Witness Name: Sally Rebecca Ogden
Statement No.: 1
Exhibits: SO01
Dated: 14 June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR SALLY REBECCA OGDEN

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1. I, Dr Sally Rebecca Ogden, will say as follows: -

2. I have been asked to give a witness statement to the Thirlwall Inquiry under a Rule 9 request to provide written answers to 69 questions as outlined in the Rule 9 request relating to the Terms of Reference of the Thirlwall Inquiry. I have had access to the following evidence/documents when completing this statement.

   INQ0000017, INQ0000698, INQ0000108, INQ0012086, INQ0003297, INQ0000859, INQ0000429, INQ0000055, INQ0008476, INQ0008944, INQ0007448, INQ0000054, INQ0007626, INQ0000131, INQ0007625, INQ0013957, INQ0001986, INQ0007627, INQ0007624, 0000508, INQ0000905, INQ0000894, INQ0000895, INQ0000052, INQ0000721, INQ0000891, INQ0010270, INQ0000132, INQ0010282.

Personal details

3. My name is Dr Sally Rebecca Ogden, I have a MBChB medical degree from the University of Liverpool and graduated in 2010. I gained my membership (MRCPCH) of the Royal College of Paediatrics and Child Health in 2015 and recently became a fellow of the college (FRCPCH) in 2024. I undertook a foundation programme training based in Southport and Ormskirk hospitals between 2010-2012 before starting paediatric training in August 2012 in Mersey. As part of my paediatric training I worked in Liverpool Women's Hospital, Alder Hey Children's Hospital, Leighton Hospital and Macclesfield Hospital prior to working in the Countess of Chester Hospital. Since working at the Countess of Chester, I have worked again in Leighton Hospital, Liverpool Women's Hospital, Macclesfield Hospital, Arrowe Park Hospital, Alder Hey Children's Hospital and St Mary's Hospital Manchester. I have completed Neonatal grid training and completed training in 2021. I am now working as a Consultant Neonatologist at Liverpool Women's Hospital since 2021.

4. I worked at the Countess of Chester in the Paediatric Department from 4th March 2015 until 1st September 2015 as a ST3 (Specialty Trainee Paediatric Registrar. This was my first post working on a tier Registrar rota. I had achieved my membership exams prior to starting this post. I did not have additional management responsibilities or specific responsibilities in this post.

The culture and atmosphere of the neonatal unit ("NNU") at the hospital in 2015-2016

5. During my 6-month rotation in the Countess of Chester, my direct managers were the Consultant Paediatricians (Dr John Gibbs, Doctor ZA, Dr V, Dr Elizabeth Newby, Dr Stephen Brearey and Dr Murthy Saladi. My personal Education and Clinical Supervisor was Dr Elizabeth Newby. I would have reported any concerns I had at the time directly to the Paediatric Consultant team. I was aware that there were other nursing managers and senior executives leading the Paediatric and Neonatal services but do not recall exactly who these individuals were. My route for escalating any potential concerns would have been through the Paediatric Consultant team.

6. I was not aware of any issues with the relationship between staff working on the wards and any managers but may not have been made aware if there were any due to my relatively junior position in the clinical team at the time.

7. As far as I was aware, there was a good relationship between the nurses, midwives, junior doctors and the Consultant team. I was not aware of how the relationship was between any of these staff groups and senior leadership teams/Executive team in the hospital at that time. I did not notice any relationships between neonatal unit staff or managers having any effects on the neonatal care provided in the unit.

8. During the 6 months I was working in the neonatal unit at the Countess of Chester from March 2015 – September 2015, I found the culture to be a positive one, where staff were encouraged to express concerns, supported in their work and a friendly, civil and supportive environment to work in. I was not aware of any professional relationships affecting the management and governance of the hospital or department at that time.

9. Compared to other hospitals in the region that I worked in around that time, the culture at the Countess of Chester was comparable and a positive and welcoming environment for learning and training. I had requested to work in the Countess of Chester for that part of my training, particularly as my first Registrar role as it had a reputation for having a positive culture and a supportive environment for training.

10. The working environment was comparable to the other Trusts I had worked in, and I did not notice any difference between Countess of Chester and other departments/ Trusts I had worked in. I had not particularly heard any specific comments that I can recall related to the Countess of Chester and the quality of care, management or the nature of the relationships between staff and managers, either prior to or whilst working there.

Child A and Child B

11. I cared for Child A on 8th June 2015. Based on my statement at **[INQ000054]**, I was the Registrar working in the neonatal unit that day. I will have seen Child A on the ward round that day and assessed his current clinical condition. I note from the clinical notes at **[INQ0000017]** that he was on cpap in air with a stable blood gas. Cpap is a form of non-invasive breathing support provided via a mask or nasal prongs. The blood gas would give information on whether his breathing was stable on this support. He

had not yet started enteral feeds (feeding with milk via a feeding tube) and was being treated for suspected infection with antibiotics. He was receiving parenteral nutrition (IV nutrition) via a peripheral intravenous cannula. This is a temporary route for providing IV nutrition and more secure central IV access is required for longer term nutrition. Due to this, I made the decision that a more secure central line (which is safer for delivering parenteral nutrition through) was required. This was via an umbilical venous catheter (UVC) where the line is inserted into the vein in the umbilical cord and thread into a central position inside the body. I performed the insertion of this line jointly with Dr MacCarrick (ST1 Paediatric Trainee) as I was teaching her how to perform the procedure. It is a sterile procedure, so we were both wearing sterile gowns and gloves to perform this procedure inside the incubator. The difficulty when inserting a UVC is that the length of the line is calculated but the line may not follow the veins directly into the inferior vena cava via the ductus venosus as intended but instead pass into the portal veins and be malpositioned. This can be identified by the position of the line on a x-ray. On reviewing the x-ray of Child A after we had inserted the UVC, we identified that the line was likely in the portal vein due to the shape the of the path the line had taken. Rather than being straight and finishing just below the diaphragm it curved towards the liver. I discussed this with Dr Jayaram (Paediatric Consultant on-call for the neonatal unit that day) and he agreed we should remove the line and try again to pass a new line via the umbilical vein, hoping it would be positioned in the inferior vena cava as intended. As Dr MacCarrick had watched and jointly put the previous line in, I asked her if she was happy to do this repeat procedure independently, which she was. She informed me and has documented in the clinical notes at **[INQ0000017]** that the line had been inserted without any difficulties and she was waiting for a repeat x-ray to review the position on the tip again. I have documented in these clinical notes that on review of the repeat x-ray, the UVC tip was again malpositioned towards the liver and needed removing.

12. We were informed in the handover the next day by Dr Lambie (Paediatric Registrar) about Child A's death. As noted in my statement at **[INQ000054],** I was surprised. I do not recall the details of exactly what we were told in that handover other than that he had died. I do not recall specifically who else was in the handover that morning or whether there was any further discussion about the death, but the morning handovers were normally attended by the day and night medical teams.

13. I have stated in my statement at **[INQ000054]** that Child A's death *"came completely out of the blue"* because I was surprised by his death. When I had left the neonatal unit on the evening of 8th June, I did not expect him to die that same day. He had been stable for a preterm baby with stable blood results and requiring relatively moderate support for a preterm baby with cpap in air.

14. There had been no complications with the UVC insertion that would have made me suspect him to deteriorate. The malposition of a UVC into the portal vein would not lead to the death of a baby, it would just mean the line cannot be used as intended and needs replacing and this is a known complication of UVC insertion. Based on his clinical condition when I had left the neonatal unit the previous evening, I did not expect him to die and was therefore surprised by his death and felt it *"came out of the blue"*.

15. I do not recall the reaction of the other staff specifically in this handover. I do not recall having a coffee with Dr Harkness (Paediatric registrar) and Dr Woods (GP trainee working in paediatrics), but I may well have done this as informal conversations and debriefs to discuss difficult events such as this would happen within the department.

16. I was not specifically concerned that the UVC insertion had led to his death, as if there were to be any difficulties or complications of the procedure, I would expect it to happen whilst the line was being inserted rather than later. However, whenever you have been involved in the care of a baby prior to their death, both in terms of the procedures and the medical decisions made, you would question all decisions made to see if anything could have changed the outcome for that child. I will have reflected on all aspects of the care I had given to see if anything could have been done differently to prevent his death.

17. I note in my statement at **[INQ0000054]** that I was working in clinic the next day 9th June alongside my Consultant colleagues. I do not recall which clinic this was, or which consultants were present. I do not believe this was a formal meeting but more of an informal conversation about what had happened and a chance for all staff to support each other and provide wellbeing support to the team. I do not recall any specific details about what was discussed, by who or whether any actions were derived from this. I am unsure if any further debrief or discussions occurred following this or whether I attended any as I cannot recall the details.

18. I also reviewed Child B on the ward round on 8th June 2015 **[INQ0000698].** I note from the clinical notes that she was stable on Bipap (a form of non-invasive respiratory support provided via a mask/nasal prong to supplement the baby's own respiratory effort) and on antibiotics at that time. On the ward round, I decided to attempt UVC insertion for them. Child B was also receiving parenteral nutrition via a peripheral line and for the same reasons as for Child A, a central line would provide a safer and more secure intravenous access for long term nutrition. Alongside Dr MacCarrick (Paediatric Trainee), I inserted a UVC under sterile conditions and on reviewing the X-ray, we noted that it was malpositioned with the tip appearing to point towards the liver indicating it was in the portal vein. This was similar to the finding on inserting the UVC in Child A. After discussion with Dr Jayaram (Paediatric Consultant on-call for the neonatal unit), Dr MacCarrick and I removed the UVC and replaced it with a second attempt. This second UVC was also malpositioned with the tip appearing on x-ray to point towards the liver and being located in the portal vein. On reviewing the repeat x-ray with Dr Jayaram, a decision was made to replace the second UVC with a peripherally inserted central line. I handed this over to Dr Harkness (Paediatric Trainee covering the neonatal unit that evening).

19. I did not care for Child B again until the day shift of 10th June 2015. I do not recall exactly when I was informed of the collapse of Child B or what my specific reaction was at that time. Following Child B's collapse, I spoke to the haematology team in Alder Hey for advice on whether any additional investigations were required to identify if there was a medical cause for Child B's collapse. This was due to the purpuric lesions (purple non blanching rash) seen by staff at the time of collapse I&S I&S. I will have been asked to do this at the request of the Consultant leading her care that day. The haematology Registrar who I spoke to discussed the case with the haematology team in Alder Hey and rang me

back at 1400 on 10th June 2015 and requested that we do blood tests I&S I&S in Child B. I do not recall the specific timings of when these samples were sent or by who. During these conversations it was advised by the haematology team Alder Hey that we also request an urgent post-mortem for Child A. This was to identify if there was any treatable cause found for Child A's death that could be relevant to Child B as they were twins. The verbal post-mortem initial findings did not identify a treatable cause for Child A's death or give an indication for the cause of Child B's collapse.

20. I cannot specifically recall what details I had been told about the similarities of the collapse for Child A and B. The clinical notes state that I spoke to the parents of Child A and B on 12th June 2015 about her being moved from Nursery 1 to Nursery 2. Nursery 1 was often used for patients receiving intensive care and Nursery 2 for those needing high dependency care. However, in the clinical notes I have documented that there would be no difference in the level of care she would be receiving by moving from Nursery 1 to Nursery 2. I am unsure of any more details as to the reason for the move, the level of care she required or was receiving at that time and do not recall any more details of this conversation than what is documented in my notes at **[INQ0000698, page 38].** What I have documented in the clinical notes is set out below.

> *"Long discussion with parents of Child B again today as Child B has moved from room 1 to room 2. I have explained this is a good thing as it shows she is stable and doing well. Dad is very anxious and feels she is being moved too soon. I have explained she will still receive the same level of care and we will still be monitoring her in the same way. There will be no change to the level of care she receives, and we will continue to be as cautious with her we have been."*

Child C

21. I attended the delivery of Child C as he was born preterm at 30 weeks gestation with an expected low birth weight. It was standard practice for the neonatal team to be present at preterm deliveries and for all these babies to be admitted to the neonatal unit immediately after birth. I was present for his birth and in my statement at **[INQ0000131]**, I have stated that I was not required to provide any resuscitation at birth as Child C had a good respiratory effort. I admitted him to the neonatal unit and inserted a peripheral cannula to give medications through. On the neonatal unit, I noted that he required increasing respiratory support as he was using more effort in his breathing. This was shown by the muscles used for breathing being more easily seen under his rib and his neck with visible subcostal recessions and a tracheal tug plus additional noises heard when he was breathing, which I described as grunting. Due to these signs indicating increased respiratory support was required, I intubated him and placed him on a ventilator for breathing support and administered surfactant medication as is routine for intubated preterm babies. Surfactant medication is delivered via the breathing tuba and is a natural protein that aids lungs in expanding and deflating more easily. Preterm babies may be deficient in this protein due their prematurity. I handed his care over to the team covering that evening. I also asked for the team that evening to discuss his case with the tertiary centre at Liverpool Women's Hospital due to his low birth weight for his gestational age as 800g was at the lower level of birthweights that we would normally care for in the neonatal unit at the Countess of Chester at that time. I thought due to his birth weight being at the lower

level, we needed to discuss with the tertiary neonatal unit if they were happy for us to continue caring for him in the Countess of Chester or to arrange transfer to a tertiary neonatal unit.

22. The next day I saw Child C on the neonatal ward round, where he was off the ventilator and on cpap breathing support. He continued on antibiotics, parenteral nutrition and routine care required for a preterm baby. I next saw him on the ward round on the morning of 13th June 2015. He remained on cpap and on parenteral nutrition. I note that he had had bilious aspirates and was not on any enteral feeds. Bilious aspirates are green aspirates from the feeding tube and indicate that there may be an infection or obstruction in the bowel or that the bowel is slow to move and digest normal bowel content due to prematurity. He remained on antibiotics, and I noted on examination of his abdomen that it was not enlarged or distended. He was later reviewed by Dr Gibbs (Paediatric Consultant on-call) who advised IV ranitidine a medication to neutralise any acid in the bowel/ stomach and ongoing concerns regarding bilious aspirates, for a repeat abdominal x-ray and a change in antibiotics to treat for an infection called Necrotising Enterocolitis.

23. I was informed of Child C's death the next day when I attended morning handover at the start of my next shift. Again, I was surprised by his death as is documented in my statement at **[INQ0000131]** and thought it was unusual, as when I had left on the evening of 13th June, he had been stable and such a sudden deterioration was not expected. In this statement I have also described a *"highly unusual set of circumstances"*. This is in reference to having several deaths in the neonatal unit at the Countess of Chester at that time but that I was not aware of anything suspicious in the care of this child and could not explain anything that caused this death.

24. I will have been aware of the death of Child A and collapse of Child B that week and will have noted this was a high frequency for episodes like this to occur in a unit of the size and level as Countess of Chester. I do not recall any specific conversations made by myself or others to raise this and I am unaware of what conversations the Paediatric Consultants were having about these events at a senior level.

25. I do not specifically recall attending the Neonatal Mortality Meeting on 27th July 2015. I am unsure of how often or when they occurred in Chester at that time and whether I attended others during my rotation there. I am unsure who led or attended this meeting or what was specifically discussed. I do not recall if any staff factors were discussed or whether the increase in episodes of collapse and unexpected deaths was discussed or what was said. I do not recall if anyone raised any concerns in this meeting or suspicions about Child C's death. I do not recall if anyone raised any concerns about the death of Child D either in this meeting or if there were a discussion about the other children that had collapsed or died on the unit. I am unsure if I attended any other similar meetings during the 6 months I worked in Chester. I do not recall if I attended any other discussions or debriefs about the death of Child C or the associations between the other deaths on the unit at that time.

Child F

26. I will have been aware that Child F's twin brother Child E had died whilst they were in the neonatal unit, but I do not specifically recall how or when I found out the news. I cannot recall my specific reactions at this time or whether there were any discussions in the department about his death.

27. I reviewed Child F on the morning of 5th August 2016 with Dr Saladi (Paediatric Consultant covering neonatal unit). We reviewed the history from overnight of raised temperature, tachycardia (raised heart rate) and feed intolerance and the need for a septic screen. This would involve me requesting investigations to look for an infection by taking blood for a blood culture, full blood count and crp (c-reactive protein). I will then have prescribed antibiotics to treat for a potential infection. We noted he had required 3 boluses of dextrose for low blood sugars overnight/ just prior to our review with the last blood sugar reading being 1.3 with a normal level being 2.6, for which he had just received the 3rd bolus dose of dextrose. We examined him and noted pain and swelling to his right groin at the position of the line delivering his medications. There was a concern that all the medications were not being delivered appropriately including his dextrose infusion, which could have caused the low blood sugars and pain. We decided to remove the line, temporarily use the peripheral line and insert a new central line that day. At the time, it will have been concerning that his blood sugars were low but there were potential causes for this such as sepsis or an occluded line or an extravasation injury (where there is leakage of injected drugs/ fluid from the blood vessel with the line into the surrounding tissues). We were treating these potential causes and needed to assess the response to them. With hindsight and the knowledge of the conviction, the findings of the low blood sugars are explained as being caused by an external factor, however, when there were potential medical causes for this finding that needed exploring, I would not have assumed an external cause or changed the treatment given at that time.

28. I do not recall if had any further involvement with the results of the blood tests other than noting his blood sugar had come up to 2.4 later that day, which was reassuring as his blood sugar level was rising from the previous level of 1.4, which I have documented in the medical notes. I do not recall if I attended any discussions or debriefs regarding Child F's care or the blood test results. I was a junior doctor working in the department at that time so it would depend on the nature of the debrief or discussion about Child's F care as to whether it would have been appropriate for me to be involved in these, especially if the senior Consultant team had concerns about individual staff members. I was not aware if any of these discussions about Child F's care and the blood results were occurring at a more senior level.

Child I

29. I was asked to review Child I on 23rd August 2015 after a period of abdominal distension, where a new nasogastric (NG) tube had been passed and an x-ray of the abdomen performed. From my statement at **[INQ000508]** and included at **Exhibit SO03**, I have documented that the NG tube had been noted to be in too far on the x-ray and been pulled back. If an NG tube is in too far, it can either curl in the stomach and not work as well at removing air from the stomach or can go from the stomach to the duodenum and be aspirating the fluid from the wrong part of the bowel. This may lead to abdominal distension and be treated by pulling the NG tube back into the correct position in the stomach. Following this, the abdomen was less distended and

there were no other concerns with Child I's abdomen that shift. I was not still working in the Countess of Chester on 30th September 2015 when the alleged first attack occurred.

HM Coroner – Child A

30. In my statement for the Coroner on 23rd February 2016 at [INQ0008476], I have not made reference to the statement I made in my police interview on 6th February 2018 that Child A's death was unexpected and *"came out of the blue"*. This is true, I did not state this in my statement for the Coroner. The reason this was not included was because I understood my statement to the Coroner was a factual statement of my involvement in relation to Child A's care and the events that occurred, rather than including opinion or speculation. At that time, I was not aware that there was a concern about any individual staff member on the unit and I had not worked on the unit since September 2015, so I was not aware of any other discussions taking place in the hospital. I was not asked directly to include whether I was surprised by the death in the statement for the Coroner, I was asked this question directly by the police. With the knowledge now of what occurred on the unit, my opinion that the death was unexpected may have been relevant, but at the time I provided a factual account of my involvement of the events and was aware that the death was being reviewed by the Coroner. I was aware at the time that by virtue of an inquest being held, this meant that the death was unusual and was being considered as such as otherwise a death certificate would have been offered without the need for an inquest.

31. I gave oral evidence at the inquest. My recollection of what this entailed was answering questions around the insertion of the UVC, how and why this procedure is done and the known complication of the line position being in the portal vein. I do not recall the specific date when I gave my evidence to the Coroner. I do not recall when I found out the conclusions to the Coroner's inquest, and I was not involved in any subsequent discussions regarding this finding.

Response to Neonatal Deaths

32. I do recall finding the number of collapses or deaths on the unit at that time as unusual and concerning. I am unsure specifically when this appeared to me as unusual, but it is likely to be around the time of several of these collapses/ deaths that occurred within a few weeks of each other in June 2015. Whilst I do not recall that I specifically approached any Consultant in particular to raise specific concerns. I believe the whole department was discussing this informally as being unusual and that the senior Consultant team were raising this and investigating what could have caused this. However, at my level I would not have been involved in these specific discussions. I felt confident that the Paediatric Consultants were taking the rise in deaths seriously. I do not think I had specific access to the mortality data from MBRACE-UK, NNRD or NHS England at this time.

Reviews of Deaths and Adverse Events

33. I do not recall specifically the process for reviewing neonatal deaths on the unit at that time or what discussions occurred at network level. I was an ST3 trainee at this time so would not expect to be involved in these specific reviews or how mortality reviews were organised in the department at this time. I do not recall the specific process for reviewing neonatal deaths on the unit at that time and which doctors were involved in

these reviews. I do not know specifically which families were offered post-mortem examinations at this time as it would not have been my role at that point to discuss this with families. I was aware that unexplained deaths would need discussion with a Coroner and that the Coroner could request a post-mortem examination, however, it would not have been my role at that time to have these conversations with the Coroner. I do not recall whether any other debriefs or discussions about the deaths occurred on the unit at that time for any other patients and whether I attended any in this time period.

Awareness of suspicions

34. During my time working in the Countess of Chester, I was not aware of any specific concerns regarding Letby. I only found this out from newspaper reports at a later date and from contact from the police. During the time I worked in the Countess of Chester, no one discussed specific concerns regarding Letby with me. Personally, I did not report any concerns regarding Letby or the babies' safety on the unit either via a formal or informal process. This was because personally I did not have any concerns about Letby, or the care given and was unaware of her association with all the patients that had collapsed or died.

Safeguarding of babies in hospitals

35. I have received level 3 safeguarding training but cannot recall that it specifically covered when to suspect or how to manage abuse by staff in hospital. I am not aware of any specific advice from the Royal College of Paediatrics and Child Health (RCPCH) regarding suspicion of abuse by staff members. If I was concerned about this, I would initially raise this with my seniors and supervisors and line managers, but I would also consider speaking to the RCPCH for their advice on this plus other professional bodies such as the General Medical Council, Nursing & Midwifery Council or a medical protection agency depending on the specific concern at that time. I did not turn to any professional bodies in respect of the events in the Countess of Chester at this time as I did not specifically have any concerns during the time I worked there about any individual staff members.

Speaking up and whether the police and other external bodies should have been informed sooner about suspicions about Letby.

36. I cannot recall the specific procedure for raising concerns within the Countess of Chester between 2015 and 2016, specifically for whistleblowing and freedom to speak up guardians. If I had had any concerns during this time, I would initially have raised these with my supervisor or other Paediatric Consultants in the department at that time. During my paediatric training as a whole, I had training on the processes used to review child deaths including Child Death Reviews, Sudden Unexpected Death in Infancy/Childhood protocols and the role of the Coroner. I cannot recall specifically how much of this I had received before or whilst working in the Countess of Chester as this was an ST3 placement and the training was cumulative throughout the 8 years of speciality training. By the time I completed my paediatric training in 2021, I think this training was sufficient for me to know when to raise suspicions and concerns. I was aware that concerns regarding a hospital or department could be raised to external sources such as NHS England, the CQC, the police or the GMC depending on the nature of the concerns. I did not raise concerns regarding Letby to any of these external

bodies as I did not have any concerns regarding Letby during my time working in the Countess of Chester. I did not provide any additional information to the Coroner about any other patients named on the indictment other than Child A as discussed above.

The responses to concerns raised about Letby from those with management responsibilities within the Trust.

37. I did not raise any concerns regarding Letby to anyone with management responsibilities within the Trust as I did not have any specific concerns whilst working there.

Reflections

38. I am unsure if CCTV would have prevented the crimes that occurred by Letby. I believe it may have stopped her from committing some of them, if she was aware she was being filmed but as some crimes were made to look like routine parts of nursing care, and these may not have been identified or prevented specifically from CCTV surveillance alone. Again, I do not know whether specific security systems could have prevented the crimes in terms of access to drugs or babies as there were many elements of routine care that covered up some of her actions. It is possible that increased security access to drugs may have allowed closer identification of what medications were accessed and when, but this alone may not have prevented any deliberate harm. I do not have any specific recommendations to make to this Inquiry for keeping babies safe from criminal actions by staff members.

Any other matters

39. I do not have any other evidence to give to the Inquiry. I am happy my statements at **[INQ0000054] [INQ0000131] [INQ0000132] [INQ0000894] [INQ0000895] [INQ0000508]** are accurate and do not wish to add or change anything. I have exhibited these statements at **SO01**. I have not given any interviews or made any public comments regarding Letby or matters of this investigation. I do not have any other documents or information relevant to this Inquiry.

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: PD

Dr Sally Ogden

Dated: 17th June 2024