

Witness Name: Martin
Leonard Sedgwick

Statement No.: 1

Exhibits: N/A

Dated: 12/6/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF MARTIN LEONARD SEDGWICK

I, Martin Leonard Sedgwick, will say as follows: -

1. My full name is Martin Leonard Sedgwick. I have been asked by the Thirlwall Inquiry to provide a witness statement providing responses to a number of questions asked of me.

These questions are responded to hereafter.

Medical Career and employment at the Countess of Chester Hospital (the “hospital”)

2. My qualifications are:

- Medicine MB ChB Honours 1984 (Leeds)
- Member of the Royal College of Physicians (Edinburgh) 1987
- Doctor of Medicine 1993 (Leeds)
- Fellow of the Royal College of Physicians (UK) 1998

3. During my medical career, I was also a member of the British Cardiac Society, European Cardiac Society, British Society of Echocardiography and British Pacing and Electrophysiology Group to benefit from their educational meetings, journals and guidelines.

4. My initial training was in the Yorkshire region between 1984 and 1988 working at Airedale General Hospital, Seacroft Hospital and Killingbeck Hospital.
5. My cardiology training was in the Glasgow area between 1988 and 1995 working at Glasgow Royal infirmary and the Royal Alexandra Hospital Paisley as a Cardiology Registrar and then at Glasgow Western Infirmary as a Cardiology Senior Registrar.
6. I was appointed as a Consultant Physician and Cardiologist at the Countess of Chester Hospital ('the hospital'), currently part of the Countess of Chester Hospital NHS Foundation Trust ('the Trust') in 1995.
7. In 2015-16 I was a Consultant Cardiologist and Physician at the Countess of Chester Hospital. I was also Divisional Medical Director for Urgent Care with 12 to 16 hours a week allocated for this administrative role.
8. During my career at the hospital, I was asked to take on a number of educational and management roles. I was the hospital representative on the North West Specialist Training and Education Committee in Cardiology for many years. I was the Royal College of Physicians Tutor for several years arranging training and rotas for the medical trainees working in the hospital. As a result of my interest in medical education I then became involved in the Mersey Deanery School of Medicine.
9. I was asked to take on the Clinical Director of Medicine role within the hospital which I agreed to, although I don't recall the date I think it was around 2010. While I was in post, the Executive team reorganised the management system into two Divisions, Urgent Care and Planned Care. As the Medical specialties were assigned to the Urgent Care Division, I decided to apply for the role of Divisional Medical Director. Although I don't recall the date I believe this was around 2012.

10. I retired in August 2021 but returned to work part time to assist with the cardiology waiting list retiring completely in September 2023. I now have no access to the Countess of Chester IT system, so my statement is constructed from memory and the supporting documents provided by the Inquiry.

Role as Divisional Medical Director (Urgent Care)

11. While I was in post as the Clinical Director for Medicine within the hospital, the Executive team decided to reorganise the management system into two Divisions with one Division looking after Urgent Care (people presenting to the hospital with acute illness often requiring admission) and Planned Care (people referred by their General Practitioner for outpatient treatment or scheduled admission for procedures). This was a difficult concept as almost all specialties have some Urgent and some Planned work.

12. Rather than having each speciality answerable to both Divisions, it was decided that most medical specialties would be managed by the Urgent Care Division and the surgical specialties in the Planned Care Division. It was decided to break up the Women and Children's Directorate, attaching Paediatrics to the Urgent Care Division and Obstetrics and Gynaecology to the Planned Care Division. Although an attempt was made to manage some outpatient based medical specialities in Planned Care, they did not fit well so were subsequently moved to Urgent Care.

13. In 2015-26 the Urgent Care Division was structured as is reproduced in [INQ0002594]. The medical part of the structure consisted of myself, as well as two Clinical Directors who looked after Adult Medicine. One Clinical Director dealt with the admission process in the Emergency Department and Medical Assessment Units and the other looked after inpatient care and the discharge process. Paediatrics did not fit into either of these two categories so Dr Jayaram managed Children's Services as Clinical Lead and reported any issues to me on a monthly basis. Any significant issues were discussed at the Monthly

Divisional meeting. Dr Jayaram was able to discuss with me any issues arising at any time outside of these meetings if needed.

14. The Neonatal Unit ('NNU') was part of Children's Services. By way of reporting structure from the NNU, Dr Brearey (NNU Clinical Lead) reported to Dr Jayaram who reported any significant issues to me at our meetings. I did not routinely meet with Dr Brearey directly.

15. The Urgent Care Division consisted of several large specialities including Emergency Medicine, Acute Medicine, Elderly Care, Paediatrics, Cardiology, Gastroenterology, Endocrinology and Respiratory Medicine and a number of smaller specialities. Each speciality had monthly meetings to discuss their performance and operational issues. Any issues that could not be resolved within the speciality would be escalated to the Division management team. The Division had weekly meetings on a Wednesday morning in the Divisional Director's office lasting for one hour to discuss operational issues and these were chaired by myself and Karen Townsend, Divisional Director. Primarily I tended to lead on the medical operational issues. Dr Jayaram did not attend these as they focussed on adult patient flow. Dr Jayaram and I had monthly meetings in my office lasting for one hour, at which any concerns or issues regarding the running of Children's services or the NNU could be discussed. There were also monthly Divisional meetings lasting for 2-3 hours to which all consultants were invited. The paediatric team were able to discuss any issues there but from my recollection were often not represented. We also had informal meetings with the hospital's Medical Director, Mr Harvey, on a monthly basis to discuss any issues. I was also invited to Trust Board meetings.

16. In order to improve co-operation between the Urgent Care and Planned Care Divisions I also had regular meetings with Mr Semple, Divisional Medical Director for Planned Care,

to discuss joint issues. I have been asked about co-operation with units but I am not sure which units this refers to. As mentioned above the Neonatal Unit reported to Dr Jayaram.

17. I have been asked to comment upon the minutes of the Quality, Safety and Patient Experience Committee dated 20 July 2015 [INQ0003211]. I was a member of this committee and would attend if not on leave, if my clinical commitments allowed. I would also typically be sent the minutes from the meeting at a later date. Due to the time elapsed, I am unable to confirm whether I received these specific minutes from 20 July 2015. I believe that these meetings were held monthly. I do not recall the remit and purpose of this committee beyond its title but these will be recorded in the Trust. My role at these meetings was as an observer to be informed of what was happening in the Trust and to contribute if issues affecting Urgent Care were discussed. I don't know how effective it was as I was not the Chair.

18. Item 3 of the meeting discusses the Divisional structure across Planned and Urgent care and noted as being a possible hindrance to maternity/neonatal/paediatric services. The Inquiry has sought my own personal view in relation to this. As Obstetric services need to work closely with Neonatal services, I would agree that splitting the two services into different Divisions was a disadvantage although I am sure the Obstetric and Neonatal teams did their best to make the new system work.

19. However, I do not think that the Divisional Structure had a significant impact on the investigations of the increased mortality noted on the NNU. When Dr Jayram reported increased mortality on the NNU I asked the paediatric team to investigate in more detail. As soon as he reported that some of the deaths were suspicious we escalated this to the Executive team which is what would have been done in the old structure.

20. Aside from the Quality, Safety and Patient Experience Committee I cannot recall exactly which meetings I was attending 9 years ago. We certainly had monthly Divisional

management meetings, regular Drug and Therapeutics meetings, several board meetings and multiple educational meetings. However, I am unable to assist beyond this. The Divisional secretarial team may have access to more accurate information from this period.

The culture and atmosphere of the NNU at the hospital in 2015-2016

21. Between 2015-2016, as well as throughout my employment at the hospital, I believe the relationships between clinicians and managers and between groups of clinicians were good. Within each specialty all the professional groups (doctors, nurses, pharmacists and therapists) worked well together. Each specialty had a clinical medical lead, nursing lead and Business Performance Manager who would meet monthly along with pharmacy and therapy representatives to discuss any issues concerning the specialty. Most issues were dealt with at that level but if any issues were felt to be relevant to the Division they would be put on the agenda for the next Divisional meeting. Urgent medical issues could also be communicated to me at any time. The relationships within the Division were good; Dr Jayaram, Dr Joseph (Clinical Director Urgent Care), Dr Chatterjee (Clinical Director Urgent Care) and I had all worked together for many years. I had also worked closely with Karen Townsend (Interim Divisional Director Urgent Care) and Karen Rees (Divisional Head of Nursing) for many years.

22. All consultants were invited to the Divisional meetings and the Clinical Leads of each specialty were expected to attend. Matters discussed were minuted and reviewed at the next meeting to ensure that they had been actioned. My main relationship with the Executive team was with Mr Harvey who I had known professionally for several years and I feel our working relationship was good. I did meet with other members of the executive team from time to time.

23. I am not aware of any relationship issues between staff groups on the NNU prior to the investigation of the increase in mortality

24. Further, I am not aware that any professional relationships affected the management or governance of the hospital between 2015 and 2016.

25. I am aware that once the medical team had raised the possibility that the increased mortality on the NNU could be due to the action of a nurse there was some friction between the nurses and medical staff on the unit. I understood from Karen Rees (Divisional Nursing Director) that the nurses were upset that one of their team was being 'blamed' by the medical team for the increased mortality.

Increased Mortality on the NNU

26. Each specialty investigated deaths under their care and discussed the results in their specialty meeting. If learning points were identified which were relevant to other specialties these points were raised at educational meetings or at the Divisional meeting. Serious events would also be discussed at the Whole Hospital Meetings. I was never involved with any Network meetings to discuss adverse incidents or deaths involving babies. Any Mortality and Morbidity meetings were usually within the specific specialty.

27. I cannot recall specifically how deaths on the NNU were investigated but I can see from the minutes of the Thematic Review of Neonatal Mortality held on 8th February 2016 [INQ0003217] that the medical staff were fully involved in this process and post-mortems were frequently obtained.

28. I was presented with The Risk Registers for the Urgent Care Division at the monthly Divisional Meeting which I chaired.

29. I do not recall who compiled the Risk Registers during that period but the increased mortality rate on the NNU would be recorded by one of the Children's services staff.

30. I have been asked if the Trust's risk management strategy or its implementation led to any investigation or evaluation of the mortality rate, the number of serious incidents, and /or the quality of care provided on the NNU. The minutes of the Review of Neonatal Deaths and Stillbirths at Countess of Chester Hospital — January 2015 to November 2015 [INQ0003222] suggests that the cases reviewed were identified by the Neonatal Badger system and the Trust DATIX reporting system suggesting that the Trust's risk management systems had identified the issues on the NNU.
31. I did not have access to data from MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other organisations about the mortality rate and number of serious adverse incidents on the NNU.
32. I was first alerted to concerns about an increase in mortality rates on the NNU during one of my meetings with Dr Jayaram. He mentioned that the death rates were increased compared to previous local levels but at that time were not outside the national range. I asked him to continue to investigate this and to let me know any conclusions. I do not recall the date of this meeting.
33. The minutes of the Quality, Safety & Patient Experience Committee on 14 December 2015 [INQ0003204] show that I did attend that meeting. Item 9 at that meeting was a report on the Mortality Review process. This process had been introduced 2 years before but was difficult to achieve due to problems obtaining a list of patients dying under each consultant's care, obtaining the paper notes for review, freeing up clinical staff to discuss the cases and administrative staff to produce the minutes. It was decided at the meeting that the Medical Director would review all deaths and feed back any areas of concern to teams and report to the Board of Directors. I understand this process was established.
34. In item 11 of the above meeting Ms Fogarty presented the results of the Neonatal and Still birth review. I was not aware of this review as it was performed by members of the Planned

Care Division and reported to the Women and Children's Governance Board which I was not a member of. The results and conclusions presented seemed reassuring.

35. I also note the Thematic Review of Neonatal Mortality performed by Dr Brearey in 2016 [INQ0003217 & INQ0003251]. Dr Jayaram had previously informed me of the increased mortality on the Neonatal unit and I was aware that this was being investigated. However I cannot recall if I was sent a copy of this review. As each speciality works closely with other specialty units in the Network the involvement of an external consultant is not unusual so would not necessarily have been reported to me. I did not discuss this review with Dr Breary.

Concerns about Letby

36. Dr Jayaram came to see me to say that after carefully examining the neonatal deaths and ruling out all other possibilities the paediatricians had come to the conclusion that the deaths may be due to the deliberate action of a staff member.
37. Having looked at the staffing, they had identified a single nurse as the most likely suspect. I don't recall if I was told the name at the time. I said that if we thought someone had deliberately harmed the children the police needed to be informed. I also said that an issue of this importance had to be escalated to the Executive team.
38. We went to find Mr Harvey but he was not immediately available.
39. Dr Jayaram, the next morning I believe, informed me that he had spoken to Mr Harvey. When I later spoke to Mr Harvey to ask what I should do he said that the Executive team would deal with the concerns that had been raised and that I should concentrate on keeping the Division running and not get involved directly.

40. As we had escalated the matter to the Executive team who we considered would now investigate and escalate as appropriate, and to the police if necessary, we did not inform the police personally ourselves.

Downgrading of NNU

41. I do not recall being personally informed about the death of Child O or Child P. Nor would I expect to be made aware of individual deaths on specific units.

42. On 7 July 2016, I was copied into an email regarding the downgrading of the NNU [INQ0002691]. I understood that the downgrading of our NNU was due to the observed increase in mortality. I felt that this was a reasonable decision to help keep patients safe.

43. Subsequently, on 18 July 2016 I understand from the documentation provided to me by the Inquiry that nurse Letby was moved off the NNU. I was not involved in the decision to move nurse Letby to a clerical role. Although we never restrict a clinician's practice lightly, in view of the concerns that had been raised I agree that she could not be allowed to continue with patient contact.

Grievance Process

44. I think Karen Rees mentioned that nurse Letby had lodged a grievance after her practice was restricted.

45. I had no involvement with the grievance process so cannot comment on its handling.

Royal College of Paediatrics and Child Health (RCPCH) review

46. I was aware that the Royal College of Paediatrics and Child Health had reviewed the deaths on the Neonatal unit. I had no involvement in the review.

47. Mr Harvey did show me the report although I was not given time to read it fully, neither was I given my own copy.

Informed of Police Inquiry

48. The document [INQ0003079] indicates that I attended the briefing by Tony Chambers on 16 May 2017 regarding the fact the police had been contacted in relation to the excess deaths on the neonatal unit. I was not involved in the decision to contact the police, but I thought it was a good idea based on the concerns that had been previously reported to me by Dr Jayaram.

Safeguarding of babies in hospitals

49. I did receive safeguarding training the dates of which will be recorded in the Trust's Mandatory Training register. The training related to anyone harming children rather than specifically staff. The training encouraged us to report any concerns to the safeguarding team.

50. The General Medical Council also encourage doctors to report concerns to a member of the safeguarding team or a lead clinician. When presented with concerns raised by Dr Jayaram that the deaths of babies on NNU may be due to the actions of a staff member, we reported the concerns to Mr Harvey who was my line manager consistent with the GMC advice.

51. My clinical practice was in adult medicine only so I had no training on the process or organisations involved in reviewing a child death. I did receive training such on when to refer to the Coroner's Office. I think the training was sufficient to support my practice and the Coroner's Office was always happy to discuss any concerns. I had no training specific to the death of children beyond this.

Consideration of referral to the Local Authority Designated Officer

52. I have been provided with the Trust's Disciplinary Policy [INQ0002879]. I note that Appendix 6 contains information on referring to a local authority designated officer where concerns are held in relation to the actions of a staff member. I do not recall Appendix 6 of the Trust's Disciplinary Policy.

53. I did not contact the Local Authority Designated Officer and I am not aware if anyone else did. As I had escalated the concerns of the paediatricians to the Executive team, I left any further action to them to take, as appropriate.

Reflections

54. I cannot think of any steps that could have been taken any earlier to identify that Ms Letby was harming babies on the NNU.

55. I don't know if CCTV on the NNU would have prevented these deaths. I also do not know if CCTV was subsequently installed on the Neonatal Unit.

56. I do not have any suggestions regarding recommendations this Inquiry should make to keep babies in NNUs safe.

57. I have not given any interviews or made any public comments about the actions of Ms Letby or the matters of investigation by the Inquiry.

Request for documents

58. I do not have any documents or other information potentially relevant to the 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.

Personal Data

Signed: _____

Dated: ____12/6/24_____