deaths in a hospital unit, unlike the Neonatal Operational Delivery Networks who do.

34. As far as I am aware, there is no other evidence which I can give from my knowledge and experience which is of relevance to the work of the Thirlwall Inquiry. In addition I have not given any interviews or otherwise made any public comments about the actions of Letby or the matters under investigation by the Inquiry. I have addressed members of the Panel to inform them that I have been asked to provide statements.

35. The only thing I can think of which might keep babies in NNUs safe from any criminal actions of staff, is the introduction of 24/7 CCTV, but this would need careful consideration in terms of the costs and benefits of such a move. This is not an environment that I am very familiar with and there are likely to be other professionals who might have more relevant recommendations.

36. I cannot think of any documents or other information which might be potentially relevant to the Inquiry's Terms of Reference, particularly relating to concerns that were raised about Letby or the safety of the babies on the NNU in 2015 and 2016.

Statement of Truth

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

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

Signed: Personal Data

Dated: 3/6/24