Witness Name:
Sarah Harper Lea
Statement No.: 1
Exhibits: SHL1-SHL23
Dated: 24 June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SARAH HARPER LEA

I, **SARAH HARPER LEA**, will say as follows: -

Personal details

1. I am Sarah Harper Lea. I have been employed at the Countess of Chester Hospital NHS Foundation Trust (the "Trust") in the role of Head of Legal Services role since 1 March 2014.

2. I have the following qualifications:

   a. Professional Certificate in Management and An Introduction to Business Studies Award, Open University, 2008
   b. National General Certificate NEBOSH Level 3 Certificate in Occupational Health & Safety, 6 August 2009
   c. The Royal Society for Public Health, Level 4 Diploma in Health Emergency Planning, 14 September 2010
   d. Chartered Institute of Legal Executives, Introduction to Law & Practice, 2013
   e. Chartered Institute of Legal Executives, Client Care Skills, September 2015
   f. Post Graduate Diploma in Senior Leadership, 2024

3. The professional positions I have held at the Trust are:

a. Band 2 part-time Clerical Officer, Radiology, June 2000 to August 2001
b. Band 3 Office Administrator, Facilities Department, September 2001 to September 2003
c. Band 4 PA to Director of Operations, September 2003 to February 2009
d. Band 6 Governance Facilitator, Facilities and Estates, February 2009 to March 2010
e. Band 5 Legal Services Team Leader, 29 March 2010 to 28 February 2014
f. Band 7 Head of Legal Services, 1 March 2014 to present

4. I do not have any medical or clinical qualifications or experience. Please see attached as **Exhibit SHL1** the job descriptions for the Band 5 and 7 roles and associated advert for the Band 5 position.

INQ0102364

Appointment as Head of Legal Services

5. I have been asked to describe the application process to become Head of Legal Services.

6. The Governance Facilitator role became 'at risk' following a restructure exercise at the Trust. The role of Band 5 Legal Services Team Leader was advertised as a vacancy at this time, and I was encouraged to apply for this as I was considered to have transferrable skills.

7. I applied to the position of Band 5 Legal Services Team Leader. I was required to complete an application form and I attended an interview on 9 March 2010. The offer of employment was made on 24 March 2010 with a start date of 29 March 2010.

8. I received two weeks training from the then Head of Legal Services, Cheryl Turbitt, and training from Stephen Cross, Director of Corporate Affairs and Legal Services, thereafter. I attended a training session at Hill Dickinson in relation to Employer and Public Liability Claims in May 2010 and a one day, comprehensive, Claims Handler Course later that same year.

9. My relevant previous experience linked back to the 12 months I spent as a Governance Facilitator, where one of my responsibilities had been the gathering of information to assist with investigations relating to non-clinical incidents and non-

clinical claims, utilising the Datix incident management system. I had undergone training and had experience in staff management and hospital processes.

10. My role within the legal team developed as I gained knowledge and experience. I was promoted to a Band 7 as Head of Legal Services in 2014 to reflect this. I took responsibility for managing staff in the bereavement team for a short period of time due to staff shortages and because they were unable to recruit a manager, so I was asked to step in.

11. When I first started in the role, I was a Band 5 member of staff. This increased to a Band 7 in 2014 to reflect my increased knowledge and experience in this position.

12. The job description for Head of Legal Services describes the role as being responsible for the management and co-ordination of coroners' inquest investigations, claims investigations and access to medical records.

13. In 2015/16, I reported to the Director of Corporate Affairs and Legal Services and continue to do so. At the start of my post, I was closely managed by the Director of Corporate Affairs and Legal Services, Stephen Cross, and reported daily to him. As my experience grew, the reporting became weekly or as required.

14. I reported the numbers of inquests, claims, and any "trends". Any identified trends would be escalated to the Trust's Serious Incident Panel (SI Panel). Before escalating, I would obtain approval from the Director of Corporate Affairs and Legal Services.

15. My role at the SI Panel was an informative one. I reminded clinical staff and the risk team completing the reports of any coroners' deadlines for witness statements and reports. I also highlighted any "trends" so they could be actioned by the clinical staff, including, for example, to take the issue to mortality and morbidity ("M&M") meetings if they felt that was needed.

16. Stephen Cross, Director of Corporate and Legal Services, was my line manager from 29 March 2010 to 31 March 2019. The frequency with which I met with him was initially daily while I was new in the role and being trained up, after the previous Head of Legal Services had retired. Stephen was a mentor initially and was hands on as my line manager. Stephen liked to be well informed and was a "*no surprises*" style

manager. I got on with him well. I felt he was a fantastic mentor who had strong communication skills. I felt we had a successful working relationship.

17. I recall being aware that the Trust was an outlier in terms of neonatal mortality and that the concerns were being reviewed. I cannot now recall the date. Stephen asked me to inform him if any claims, inquests, or subject access requests came into the department related to the Women's and Children's Division or if any staff sought support from legal services, as it could be important. I was not responsible for the complaints process at the Trust.

18. The concerns about the neonatal unit ("NNU") were being contained and led at a senior level. I did not feel that I needed to know any further detail to carry out my responsibilities.

Discussions about Lucy Letby ("Letby") and or neonatal unit ("NNU") deaths

19. I was not directly approached by the paediatric consultants or any other staff member about Letby or about the NNU deaths.

20. As my role in Legal Services is not a director role, the consultants would not have approached me with any concerns that they had, nor would any other staff member.

21. Stephen Cross did not mention anything about Letby or NNU deaths to me as this was not in my remit. When NNU deaths were considered to be a "trend", Stephen asked me to let him know of any inquests or claims relating to the Women's and Children's Division, as I have described above.

Relationship between Head of Legal Services and HM Coroner's Service

22. My role included, and still does, specific responsibilities for liaison with the HM Coroner's Service to action the Directions of the Coroner during the preliminary investigation stage and up to the inquest hearing. It is important that good relationships are built with the Coroner's Officers to ensure concerns are triangulated and addressed between the Trust, the coroner, and the family of the deceased.

23. The legal services team receive notification of an inquest. The first stage is handled by an Inquest Assistant from the Trust's legal team. The team's role is mainly

organisational, following set processes to co-ordinate preparation for the inquest hearing, for example:-

a. obtaining witness statements;
b. staff support;
c. obtaining documents the clinical staff or coroner requires;
d. arranging pre-inquest meetings; and
e. liaising with legal representatives, if required, for more complex inquests, where, for example, a claim may follow or where the family or other interested person has legal representation.

24. I felt that my team had good working relationships with the Coroner's Officers and their teams. Any direct meetings with the Senior Coroner for Cheshire were attended by Stephen Cross, the Trust's external solicitors, and Ian Harvey, Medical Director. I did not meet with the Senior Coroner for Cheshire.

25. The role of the Inquest Assistant was to provide witness statements and any reports relating to the Trust's investigations, for example, incident and complaint investigations if needed. They would also attend the inquest to support staff and provide feedback to the Trust.

26. I managed the inquest handler's role, and reported the outcome of inquests, which would include reporting to the SI Panel meetings. This was a triangulation process between legal services, risk management and complaints (which are three separate teams within the Trust). We would work collaboratively to ensure that witness statements, incident reports and complaint reports were sent to the Coroner's Office to meet their deadlines.

Role since 2017

27. I have been asked to provide a short summary of my career since April 2017.

28. My role and responsibilities remain the same since I started in post in 2009/10. I had leave from August 2017 to December 2017 I&S. My understanding is that Stephen Cross covered my role during that time and no interim Head of Legal Services was formally brought in. The Inquest Handler and the Claims Handler, within

the legal team, therefore escalated to Stephen Cross in my absence for him to inform SI Panel meetings.

29. After Stephen Cross left the Trust in March 2019, I reported to the Medical Director whilst Stephen Cross' replacement was being recruited. The new Director of Corporate Affairs and Legal Services was appointed in November 2019, and I then reported to them. The managers that I have reported into since Stephen Cross left the Trust are as follows:

    a. Darren Kilroy, Medical Director, April 2019 to November 2019
    b. Anna Collins, Director of Communication and Corporate Affairs, November 2019 to September 2020
    c. Hayley McCaffrey, Associate Director of Quality Governance, September 2020 to February 2021
    d. Elizabeth Kanwar, Head of Quality, February 2021 to August 2021
    e. Refeth Mirza, Interim Associate Director of Quality Governance, August 2021 to December 2021
    f. Paul Edwards, Director of Corporate Affairs, January 2022 to January 2024
    g. Laura Leadsom, Acting Director of Corporate Affairs, January 2024 to June 2024
    h. Karan Wheatcroft, Director of Corporate Affairs, June 2024 to date

30. I have been asked how I would describe the relationships between (i) clinicians and managers; (ii) nurses, midwives, and managers; and (iii) medical professionals (doctors, nurses, midwives, and others) in the NNU in 2015/16.

31. I am not aware of any issues in the relationships between any of the above staff groups. I did not have any concerns escalated to me during this time by anyone within those staff groups.

32. I have also been asked whether I think the quality of relationships on the NNU affected the quality of care being given to the babies on the NNU, or whether professional relationships affected the management and governance of the hospital (and the NNU in particular) in 2015/16. I do not consider that I have the knowledge to be able to respond to this question as I did not work closely with these staff groups, as that was not within the remit of my role.

33. I do not have the knowledge to answer whether I was aware of any change in the quality of relationships, or the culture of the NNU after June 2016 or whether suspicions should have been raised earlier and whether Letby should have been suspended earlier. I was not party to any discussions about Letby.

34. I was aware that there had been a number of deaths on the NNU between 2015 and 2016 as they were being investigated by the Coroner or notified to me via the SI Panel Meeting. I would also be aware of any claims notified to the legal services department.

35. My role did not include the surveillance of NNU mortality.

36. I recall the SI Panel papers for the SI Panel Meeting held on 29 June 2015 were circulated via email on 26 June 2015 by Ruth Millward, Head of Risk & Patient Safety **[INQ0003144, page 2]**. This documented that three neonatal deaths were under review via speciality M&M. I was aware that Trust investigations were being undertaken which reassured me at the time.

37. On 28 June 2016, Stephen Cross requested that I prepare a Neonatal Report for the Executives to detail obstetric and neonatal inquests opened from 1 April 2012 to date. I completed the report on 1 July 2016. I have attached the resulting inquest report covering inquests opened from 1 April 2012 to 30 June 2016 as **Exhibit SHL2** INQ0102364

38. I would not be aware of deaths recorded as being due to natural causes. I would only be aware if they were the subject of a Coroner's inquest, investigation, claim or review by the SI Panel.

39. I was concerned when I became aware that there had been three deaths in the NNU which were being investigated and which were subject to an inquest investigation. It was concerning to hear that the Trust's NNU mortality rate was higher than expected, but I would have been reassured as action was being taken by the Trust.

40. My responsibility was to immediately notify Stephen Cross of any new inquest investigations or claims associated with the Women's and Children's Division, which is what I did.

41. Where an inquest investigation was notified to legal services in relation to a NNU death, both Stephen Cross, the Trust's external solicitor, and the SI Panel received timely notifications, as explained below.

42. I cannot recall the exact date that I became aware of the suspicions or concerns of others about the conduct of Letby.

43. I do not recall when I first heard Letby's name in association with the NNU deaths. I believe it was before the press coverage, around the time that she was going to be arrested. It might have been from official Trust communications to staff.

44. I was absent from work on I&S leave from 4 July 2016 to 29 December 2016.

45. Once the involvement of Cheshire Police had been requested by the Executives, my team dealt with the medical record disclosure requests made by the police. The first request was on 19 May 2017. I do not recall being provided with detailed information, but I was aware that a police investigation had commenced.

46. In the context of our roles, my team would not require more detailed information to be able to undertake their responsibilities. I was aware that the matter was being dealt with at executive level by the Trust as it was a confidential and sensitive issue.

June 2015 – Child A and Child D / June 2016 - Child O and Child P

47. I have been asked how I consider I managed concerns once they were raised with me.

48. I was instructed to inform Stephen Cross, my line manager, of any new inquest investigations or claims notified to legal services relating to the Women's and Children's Division at the earliest opportunity.

49. The SI Panel were also notified of any inquests or claims within the legal services division. My team were also aware of the requirement for this escalation.

50. From reviewing the SI Panel notes, the legal services department was notified of the inquests of Child A and Child D in June 2015, and of Child O and Child P in June

2016. This was escalated to Stephen Cross, and the SI Panel also received notification.

My Role on the SI Panel

51. My role on the SI Panel was to provide weekly updates in relation to claims and inquest investigations notified to the Trust. It involved triangulating those matters with any prior Trust investigation (for example, identifying any associated incidents or complaints reported on the Trust's Datix system), and highlighting those matters where there was no prior knowledge for the Panel to then decide if retrospective investigation was required with a view to addressing any ongoing risk to patient safety.

52. I would also notify the SI Panel who I was approaching for inquest reports and seek advice, where required, to ensure that whilst the Panel were discussing incidents, that anything linked to the inquest investigation was raised to ensure deadlines were met in respect of inquests.

53. I would also question whether the Trust's Duty of Candour (the statutory duty to be open and honest with patients and their families) had been complied with during discussions with the patient's family. This was in the context of incident investigations and disclosure of information and documents to the coroner. I wanted to ensure that the Trust had made initial contact with families in a timely manner rather than becoming aware of matters via onward disclosure from the Coroner. This sought to ensure that bereaved families had Trust support when receiving documentation and had the opportunity to engage with the Trust in relation to matters that fell outside of the Coroner's remit, for example, issues that might fall within the complaints process.

54. I also provided feedback from Coroner's inquest hearings including the outcome, lessons learnt, and any associated actions required.

55. I understand that the risk team had a spreadsheet where they monitored incidents with associated inquest investigations at their team meetings to ensure that they were completed on time.

56. I did not take part in the decision-making process in respect of the outcome of the SI's.

57. I am the author of the SI Panel reports save for the period July 2016 to December 2016, and August 2017 to December 2017, when I was on leave I&S In my absence, the authors of the reports were members of the legal services team.

Death of Child A (8 June 2015)

58. On 8 June 2015, Child A died. Letby has been convicted of murdering Child A.

59. This death was notified to the SI Panel on 15 June 2015 by Ruth Milward, Head of Risk and Patient Safety, for determination of the level of investigation required.

60. The Coroner's inquest investigation was notified to legal services in correspondence from Coroner's Officer, Karen Shaw, dated 23 June 2015. This was received by post into legal services on 29 June 2015. The SI Panel were notified of the inquest investigation on 6 July 2015 in the legal report dated 29 June 2015 to 4 July 2015. I can confirm that I was the author of that report.

Sudden and expected deterioration of Child B (10 June 2015)

61. On 10 June 2015, Child B (the twin of Child A) suddenly and unexpectedly deteriorated. Letby has been convicted of attempting to murder Child B.

62. I was not informed of the deterioration of Child B. It would not be in my remit to be informed. It would be a matter for clinical staff to address and follow the usual incident management process if needed at the time of the incident.

Death of Child C (14 June 2015)

63. On 14 June 2015, Child C died. Letby has been convicted of murdering Child C.

64. I was notified in an email that three neonatal deaths were being reviewed at an M&M meeting. I was not provided with any detail as this was not related to an inquest investigation or claim investigation at that time.

65. The SI Panel papers for the SI Panel meeting to be held on 29 June 2015 were circulated via email on 26 June 2015 by Ruth Milliard **[INQ0003144, page 3]**, who stated:

"To note:

*We have 3 neonatal deaths under review via specialty M&M. The plan is to arrange a specialty specific SI Panel for next Friday 3rd July to go through all 3 cases. *child death is no longer included as a Serious Incident by definition [in the SI Framework or on StEIS], however it may be reported as a serious incident under another category e.g. medication error"*

66. Following a telephone call between myself and Dr Stephen Brearey on 2 March 2016 (see note of the telephone call at **[INQ0008890]**, Dr Brearey shared copies of the Perinatal M&M Meeting Record dated 24 June 2015 **[INQ0008853, pages 21 – 22]**, NNU Mortality Thematic Review dated 2 March 2016 **[INQ0003251, page 11]** and Summary Report reviewing Child A, Child C and Child D (see **Exhibit SHL3)** INQ0102364 by email on 2 March 2016 **[INQ0008869]**. I forwarded these reports and the content of Dr Stephen Brearey's email to Stephen Cross on 28 June 2016 by email, as requested, for his urgent consideration with the Head of Risk and Patient Safety, Ruth Millward. They were to determine what we would be required to submit to the Coroner in relation to the Trust's investigation into the death of Child A, and any other associated information required to be disclosed. I attach to my statement marked **Exhibit SHL4** INQ0102364 a copy of the email dated 28 June 2016.

Death of Child D (22 June 2015)

67. On 22 June 2015, Child D died. Letby has been convicted of murdering Child D.

68. On 26 June 2015, Ruth Millward wrote an email **[INQ0003144, page 2 - 3]** to SI Panel members, which included me, circulating the papers for the SI Panel scheduled to be held on 29 June 2015. Within the email the following note was made:

"*3 neonatal deaths under review via speciality M&M. The plan is to arrange a speciality specific SI Panel for next Friday 3rd July to go through all 3 cases.*"

69. I was not provided with any further detail at that time.

70. My reaction to receiving this email was that a theme in neonatal deaths had been identified by the risk team and that a specialty specific M&M review meeting, conducted by the clinicians, was being arranged at which the clinicians would go through the cases in detail. I felt assured the deaths were being investigated and that process was being followed. I noted that it was a theme to be aware of and to escalate any further information/correspondence from the Coroner or via the claims handling or subject access request workstreams, that may be notified to legal services, to Stephen Cross and the SI Panel.

71. I did not attend the specialty specific M&M review meeting as it was not part of my role to do so. I am not clinically trained. The meeting was to undertake a detailed clinical review of the deaths and to understand whether an incident had taken place. It was not a meeting that I would have expected to be invited to. I would need to be informed of the outcome if further investigations were to take place to ensure that the Coroner was updated with the level of investigation being undertaken, the timescale for completion of any investigation and to be provided with copies of investigations undertaken to disclose to the Coroner along with confirmation that any investigation report had been shared with the family.

72. The Head of Complaints (a member of the SI Panel) would also not have been required to attend the specialty specific M&M review meeting.

73. I was not provided with any other information in relation to the deaths of Child A, Child C and Child D in advance of this meeting.

74. Ruth Milliard's email referred to above **[INQ0003144, page 3]**, stated:

"……*death is no longer included as a Serious Incident by definition [in the SI Framework or on StEIS], however it may be reported as a serious incident under another category e.g. medication error*."

75. I do not know why this decision was made, what impact it had or whether it was a reasonable decision to take. This was a decision that would be appropriate for the risk team to answer. This did not fall under my remit as Head of Legal Services or within my area of expertise.

76. I did not have responsibility for recording serious incidents or for categorising them. It was not, and never has been, part of my role. I cannot answer whether under the then new SI Framework, a sudden and unexpected life-threatening deterioration and/or death of a baby, for which there was no immediately obvious explanation, should have been recorded as a serious incident.

SI Panel meeting (2 July 2015)

77. A handwritten note indicates that on 2 July 2015, a SI Panel meeting took place **[INQ0003530]**. A record of the meeting is also included at **[INQ0002656]**.

78. I did not attend the SI Panel meeting held on 2 July 2015. I was absent from work on annual leave on 2 July 2015. In an email dated 26 June 2015 **[INQ0008157]** I stated that I was away on leave during the week that the meeting took place. I cannot therefore add anything to the recorded minutes.

79. In terms of the purpose of the meeting, from review of the handwritten notes **[INQ0003530]** the meeting held on 2 July 2015 was a SI Meeting to review three neonatal deaths and not an SI Panel Meeting. I would not be invited to attend SI Meetings as that would be the responsibility of clinical staff and the risk and patient safety leads. Incident reviews did not fall within my area of responsibility.

80. I did not discuss any of the deaths in advance of the meeting held on 2 July 2015 with any of the attendees. It was not intended that I would be present at the meeting.

81. The handwritten note of the meeting records "advice from LWH" **[INQ0003530]**. This appears to relate to Child D.

82. It would not be my role to obtain or action that advice. It would be for the Risk and Patient Safety Lead, who sat within the risk team, to undertake the incident investigation.

83. The handwritten note documents that a SI review took place on 2 July 2015.

84. The meeting was attended by Alison Kelly, Director of Nursing, Ruth Milliard, Head of Risk and Patient Safety, Erian Powell, Dr Stephen Brearey, Consultant, and Debbie Peacock, Risk and Patient Safety Lead. I understand from the summary

email received from Dr Stephen Brearey that the meeting was to go through the care provided in detail and to decide if a SI was necessary. I also understand, from Dr Stephen Brearey's email dated 2 March 2016 **[INQ0008869]** that the consensus at the end of the meeting was that it was not required.

85. I have been asked to consider Dr Stephen Brearey's chronology **[INQ0003182]** and statement **[INQ0006890]** at paragraphs 7 to 10.

86. I was not aware of any discussion in relation to Letby, prior to or at that meeting, as someone who was identified as being on duty at the time of the deaths of Child A, Child C and Child D. I was not in attendance at that meeting.

87. In my email of 26 June 2016 **[INQ0008157]**, I asked to be kept informed in relation to all three deaths. I was managing the bereavement team at the time and wanted to be aware of any changes in the administrative process for postmortem examination arrangements so that I could communicate this to the team. I would also need to be informed of any decision relating to the level of investigation for any associated inquest investigations or claims notified to the Trust, to ensure that processes were joined up and that triangulation/aggregation was included in any reports.

88. In relation to the inquest investigation into Child D, I was provided with the Perinatal Morbidity and Mortality Meeting Record, NNU Mortality Thematic Review and summary of cases prepared by Dr Stephen Brearey on 2 March 2016 (see paragraph 66 above), which set out that there was no requirement for a Serious Untoward Incident (SUI) investigation into the death of Child D.

89. On 28 August 2015, a Level 2 Root Cause Analysis Investigation Report was completed in relation to Child D **[INQ0014204].** The Report stated that:

"*The incident was escalated to the Medical Director ... and was subsequently discussed at an extraordinary Executive Serious Incident Panel on 2nd July 2015*".

90. I have been asked how the death of Child D was "escalated" to Ian Harvey. It is the responsibility of the Head of Risk and Patient Safety, Ruth Millward, to respond to how the incident was escalated to the Medical Director. It was my responsibility to inform and update the SI Panel with information relating to inquest or claims investigations. The inquest investigation was notified to the SI panel on 30

September 2015 via the legal report for SI Panel for the period 19 September to 25 September 2015.

91. I am not able to comment on when any other direct escalations would have taken place to Ian Harvey from other members of staff.

92. I have been asked if I was made aware of the discussion of the circumstances "*to identify if there was any commonality which linked the deaths*."

93. I was aware that there had been 3 neonatal deaths which would be considered a theme and that an M&M Review was taking place. I was not aware of any other discussions.

94. On 2 July 2015 a Sudden Unexpected Death meeting took place **[INQ0000108, page 178]**.

95. I was not present at this meeting as explained above. I understand that the meeting was to undertake a clinical review of the three neonatal deaths in detail to establish if there were any concerns about care that would require further investigation. I would not be expected to attend such meetings as I have no clinical training. In addition, I was away on annual leave on 2 July 2015.

96. I was not provided with a specific name at the time of being informed that the review was taking place and so did not know it related to Child C.

97. My understanding at the time was that Child A was being discussed, as I was provided with a copy of the notes of the meeting as an inquest investigation had been notified at the time. In relation to Child D, I was not provided with the name and a Coroner's investigation was not notified until September 2015, after the meeting took place. However, Child D was subject to a Level 2 investigation by the risk team.

Serious Incident Panel meeting (6 July 2015)

98. A legal report was prepared for the Serious Incident Panel meeting on 6 July 2015 **[INQ0008160].** The entry for Child A reads:

Record name	Ref	Date of Death	Claim Opened Date	Description	No. of Linked	No. of Linked Incidents	Specialty
Child A [redacted]	I&S	08/06/15	29/06/2015	The patient died unexpectedly on 08/06/15 at COCH. He was born on PD/06/15. A post-mortem was carried and the cause of death is withheld pending toxicology, histology and other tests. Report to be requested from Dr Brearey.	0	I&S 8	Neonatology

99. The record confirms that:

a. I notified the SI Panel that the Coroner has opened an inquest investigation into the death of Child A. My report details Child A's hospital number, Datix Inquest identification (ID): PD the date of Child A's death and the date that the inquest investigation was opened by the legal services department following notification from the Coroner's Officer.

b. I provide a description of the information provided by the Coroner's Officer and note that Dr Brearey is to be approached for a report.

c. A search of the Trust's Datix incident management system took place to identify any associated incidents or Trust investigations and I reported that no complaints had been identified and that an incident had been identified.

d. I provided the ID of that incident Datix Ref: I&S The incident ID will have been linked to the inquest ID: PD on Datix.

e. I stated that the death fell under the specialty of neonatology.

100. I do not hold any notes of the meeting, but usual practice would be for the Panel to note that an inquest has been opened and that the incident investigation would

require monitoring for timely completion. The Panel would note that an incident had been reported on Datix for internal review via the risk management process.

Death of Child E (4 August 2015)

101. On 4 August 2015, Child E died. Letby has been found guilty of murdering Child E.

102. This death was not subject to a coroner's investigation. I was first informed of it at SI Panel on 13 August 2015. From review of the SI Panel email dated 13 August 2015, an SBAR was presented to Panel I&S. The SI Panel Datix notes **[INQ0002659, page 5]** read that:

'likely cause of death was NEC. No PM, has been discussed with the Coroner. Will be discussed in Neonatal review. Await OPR.' (Obstetric Primary Review)

103. The level of investigation agreed was an SBAR report. An SBAR provides detail in relation to an incident. It summarises the situation, the background, the action taken and the recommendation (SBAR). SBAR reports were completed by the Risk and Patient Safety Leads and presented to the SI Panel for a decision as to whether further investigation of the incident was required and what level/type of investigation was required.

Sudden and unexpected deterioration of Child F (5 August 2015)

104. On 5 August 2015, Child F (Child E's twin) suddenly and unexpectedly deteriorated **[INQ0000859 at page 23]**. Letby has been convicted of attempting to murder Child F on this occasion.

105. I was not informed of this sudden and unexpected deterioration. I would not have expected to have been informed of this event as I am not clinically trained, and it would not fall within the scope of my responsibilities. It was (and remains) my responsibility to manage the coordination of information for claims against the Trust and coroner's inquest investigations. Incidents were managed by the risk team. Any themes and trends were monitored by the risk team with input from the clinicians.

Serious Incident Panel meeting in relation to Child E (13 August 2015)

106. On 13 August 2015, a SI Panel meeting in relation to Child E took place **[INQ0002659]**. I attended the meeting.

107. The record indicates: "*Will be discussed in Neonatal review*". It is my understanding that all deaths are reviewed within the speciality with support from the Risk & Patient Safety Lead. I do not know what the terms of reference were as this was a risk management/speciality process. It was my understanding that a review would take place into any neonatal death.

108. Letby is recorded as being the "Incident Reporter". I do not recall any discussion about Letby at any of the SI Panel meetings that I attended.

109. Due to the passage of time, I am unable to recall any specific discussion about the sudden increase in the NNU mortality rate at the SI Panel Meeting held on 13 August 2015. There is no reference to the mortality rate recorded in Datix ID: PD

110. I do not recall any specific discussion at the SI Panel about the Trust complying with its Duty of Candour but this was the responsibility of the clinical and risk team, specifically the risk and patient safety leads, within the incident management process.

Sudden and unexpected deterioration of Child G (21 September 2015)

111. On 21 September 2015, Child G suddenly and unexpectedly deteriorated. Letby has been convicted of attempting to murder Child G on this day.

112. I was not informed of this sudden and unexpected deterioration. I would not have expected to have been informed of this event as I am not clinically trained, and it would not fall within the scope of my responsibilities. It is my responsibility to manage the co-ordination of information for claims against the Trust and for Coroner's inquest investigations. Incidents were managed by the risk team. Any themes and trends were monitored by the risk team with input from the clinicians.

Sudden and unexpected deterioration of Child H (26 September 2015)

113. On 26 September 2015, Child H suddenly and unexpectedly deteriorated on two occasions **[INQ0000972, page 18**]. Letby was acquitted of attempted murder in

relation to one of these occasions and the jury did not return a verdict on a count of attempted murder in relation to the other occasion.

114. I was not informed of this sudden and unexpected deterioration. I would not have expected to have been informed of this event as I am not clinically trained it would not fall within the scope of my responsibilities. It is my responsibility to manage the co-ordination of information for claims against the Trust and for Coroner's inquest investigations, incidents were managed by the risk team. Any themes and trends were monitored by the risk team with input from the clinicians. This question would be best addressed by the risk team.

Death of Child I (23 October 2015)

115. On 23 October 2015, Child I died. Letby has been convicted of murdering Child I.

116. I do not recall this death being notified to the SI Panel or specifically discussed at the SI Panel. I note that the death was reviewed within the NNU Mortality Thematic Review undertaken by Dr Stephen Brearey in March 2016. I received a copy of this review in relation to the inquest investigation into the death of Child A on 2 March 2016.

117. This death was not subject to a Coroner's inquest investigation. A disclosure of medical records request was received by legal services on 8 August 2018 in relation to a potential claim.

SI Panel meeting (26 October 2015)

118. On 26 October 2015, a SI Panel meeting took place **[INQ0003614].** Attached to the email from Ruth Millward was "*NNU review by Dr Stephen Brearey*" **[INQ0003256].**

119. I have been asked what the purpose of this meeting was and the circumstances in which it was arranged. The SI Panel meeting was held weekly. New incidents were presented to the meeting, by the Head of Risk and Patient Safety, Ruth Millward. Decisions were made by the Executives in attendance as to whether any further investigation was required and what the level of that investigation should be. Due to the passage of time, I do not recall specifically what was discussed at the meeting on 26 October 2015. Following review of Datix, an email was sent from Ruth Millward,

Head of Risk and Patient Safety, to the Risk and Patient Safety Lead for the Division of Women and Children's (see **Exhibit SHL5**), which detailed the following: INQ0102364

"26/10/2015:

I&S *– NNU review by Dr Stephen Brearey*

'Agreed: LWH have reported as a L2. Please contact your equiv there to ensure that we are part of the L2 and that there can be sharing. There is no point in doing 2 RCA's'.

120. The document details an incident review carried out by Dr Stephen Brearey on 12 October 2015. The incident relates to difficulties during an umbilical arterial line insertion and details that this is a known complication. This incident did not relate to an inquest investigation or claim against the Trust and did not require the involvement of legal services.

121. I am unable to find an email in the supporting documents where I send apologies to the meeting held on 26 October 2015. In my email to the SI Panel attaching my report INQ0102364 (see **Exhibit SHL6**), I do not send apologies and I attached a legal report to that email **[INQ0008195].**

122. I have been asked whether Child D was discussed at the meeting. The following entry relates to Child D.

Hospital Number	Ref	Incident date	Claim Opened Date	Description (Policies)	Linked Complaints	Linked Incidents	Specialty
Child D [redacted] (deceased 22.06.2015) I&S	I&S	20/06/2015	23/10/2015	Potential claim - disclosure request for Root Cause Analysis only at this stage - no request for records. Gamlins Law Solicitors investigating potential breach of duty relating to	0	**I&S** Neonatal Death I&S NNIRG	Obstetrics

				birth of baby [redacted] on PD 06/2015. Spontaneous rupture of membranes at 36+6 after a failed induction of labour baby was delivered by C-section and died on neo-natal unit I&S No invoice sent. Documents requested from Risk Team - 23/10/15			

123. Due to the passage of time, I am unable to recall what was discussed at the meeting. From review of my report set out above, I notified the SI Panel that:

a. a request for disclosure of medical records was made by Gamlins Law Solicitors in respect of a possible clinical negligence claim against the Trust; and
b. the incident documents were requested from the risk team on 23 October 2015.

124. It was my responsibility to inform the SI Panel meeting of new claims and inquest investigations notified to the Trust.

SI Panel meeting (23 November 2015)

125. A legal report was prepared for the SI Panel meeting on 23 November 2015 **[INQ0008206]**. I have set out a summary of the entry for Child D below.

Hospital Number & Inquest Ref	Date of Death	Specialit y	Description	Complaint	Incident	Witnes ses	Current Position
Child D DOB PD /0 6/2015	I&S	22/06/20 15	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD /06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	Level 2 Invest igatio n **I&S**	Neonat ology	Unexpected Death

126. Child A had been added to the "inquest monitoring" section of the report. Due to the passage of time, I am unable to recall why this entry was made on 23 November 2015. It would be my usual process to discuss any new cases added to the report at each meeting. In this case, I would have been requesting monitoring of the finalisation of the Level 2 Investigation.

Sudden and unexpected deterioration of Child J (26 to 27 November 2015)

127. On 26 and 27 November 2015, Child J suddenly and unexpectedly deteriorated on two occasions **[INQ0001065, page 319].** The jury did not reach a verdict on two counts of attempted murder against Letby.

128. I was not notified of this deterioration at the time as it was not linked to an inquest or claim investigation. It would not be usual process to notify legal services of a patient's deterioration. It was the role of the clinical and risk teams to investigate.

129. I do not recall being informed of any incidents relating to Child J.

Serious Incident Panel meeting (30 November 2015)

130. A legal report was prepared for the SI Panel meeting on 30 November 2015 **[INQ0008212]**.

131. The entry for Child D is set out below:

Hospital Number & Inquest Ref	Date of Death	Specialit y	Description	Complaint	Incident	Witness es	Current Position
Child D [redacted] DOB PD 06/ 2015	I&S	22/06/2 015	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD /06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously	0	Level 2 Investigati on **I&S**	Neonato logy	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician.

			requested a copy of her maternity records and of the baby's records - these were sent to her.				

132. I can confirm that I was the author of the report dated 30 November 2015. I have updated the report dated 30 November 2015 to detail progress with the inquest investigation. My update details that reports had been received from the Head of Midwifery, Consultant Obstetrician and Consultant Paediatrician.

133. Due to the passage of time, I am unable to recall what was discussed at the meeting. It would be usual process for me to update the Panel on any new entries that I had made to the report. It is therefore likely that I updated the Panel that reports had been received.

Serious Incident Panel meeting (8 December 2015)

134. A legal report was prepared for the SI Panel meeting on 8 December 2015 **[INQ0008231].**

135. The summary of the entry for Child D is set out below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position

I&S **Child D** DOB PD/06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors.	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician .

136. I can confirm that I was the author of the report dated 8 December 2015. I have added an entry to this report in relation to Child D to state that '*the family have instructed solicitors*' to represent them at the inquest hearing.

137. Due to the passage of time, I am unable to recall what was discussed at the meeting. It would be usual process for me to update the Panel on any new entries that I had made to the report. It is therefore likely that I updated the Panel that the family were to be legally represented at the inquest hearing.

Serious Incident Panel meeting (21 December 2015)

138. A legal report was prepared for the Serious Incident Panel meeting on 21 December 2015 **[INQ0008235]**.

139. I can confirm that I was the author of the legal report to the SI Panel dated 21 December 2015. The relevant entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** DOB PD/06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors.	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician.

140. I note that there have been no updates made to this report since 8 December 2015 when I notified the Panel that the family had instructed solicitors.

141. Due to the passage of time, I do not recall what was discussed at this meeting. As per usual process, as the report did not contain any updates in relation to Child D it is unlikely that I discussed Child D at the meeting.

142. The summary for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child A** DOB: PD/06/15	08/06/15	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is inconclusive.	0	OSR Review I&S	Dr Jayaram (Paeds) Dr Saladi (Paeds)	Monitor closely Post mortem received 23 Dec 2015 and report is inconclusive – COD is: 1a) Unascertained Awaiting action from Coroner Office as to how proceeding PM sent to Saladi and Jayaram 29 Dec 2015

143. It is noted that in the first column Child A's date of birth is written as I&S 06/15. I understand this is a typographical error as Child A was born on PD June 2015. This error is replicated on legal reports referred to throughout this statement and the same clarification is applicable throughout.

144. I note that there had been no updates made to the report since Child A was first added to the monitoring section of the report on 8 December 2015.

145. I have been asked whether Child A's case was monitored 'closely'. From review of my report dated 21 December 2015, all the inquests in the 'Inquest Monitoring' section were labelled as "*Monitor closely*" unless there was specific action required at that time.

146. Due to the passage of time, I do not recall what was discussed at the meeting. As per usual process, as the report did not contain any updates in relation to Child A, it is unlikely that I discussed Child A at the meeting.

Inquest into the death of Child A (23 December 2015)

147. On 23 December 2015, an inquest into the death of Child A was opened **[INQ0002042]**.

148. On 10 October 2016 an inquest hearing took place. I have been asked to consider Dr Ravi Jayaram's evidence to the criminal trial **[INQ0010268 at page 178]** in which he stated that around the time of the inquest "*members of the senior management team*" were telling clinicians "*that really [they] should not be [raising concerns] and not making a fuss.*"

149. I was not aware of this. I was not involved in any meetings between the Executives and clinicians. I was not involved in any conversations or communication with Dr Jayaram about the concerns he raised. I cannot comment on what was said during any conversations that he says he had with senior management.

150. From July 2016 to December 2016, I was absent from the Trust on I&S leave and had no further involvement in the inquest process.

Serious Incident Panel meeting (4 January 2016)

151. A legal report was prepared for the SI Panel meeting on 4 January 2016 **[INQ0008239]**.

152. I have been asked about a report dated 21 December 2015 which I completed and submitted in preparation for the meeting on 4 January 2016. From review of the report, it appears that I did not change the date from the previous report compiled on 21 December 2015.

153. A summary of the entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** DOB PD 06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015

154. I can confirm that I was the author of this report. I updated the report to state that the Level 2 investigation was sent to the Coroner on 1 December 2015.

155. Due to the passage of time, I am unable to recall what was discussed at the meeting. It would be usual process for me to update the Panel on any new entries that I had made to the report. It is therefore likely that I updated the Panel of the above.

156. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child A** DOB: PD 06/15	08/06/15	Neonatology	Twin babies born by PD .06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is inconclusive.	0	OSR Review I&S	Dr Jayaram (Paeds) Dr Saladi (Paeds)	Monitor closely Post mortem received 23 Dec 2015 and report is inconclusive – COD is: 1a) Unascertained Awaiting action from Coroner Office as to how proceeding PM sent to Saladi and Jayaram 29 Dec 2015

157. In relation to Child A, I updated the report in red text to notify the SI Panel that the Post-Mortem Report was received on 23 December 2015 and that the report was inconclusive, with the cause of death given as 1a) unascertained.

158. I noted that we were awaiting further Direction from the Coroner's Office as to how the investigation was to proceed. I also noted that a copy of the Post-Mortem Report had been sent to Dr Saladi and Dr Jayaram on 29 December 2015.

159. Due to the passage of time, I am unable to recall what was discussed at the meeting. It would be usual process for me to update the Panel on any new entries that I had made to the report. It is therefore likely that I updated the Panel of the above.

SI Panel meeting (11 January 2016)

160. A legal report was prepared for the Serious Incident Panel meeting on 11 January 2016 **[INQ0008242]**.

161. I can confirm that I was the author of the report dated 11 January 2016. In respect of Child D, the following entry was made:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted]) DOB PD/06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner.

162. This entry updated the SI Panel that the Coroner was instructing independent medical experts to consider the care provided to Child D. I was also informing the SI Panel that a copy of the medical records was to be disclosed to the Coroner.

163. I highlighted the above in my covering email in which I circulated my report to the SI Panel. I also informed them that I would notify NHS Resolution of the inquest and apply for funding for the Trust to have legal representation at the inquest hearing.

164. My covering email stated (see **Exhibit SHL7**): INQ0102364

Child D – *Coroner to instruct independent medical expert. NHSLA to be notified and Inquest funding requested for legal representation'.*

165. I sent apologies to the meeting and do not know if Child D was discussed at the meeting.

166. A summary of the entry for Child A is set out below.

Hospital Number & Inquest Ref	Date of Death	Specialit y	Description	Complaint	Incident	Witnesses	Current Position
I&S Child A [redacted] DOB: PD 06/15	08/06/ 15	Neonato logy	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. I&S A post mortem was carried and the cause of death is inconclusive.	0	OSR Review PD	Dr Jayaram (Paeds) Dr Saladi (Paeds)	Monitor closely Post mortem received 23 Dec 2015 and report is inconclusive – COD is: 1a) unascertained Awaiting action from Coroner Office as to how proceeding PM sent to Saladi and Jayaram 29 Dec 2015

167. In relation to Child A, I have not included any new updates in my report dated 11 January 2015.

Serious Incident Panel meeting (18 January 2016)

168. A legal report was prepared for the Serious Incident Panel meeting on 18 January 2016 **[INQ0008245]**.

169. A summary of the entry for Child D is set out below.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB PD/ 06/2015	22/06/ 15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	Level 2 Investigation I&S	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner.

170. I can confirm that I was the author of this report. I have not added any updates to this report in relation to Child D since the previous report dated 11 January 2016, in which I stated that the Coroner was instructing independent medical experts to consider the care provided to Child D. I also informed the Panel that a copy of the medical records was to be disclosed to the Coroner.

171. Due to the passage of time, I am unable to recall whether or not Child D was discussed at the meeting held on 18 January 2016. As I did not add any updates to the report, I do not expect that I raised any issues in relation to this investigation.

172. A summary of the entry for Child A is set out below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child A** Baby [redacted] DOB: PD/06/15	08/06/15	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unacertained.	0	OSR Review I&S	Dr Jayaram (Paeds) Dr Saladi (Paeds)	Monitor closely Awaiting action from Coroner Office as to how proceeding. PM sent to Saladi and Jayaram 29 Dec 2015 Copy medical records sent to the Coroner.

173. I have not included any new information in relation to Child A in my report dated 18 January 2015.

174. Due to the passage of time, I am unable to recall whether Child A was discussed at the meeting held on 18 January 2016. As I did not add any updates to the report, I do not expect that I raised any issues in relation to this investigation.

SI Panel meeting (25 January 2016)

175. A legal report was prepared for the SI Panel meeting on 25 January 2016 **[INQ0008254]**.

176. A summary of the entry for Child D is set out below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** (Baby [redacted]) DOB PD/ 06/2015	22/06/ 15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner.

						Dr Newby (Paeds)	Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson.

177. I can confirm that I was the author of this report. I updated the Panel that inquest funding for legal representation at the inquest hearing had been granted and that the Trust was being represented by Hill Dickinson.

178. Due to the passage of time, I am unable to recall whether or not Child D was discussed at the meeting held on 25 January 2016. It would be usual process for me to inform the SI Panel of any updates added to the report, as outlined above.

179. A summary of the entry for Child A is set out below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position

I&S **Child A** [redacted] DOB: PD/06/15	08/06/15	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unacertained.	0	OSR Review I&S	Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae)	Monitor closely Awaiting action from Coroner Office as to how proceeding. PM sent to Saladi and Jayaram 29 Dec 2015 Copy medical records sent to the Coroner. Maternity report requested from Coroner's office – Dr Davies completing. Inquest has been set for 23/03/16 but no witness list yet.

180. In relation to Child A, I have updated the report to inform the Panel that the Coroner requested a report to detail the antenatal care afforded to Child A's mother and that Dr Davies was writing this report. I also notified the Panel that the inquest date had been set down for 23 March 2016 and that no witnesses had been confirmed at that time.

181. Due to the passage of time, I am unable to recall whether Child A was discussed at the meeting held on 25 January 2016. It would be usual process for me to inform the Panel of any updates added to the report, as outlined above.

SI Panel meeting (17 February 2016)

182. I have been referred to a legal report that was prepared for the SI Panel meeting on INQ0102364 17 February 2016 (see **Exhibit SHL8**), The meeting was held virtually on 15 February 2016.

183. A summary of the entry for Child D is set out below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB PD/ 06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

184. I can confirm that I am the author of the report dated 15 February 2016. In relation to Child D, I changed the colour of "*ALSO A POTENTIAL CLAIM*" to red in this report but have not made any further changes. Due to the passage of time, I am unable to clarify why I changed the colour of the text.

185. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Specialty	Description	Complaint	Incident	Witnesses Current Position
I&S **Child A** DOB: PD/06/15	08/06/15	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unacertained.	0	OSR Review I&S	**Inquest set down for**: Wednesday 23 March 2016 but no witness list yet. Monitor closely Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Maternity report received from Dr Davies to be sent to Coroner. Coroner has now requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH to be sent 15.02.2016). Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. NHSLA to be notified 15/02/2016 Decision on format of investigation to be decided at SUI Panel. Coroner has recommended consideration be given to a SUI Report. ***Discuss at SUI Panel following review on 8 February 2016.*** • ***Are we able to meet deadline of 23 March 2016 for all reports and***

						investigations. Coroner requires decision by 19.02.2016?

186. I updated in the report that NHS Resolution were to be informed that the family were instructing legal representation. I asked panel members if we would be able to submit all reports to the Coroner in time for the inquest hearing on 23 March 2016. I also notified the SI Panel that the Coroner required a decision by 19 February 2016.

187. I can confirm that Child D did not form part of any discussion at this meeting. However, On 8 February 2016 I emailed the Risk and Patient Safety Lead, Debbie Peacock, to acknowledge that a Neonatal Review was to take place into the Care of Child D and to ask for the Risk and Patient Safety Lead to have a discussion with the Head of Risk and Patient Safety to agree the format of the review. I attach to my statement marked **Exhibit SHL9** a copy of my email dated 8 February 2016, and the response via email of Debbie Peacock, Risk and Patient Safety Lead.

INQ0102364

188. I informed the SI Panel that the Coroner had asked the Trust to consider undertaking a SI Investigation and asked if it would therefore be beneficial to undertake the review in this format. I raised that it is important to note that the family had raised some questions. I advised who inquest reports were being obtained from and that we had been asked to obtain reports from all paediatric doctors involved in providing care.

189. I asked for an early decision due to the time pressure, with the inquest hearing being 23 March 2016, and stated that I would update the SI Panel at the meeting later that day, which I did as below.

Sudden and unexpected deterioration of Child K (17 February 2016)

190. On 17 February 2016, Child K suddenly and unexpectedly deteriorated. The jury in Letby's trial did not reach a verdict on the charge of attempted murder and it is the subject of a re-trial.

191. I was not notified of this deterioration at the time as it was not linked to an inquest or claims investigation. It would not be usual process to notify legal services of a patient's deterioration. That would have been for the clinical and risk teams to investigate.

SI Panel meeting in relation to Child A (22 February 2016)

192. On 22 February 2016, a SI Panel meeting in relation to Child A took place **[INQ0008267]**.

193. I can confirm that to the best of my knowledge, I attended the meeting on 22 February 2016.

194. Letby was identified as one of the "Employees involved" **[INQ0014192]**. I do not recall any discussion about Letby at the SI Meeting. I was not involved with or aware of any discussion about Letby in connection with this serious incident.

195. I do not recall any discussion about the sudden increase in the NNU mortality rate at this meeting.

196. I provided a legal report for the meeting **[INQ0008268]**:

197. A summary of the entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Specialit y	Description	Complaint	Incident	Witnesses	Current Position

I&S Child D DOB PD /06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

198. In my covering email I highlighted Child A as one of the main items for discussion **[INQ0008267, page 1]**:

"1.0 Child A – Obstetrics Secondary Review- Sudden and unexpected deterioration and death of a patient on the Neonatal Unit after full ***resuscitation***

Datix ID: Personal Data

Inquest & Potential Claim

- *Discuss outcome of review 8 February 2016*

- *Reach a decision on format of Trust investigation (Coroner has asked for consideration to be given to a SUI)*
- *Potential claim received."*

199. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Specialty	Description	Linked complaints	Linked Incidents	**Current Postition**
I&S **Child A** DOB: PD/06/15	08/06/15	Neonatology	Twin babies born by PD.06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unacertained.	0	OSR Review I&S	**Inquest set down for**: Wednesday 23 March 2016 (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Maternity report received from Dr Davies to be sent to Coroner. Coroner has now requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH to be sent 15.02.2016). Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. Potential Claim received. NHSLA to be notified of Inquest/claim ***Decision on format of investigation to be decided at SUI Panel.*** ***Coroner has recommended consideration be given to a SUI Report.*** ***Discuss at SUI Panel following review on 8 February 2016.*** ***Are we able to meet deadline of 23 March 2016 for all reports and investigations. Coroner requires decision by 23.02.2016?***

200. I updated the legal report to summarise the above. I asked for this inquest investigation to be discussed at the SI Panel meeting following the review of care undertaken by Dr Brearey and the Risk and Patient Safety Lead, Debbie Peacock on 8 February 2016. I noted that a decision needed to be made as to whether the Trust would be able to disclose all the reports that were required by the Coroner ahead of the inquest hearing set for 23 March 2016. I noted again that the Coroner required a decision by 23 February 2016.

201. I confirm that Child A was discussed at this meeting. I was asked to send all available information to the Director of Nursing and the Medical Director to enable them to fully assess the position with the incident investigation, potential claim and inquest hearing. I sent the email on 23 February (see **Exhibit SHL10**). INQ0102364

202. I asked for a decision to be made as to whether a SI investigation, as suggested by the Coroner, should be undertaken or whether Dr Brearey's Neonatal Review would be sufficient to address the concerns raised.

203. I reiterated the date of the inquest hearing, 23 March 2016, and asked if the Trust would be able to meet this deadline in terms of disclosure of all reports required by the Coroner including an SI Report, if that was what was decided upon.

204. In addition to the review being undertaken by Dr Stephen Brearey not having been finalised, we were also required to obtain reports from junior doctors, the majority of whom no longer worked at the Trust and who no longer had access to the medical records. I highlighted that the inquest hearing date of 23 March 2016 was not realistic and, if that was agreed, then I would advise the Coroner as soon as possible.

205. The Medical Director responded to this email on 24 February 2016 **[INQ0008853, page 39]**. The Medical Director agreed that the timescale was unrealistic. He commented that it was his understanding that Dr Brearey's report was equivalent to an SI Report but that a decision could be made once the report had been seen. The Medical Director added that an external neonatologist was involved in the review, which may have contributed to the delay in the review being finalised for disclosure.

206. I have been asked why Child B was not included in this report **[INQ0008268].** Child B was not subject to an inquest investigation or a claim investigation at this time and would therefore not appear on a legal report.

Hospital Number & Inquest Ref	Date of Death	Specialit y	Description	Complaint	Incident	Witnesses	Current Position
I&S Child D [redacted]) DOB PD /06/201 5	22/06/1 5	Neonatol ogy	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

207. Due to the passage of time, I do not recall whether the Trust's Duty of Candour was discussed at this meeting. The usual process would be for the risk team to take any steps associated with Duty of Candour. It is my usual process to highlight the

importance of family communication ahead of the inquest hearing. The aim is to ensure that timely communication takes place so that bereaved families can engage with the Trust, receive appropriate support and be given the opportunity to ask questions in response to any SI reports that have been completed.

208. The Trust would wish to explore and respond to any questions about SI reports at the earliest opportunity and ahead of the inquest hearing. The coroners' remit is to determine the cause of death. Often families have questions for the Trust outside of this remit that are better addressed and resolved ahead of the inquest hearing.

SI Panel meeting (29 February 2016)

209. On 29 February 2016, a SI Panel meeting took place. I circulated a legal report ahead of the meeting **[INQ0008275 / INQ0008276]**. I do not recall any discussion taking place in relation to the increase in the NNU Mortality rate at the meeting held on 29 February 2016.

210. The entry for Child D in relation to the meeting on 29 February 2016 is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB **PD** 06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on **PD** 06/15. Mother had spontaneous rupture of membranes at 36+36 on **PD** June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died **I&S** on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.	0	Level 2 Investigation **I&S**	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

211. I did not make any changes to the report dated 29 February 2016 to that of the previous report dated 15 February 2016. The summary remained on the report for monitoring and to confirm the current position in that the Coroner had instructed an independent expert to provide a report. That report would be shared once received. I also stated that we now had legal representation to support with the inquest investigation and witness support.

212. Due to the passage of time, I do not recall if Child D was discussed at the meeting. If I had discussed the inquest, I would have updated the SI Panel that we awaited the Croner's expert report.

213. The entry in relation to Child A is set out below:

Hospital Number & Inquest Ref	Date of Death	Specialty	Description	Linked complaints	Linked Incidents	**Current Position**
I&S **Child A** [redacted] DOB: PD/06/15	08/06/15	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unacertained.	0	OSR Review **I&S**	**Inquest set down for**: Wednesday 23 March 2016 (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). Family questions raised & answered by Dr Jayaram.

						Family are instructing Legal Representation. **Potential Claim received.** NHSLA to be notified of Inquest/claim ***Format of investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.*** • ***Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.***

214. In my email prior to the SI Meeting on 29 February 2016, I stated in relation to Child A **[INQ0008275, page 1]**:

"We have notified the Coroner that the Inquest date of 23 March 2016 is going to be unrealistic. The Coroner has acknowledged our email and again asked for the level of investigation that is being undertaken. Update required from Dr Brearey regarding expected date of completion of external report. Monitor closely."

Timeline of preparation for Child A's Inquest

215. I have been asked why the inquest date of 23 March 2016 was unrealistic:

(a) The inquest was notified to the Trust on 29 June 2015. The Coroner's Officer informed the Trust that the Post-Mortem investigation could take 6 months to be completed and that we should expect it to be available in December 2015.

(b) In December 2015, the Coroner requested copies of medical records which were disclosed on 12 January 2016.

(c) On 20 January 2016, the Coroner's Officer informed the Trust that that inquest date had been set for 23 March 2016. An additional report was requested by the Coroner from the Trust to detail the maternity care provided to Child A's mother.

(d) A witness list was not available at that time. Witness lists were usually provided by the Coroner to the Trust no later than 6 weeks ahead of an inquest hearing.

(e) On 28 January 2016, the Coroner requested an additional 8 reports from junior doctors involved in the care of Child A. The Coroner also suggested that the Trust should consider completing a SI Report due to the complications with the long line catheter insertion.

(f) On 29 January 2016, Child A's mother provided the Coroner with the family's concerns which the Coroner's Officer shared with the Trust, asking for the concerns be addressed.

(g) From 8 February 2016, the legal report to the SI Panel asked for a decision to be made by the Head of Risk and Patient Safety and the Executives on the format of the Trust's investigation considering the Coroner's recommendation that a SI Report should be considered. SI Panel decided that a Thematic Review should take place and that next steps would be decided once this had been completed.

(h) I also sent an email to the Risk and Patient Safety Lead and Head of Risk and Patient Safety on 8 February 2016 (see **Exhibit SHL9**) notifying them that the Coroner had recommended a SUI Report be undertaken and asked that the Risk and Patient Safety Lead and the Head of Risk and Patient Safety consider this. I attached the family's questions, and the Post-Mortem report. I notified them of the inquest date and that, due to the time pressures of the inquest having been set to be heard in 6 weeks' time, I asked if an early decision could be made so that the Coroner could be updated. INQ0102364

(i) On 9 February 2016, the Risk and Patient Safety Lead informed me that a decision would be made on the format of any report once Dr Stephen Brearey had completed the Thematic Review (see **Exhibit SHL9**). INQ0102364

(j) The Coroner asked for a decision to be made as to whether the Trust would have all reports finalised and disclosed by 23 March 2016 and asked that this decision be

reached by 19 February 2016. This was detailed on all reports to the weekly SI Panel and raised as a decision that was required to be reached.

(k) Following the SI Panel on 22 February 2016, I sent an email to the Director of Nursing and the Medical Director (see **Exhibit SHL10**) attaching all documents gathered to date to enable their consideration as to whether all reports would be available to the coroner ahead of the inquest hearing scheduled for 23 March 2016. INQ0102364

(l) At this stage, there were 8 reports to obtain from junior doctors, who in the main had since left the Trust. The Trust had also not decided on the level of investigation required. The family required communication and support from the Trust following completion of the investigation. I felt that it would therefore not be possible to meet the Coroner's deadline and that the Coroner should be informed of that as soon as possible.

(m) The Coroner was notified on 29 February that the deadline of 23 March 2016 for the inquest hearing had become unrealistic. The Coroner again asked the Trust to confirm the level of the investigation being undertaken. I asked the SI Panel on 29 February 2016 to obtain an update from Dr Stephen Brearey as to the expected date of completion of the report. I understood that report to have the involvement of an external contributor. I asked that completion of this report was kept under close monitoring.

216. On 2 March 2016, I called Dr Stephen Brearey directly for an update (see note of the telephone call at **[INQ0008890]**). Dr Stephen Brearey advised that he was working on the report that day following the Thematic Review. Dr Stephen Brearey advised that the review of the insertion of the longline and UVC had taken place, and all had been in in agreement, including a neonatologist from Liverpool, that practice was reasonable and did not contribute to the patient's arrest.

217. It had been concluded that an SI was not required as no concerns in care had been identified that would warrant a SI being undertaken. All reviews that had been undertaken were to be sent to legal services. I asked if duty of candour had been considered. Dr Stephen Brearey advised that a family meeting was to be offered.

218. Dr Brearey stated that he was reviewing the care provided by nursing staff (observations etc.) in the hours leading up to the arrest and that medical records were

required to do this. My actions were to follow up for an update on Duty of Candour and consider an update for the coroner's office.

219. On 2 March 2016, I received an email from Dr Stephen Brearey **[INQ0008869]**, which was cc'd to Dr Jayaram. The minutes of the Perinatal M&M Meeting from June and the Thematic Review from February were attached. Dr Stephen Brearey informed me that the matter had not been reviewed at the Neonatal Mortality Meeting but had been discussed at a Special Meeting with Alison Kelly, Ruth Milliard, Eirian Powell, and Deborah Peacock on 2 July 2015. The care had been reviewed in detail to decide if an SUI was necessary. I was informed that the consensus was that it was not.

220. I continued to raise this at the SI Panel meetings each week and emailed the Medical Director directly on 18 March 2016 to seek direction **[INQ0008311, page 1]**. I stated:

"In order to prepare for the Inquest we need to consider Duty of Candour which Steve Brearey has advised Dr Saladi would be best placed to do.
Steve also stated that from the questions that the family have asked there still appears to be some confusion around their understanding of the circumstances and that the offer of a family meeting may be helpful to them.
Can SUI consider communication with the family now that the review is complete and also what we will disclose to the Coroner in terms of the reviews that have taken place as the Coroner had suggested that a 'SUI be undertaken due to complications in longline and catheter insertion".

221. During April 2016, reports were gathered from the junior doctors. The SI Panel were asked for decisions to be made on Duty of Candour following the Neonatal Review.

222. On 5 April 2016, at the SI Panel meeting, it was agreed that that Head of Risk and Patient Safety was to review the Obstetric Secondary Review Report and Neonatal Review Report and chase any action plan that had been agreed.

223. The Coroner's Officer asked for all reports by 2 May 2016 and this was communicated to the SI Panel on 20 April 2016.

224. On 22 April 2016, a further 7 reports were submitted to the Coroner; the maternity report, Dr Jayaram's response to the family questions and 5 of the 8 reports requested from the junior doctors.

225. On 22 April 2016, I updated the SI Panel that reports had been disclosed and that a decision was still required in relation to disclosure of all relevant investigation reports and any associated action plan to the Coroner and the family's solicitor together with Duty of Candour to the family.

226. At the end of April 2016, my inquest assistant left the Trust and recruitment was underway for her replacement.

227. I continued to request the investigation report and action plan throughout May 2016 and June 2016 from the SI Panel and kept my manager Stephen Cross updated.

228. On 30 June 2016, I sent an email to the Head of Risk and Patient Safety to inform them that Stephen Cross had briefed me about the concerns regarding neonatal services and reminded her that an update on the investigations to be disclosed to the Coroner was required within the next 7 days (see **Exhibit SHL11**). INQ0102364

229. On 1 July 2016, I sent an inquest report to the Head of Risk and Patient Safety detailing the obstetric and neonatal inquests opened between 1 April 2012 and 30 June 2016, as had been requested (see **Exhibit SHL2 and SHL12**). This was escalated to Stephen Cross. INQ0102364

230. Unfortunately, I went off I&S leave from 4 July 2016 to 29 December 2016

I&S

231. From review of the inquest file, one member of staff from whom a statement had been requested was I&S

Serious Incident Panel meeting (7 March 2016)

232. I did not attend the meeting held on 7 March 2016 as I was away on annual leave.

233. I provided a legal report for the meeting (see **Exhibit SHL13**). A copy of my email sent prior to the meeting on 4 March 2016 is at **Exhibit SHL14.** INQ0102364 INQ0102364

234. I was not in attendance at the meeting and cannot comment on any discussion that may have taken place.

235. The following was documented for Baby A.

Hospital Number & Inquest Ref	Date of Death	Specialty	Description	Linked complaints	Linked Incidents	**Current Position**
I&S **Child A** [redacted] DOB: PD 06/15	08/06/15	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unacertained.	0	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. **Potential Claim received.** NHSLA to be notified of Inquest/claim ***Format of investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.***

						Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.

236. A summary of the entry for Child D is below. I provided the current position in relation to the inquest investigation, namely that we were awaiting the Coroner's expert report and that we had legal representation in relation to the inquest and claim.

237. I was not in attendance at the meeting and cannot comment on any discussion that may have taken place.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaints	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB: PD/06/2015	22/06/15	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner. Reported to NHSLA and Inquest funding

			cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her.				granted – Joanna Trewin from Hill Dickinson representing Trust.

238. A version of the Thematic Review of Neonatal Mortality report is dated 2 March 2016 **[INQ0003251, page 11]**. This is the same version that I had circulated on my email of 4 March 2016, as it is forwarding on Dr Stephen Brearley's email to Debbie Peacock and others. I was escalating this issue to them and updating them that I had no knowledge of the concerns about Letby and was not involved in any discussions.

239. I was not in attendance at the meeting, but Duty of Candour with the family and the Coroner was a matter of importance that I flagged on my repot and raised at each meeting.

240. I have been referred to an email I sent on 18 March 2016 **[INQ0008311]**. This email asked the Medical Director, Ian Harvey, to provide an update on Duty of Candour and advise on plans for updating the family regarding the thematic review that had been undertaken. It was important that the update came from the Trust so that the Coroner could be informed that this had been done. I have searched my emails and have been unable to find a response.

Serious Incident Panel meeting (31 March 2016)

241. A legal report was prepared for the SI Panel meeting on 31 March 2016 **[INQ0008340].**

242. A summary of the entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] [redacted] DOB PD 06/2015	22 June 2015	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response.	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records requested by Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

			Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.				

243. My report details that the family statement had been circulated to Dr Newby and Dr Davies with the Head of Midwifery, Julie Fogarty, copied in. It also states that the inquest file is with the Coroner who is waiting receipt of the expert report that he has instructed.

244. Due to the passage of time, I do not recall whether Child D was discussed at the meeting. My usual process would be to update the meeting with the matters highlighted in red on my report.

245. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child A** [redacted] DOB: PD/06/15	8 June 2015	Neonatology	Twin babies born by PD06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH.	0	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds)	

			I&S A post mortem was carried and the cause of death is 1a) Unascertained. Need to decide if we are to report to the NHSLA. Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. **Potential Claim received.** **NHSLA to be notified of Inquest/claim** ***Format of investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.***			Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015

			Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.			

246. Due to the passage of time, I do not recall whether Child A was discussed at the meeting, but my usual process would be to update the meeting with the matters highlighted in red on my report. This included that a decision needed to be reached about reporting the case to NHS Resolution given that a potential claim had been received. The format of investigation was thought to be equivalent to an SUI.

247. The Coroner had recommended consideration be given to an SUI report. The Coroner had been notified that we were unable to meet the deadline of 23 March 2016 for all reports and investigations to be provided. The Coroner's Officer had again asked about the level of investigation.

248. I do not recall any discussion about Letby at any of the SI panels that I attended.

Letby

249. I have been advised that Dr Stephen Brearey stated that on 7 April 2016, Letby was moved to day shifts **[INQ0006890, paragraph 41].** I was not aware of this and was not involved in any discussions about it. It would not form part of my role as it did not impact on any inquest or claims process. It was a confidential HR issue. I did not have enough information to make a judgement about possible criminal investigations.

250. I was not involved with any discussions in respect of Letby. The decision to move Letby to day shifts would not have been something that would have been discussed with me as my role as Head of Legal Services. It is my understanding that this would be made by Women and Children's Department's senior management, the Director of Nursing and Human Resources.

Serious Incident Panel meeting (11 April 2016)

251. A legal report was prepared for the Serious Incident Panel meeting on 11 April 2016 **[INQ0008356]**. I can confirm that I was the author of this report.

252. A summary of the entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB: PD/06/2015	22 June 2015	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

			baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.				

253. The matters for consideration are highlighted in red in my report. My report details that the family statement has been circulated to Dr Newby and Dr Davies with the Head of Midwifery Julie Fogarty copied in and that the inquest file was with the coroner who was waiting for receipt of the expert report that he had commissioned.

254. Due to the passage of time, I do not recall if Child D was discussed at the SI Panel Meeting. There are no changes to my report in relation to Child D on this date and it is likely that I updated that the coroner's expert report had not yet been received.

255. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses Current Position
I&S **Child A** [redacted]	8 June 2015	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male.	0	1 I&S I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds)

DOB: PD 06/15			Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unascertained. **Potential Claim received.** To be reported to the NHSLA for Inquest funding. Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.***			Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby Child A's care found to be acceptable. **Duty of Candour to be considered** following Neo-natal Review. 05.04.2016 RM to review OSR report & NNU Review and chase action plan

			Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.			

256. Due to the passage of time, I do not recall if Child A was discussed at this meeting. Ruth Milliard was not in attendance at the meeting on 11 April 2016. It is likely that I stated that we awaited the Obstetric Secondary Review (OSR) and NNU Report with associated Action Plan together with Duty of Candour arrangements to be able to update the Coroner.

Serious Incident Panel meeting (20 April 2016)

257. A legal report was prepared for the SI Panel meeting on 20 April 2016 **[INQ0008375]**.

258. A summary of the entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position

I&S **Child D** [redacted] DOB PD 06/2015	22 June 2015	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.	0	Level 2 Investigation I&S	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

259. The matters for consideration are highlighted in red in my report. My report details that the family statement had been circulated to Dr Newby and Dr Davies with the Head of Midwifery, Julie Fogarty, copied in and that the inquest file is with the Coroner who was waiting for receipt of the expert report that he had instructed.

260. I sent my apologies to the SI Panel meeting held on 20 April 2016 as I was interviewing that day.

261. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses Current Position

I&S Child A [redacted] DOB: PD 06/15	8 June 2015	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. I&S A post mortem was carried and the cause of death is 1a) Unascertained. **Potential Claim received.** To be reported to the NHSLA for Inquest funding. Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient	0	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby Child A care found to be acceptable. **Duty of Candour to be considered** following Neo-natal Review. 05.04.2016 RM to review OSR report & NNU Review and chase action plan Coroners Officer has asked for a reports to be sent to Coroner by w/c 2 May 2016.

			(8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.*** ***Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations.*** ***Coroner's Officer has again asked about the level of investigation.***			

262. The matters for consideration are highlighted in red in my report. I provided an update that a witness list for inquest attendance had not yet been received, that Duty of Candour with the family and coroner needed to be considered once the Neonatal Review had been concluded. That was the responsibility of the Risk Leads and the clinicians. I provided an update that that the Head of Risk and Patient Safety, Ruth

Millward, was to review the Obstetric Secondary Review Report and the Neonatal Review and was to follow up on the Action Plan.

263. The Coroner had been notified that we had been unable to disclose all reports ahead of the inquest hearing date of 23 March 2016. The Coroner had recommended that consideration be given to the Trust undertaking a Serious Untoward Incident Investigation Report (in relation to the issues with the long line catheter) and that the coroner wished to be notified of the level of investigation being undertaken by the Trust.

264. I do not know if Child A was discussed at the meeting. I sent my apologies to the meeting as I was interviewing that day.

Serious Incident Panel meeting (25 April 2016)

265. A legal report was prepared for the Serious Incident Panel meeting on 25 April 2016 **[INQ0008392]**. I can confirm that I was the author of this report.

266. A summary of the entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB PD 06/2015	22 June 2015	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was	0	**I&S**	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert.

			floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.				Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

267. The matters for consideration are highlighted in red in my report. My report details that the family statement had been circulated to Dr Newby and Dr Davies with the Head of Midwifery, Julie Fogarty, copied in and that the inquest file was with the Coroner who was waiting to receive the expert report that he was obtaining.

268. Due to the passage of time, I do not recall if Child D was discussed at this meeting. It is likely that I updated the matters in red in that the expert report was yet to be received from the Coroner.

269. A summary of the entry for Child A including why this entry was made.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses Current Position
I&S Child A [redacted] DOB: PD 06/15	8 June 2015	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. I&S A post mortem was carried and the cause of death is 1a) Unascertained. **Potential Claim received.**	0	130151 & 132587 OSR Review	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby [redacted]'s care found to be acceptable. **Duty of Candour to be considered** following Neo-natal Review. 05.04.2016 RM to review OSR report & NNU Review and chase action plan

			To be reported to the NHSLA for Inquest funding. Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.*** ***Coroner notified that we are unable to meet deadline of***			Coroners Officer has asked for a reports to be sent to Coroner by w/c 2 May 2016.

			23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.			

270. There was no change to the position in relation to the inquest investigation into the death of Child A. The matters for consideration are highlighted in red in my report. I am updating the SI Panel that a witness list for inquest attendance had not yet been received, that Duty of Candour with the family and Coroner needed to be considered once the Neonatal Review had been concluded, which was the responsibility of the Risk Leads and the clinicians.

271. I also provided an update that the Head of Risk and Patient Safety, Ruth Millward, was to review the OSR Report and the Neonatal Review and was to follow up on the action plan. The Coroner had been notified that we had been unable to disclose all reports ahead of the inquest hearing date of 23 March 2016. The Coroner had recommended that consideration be given to the Trust undertaking a SUI investigation report (in relation to the issues with the long line catheter) and that the Coroner wished to be notified of the level of investigation being undertaken by the Trust.

272. I also highlighted that the Coroner's Officer had asked for all reports to be disclosed to him by the week commencing 2 May 2016.

273. Due to the passage of time, I do not recall if Child A was discussed at this meeting. It is likely that I continued to highlight the outstanding matters relating to the inquest investigation, such as updating the Coroner that Duty of Candour had taken place with the family in relation to the Trust investigation, to update the Coroner on the level of investigation that the Trust was undertaking, to receive reports for disclosure to the Coroner that were being followed up by the Head of Risk and Patient Safety, Ruth Millward.

Email from the Coroner's Officer (27 June *(not April)* 2016)

274. I have been asked about an email on 27 April 2016 when the Coroner's Officer emailed me in relation to Child A **[INQ0008930]**. The email is dated the 27 June 2016 and this is the date on the email in the Supporting Document Bundle.

275. The Coroner asked for an update. I acted upon this email immediately by forwarding the email from the Coroner's Officer to the Head of Risk & Patient Safety, Ruth Millward, requesting her to prioritise the outstanding reports and SUI for the inquest into the death of Child A. I attach a copy of this email to my statement marked **Exhibit SHL15.** INQ0102364

276. This had been flagged in the weekly SI Panel Reports that the Head of Risk and Patient Safety, Ruth Millward, was obtaining the investigation reports and action plan to be sent to the Coroner. I requested a meeting to discuss it before Friday 1 July 2016 as below.

Serious Incident Panel meeting (3 May 2016)

277. A legal report was prepared for the Serious Incident Panel meeting on 3 May 2016 **[INQ0008409].** I can confirm that I was the author of this report.

278. Due to the passage of time, I do not recall if Child D was discussed at this SI Panel Meeting.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB: PD 06/2015	22 June 2015	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby	0	**I&S** Level 2	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015

			delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm			(Head of Midwifery) Dr Newby (Paeds)	Coroner Instructing Independent Medical Expert. Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

			timescale for Expert Report.				

279. There were no changes made to the current position in relation to the inquest investigation. The matters for consideration are highlighted in red in my report. My report details that the family statement has been circulated to Dr Newby and Dr Davies with the Head of Midwifery, Julie Fogarty, copied in and that the inquest file is with the Coroner who is waiting receipt of the expert report that he has instructed.

280. A summary of the entry for Child A is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses Current Position
I&S **Child A** [redacted] DOB: PD/06/15	8 June 2015	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. **I&S** A post mortem was carried and the cause of death is 1a) Unascertained.	O	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby [redacted]'s care found to be acceptable.

			Potential Claim received. To be reported to the NHSLA for Inquest funding. Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.*** ***Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports***			**Duty of Candour to be considered** following Neo-natal Review. 05.04.2016 RM to review OSR report & NNU Review and chase action plan Coroners Officer has asked for a reports to be sent to Coroner by w/c 2 May 2016.

			and investigations. Coroner's Officer has again asked about the level of investigation.			

281. There was no change to the position in relation to the inquest investigation into the death of Child A. The matters for consideration are highlighted in red in my report. I provided an update that a witness list for inquest attendance has not yet been received, that Duty of Candour with the family and Coroner needed to be considered once the Neonatal Review had been concluded, which was the responsibility of the Risk Leads and the clinicians.

282. I stated that the Head of Risk and Patient Safety, Ruth Millward, was to review the OSR Report and the Neonatal Review and was to follow up on the Action Plan. The Coroner had been notified that we had been unable to disclose all reports ahead of the inquest hearing date of 23 March 2016. The Coroner had recommended that consideration be given to the Trust undertaking a Serious Untoward Incident Investigation Report (in relation to the issues with the long line catheter) and that the Coroner wished to be notified of the level of investigation being undertaken by the Trust.

283. I stated that the Coroner's Officer had asked for all reports to be disclosed to him by the week commencing 2 May 2016 due this week.

284. Due to the passage of time, I do not recall if Child A was discussed at this meeting. It is likely that I continued to highlight the outstanding matters relating to the inquest investigation such as the need to update the Coroner that Duty of Candour had taken place with the family in relation to the Trust investigation, to update the Coroner on the level of investigation that the Trust was undertaking, to receive reports for disclosure to the Coroner that were being followed up by the Head of Risk and Patient Safety, Ruth Millward.

Serious Incident Panel meeting (9 May 2016)

285. A legal report was prepared for the Serious Incident Panel meeting on 9 May 2016 **[INQ0008449]**.

286. The entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** [redacted] DOB PD /06/2015	22 June 2015	Neonatology	ALSO A POTENTIAL CLAIM***The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust.

			previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.				

287. There are no changes made to the current position in relation to the Inquest Investigation. The matters for consideration are highlighted in red in my report. My report details that the family statement had been circulated to Dr Newby and Dr Davies with the Head of Midwifery Julie Fogarty copied in and that the inquest file was with the coroner who was waiting to receive the expert report that he had instructed.

288. Due to the passage of time, I do not recall if Child D was discussed at this SI Panel meeting.

289. The entry for Child A is below:

Hospital Number & Inquest Ref		Speciality	Description	Complaint	Incident	Witnesses

	Date of Death					Current Position
I&S **Child A** [redacted] DOB: PD/06/15	8 June 2015	Neonatology	Twin babies born by PD 06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. I&S A post mortem was carried and the cause of death is 1a) Unascertained. **Potential Claim received.** To be reported to the NHSLA for Inquest funding. Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only	0	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby [redacted]'s care found to be acceptable. **Duty of Candour to be considered** following Neo-natal Review. 05.04.2016 RM to review OSR report & NNU Review and chase action plan 22/04/2016 Reports submitted to Coroner. Update email to RM requesting confirmation of reports to be disclosed and action plan.

			1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI. Coroner has recommended consideration be given to a SUI Report.*** ***Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations.*** ***Coroner's Officer has again asked about the level of investigation.***			Coroners Officer has asked for a reports to be sent to Coroner by w/c 2 May 2016.

290. Due to the passage of time, I do not recall if Child A was discussed at this meeting. It is likely that I updated the SI Panel that witness reports had been submitted to the Coroner on 22 April 2016 and that I had sent an email to the Head of Risk and Patient Safety on 22 April 2016 to request confirmation of reports to be disclosed to the Coroner together with the associated action plan. Please see my email attached as **Exhibit SHL16**. **INQ0102364**

Email from me (16 May 2016)

291. On 16 May 2016, I sent an email to Ruth Millward and others in which Child A was mentioned **[INQ0008457]**. I have been asked to explain the cause of the delay in providing the Coroner with material in relation to Child A. The email I sent on 16 May 2016 was to all members of the SI Panel. I had attached the updated Legal Services

Report dated 16 May 2016 and had flagged in my covering email that the priority for this week was to provide the Coroner with any outstanding reports in relation to the inquest investigation of Child A. The Coroner's deadline for disclosure of all reports had been 2 May 2016 and therefore disclosure of any incident or Trust review reports was now overdue. The Head of Risk and Patient Safety was responsible for providing copies of any incident reports and Trust reviews for onward disclosure to the Coroner.

292. I have been asked what efforts I had made to ensure the Coroner was provided with materials in a timely fashion. I had communicated the Coroner's deadlines to the SI Panel at each weekly meeting and via the Legal Services SI panel Report each week.

INQ0102364

293. I attach to my statement marked **Exhibit SHL17**, a copy of my emails to the team concerning the documents required for the Coroner, between February 2016 and April 2016.

294. On 22 April 2016, I emailed the Head of Risk and Patient Safety to flag that we must now disclose the relevant investigation reports and action plan to the Coroner. My email set out that the submission deadline for the Coroner was 3 May 2016. In my email, I asked that this matter be reviewed as soon as possible. I also asked for consideration of Duty of Candour to take place which was the responsibility of the Head of Risk and Patient Safety. I copied in all members of the SI Panel to this email (see above at **Exhibit SHL16**). INQ0102364

295. I had also escalated the delay to Stephen Cross who had arranged a meeting with the Head of Risk and Patient safety to discuss this.

296. I have been asked to provide a chronological account of my liaison with the Coroner in relation to Child A up to this date. A chronology is set out below. If the Inquiry requires copies of any of these documents, please let me know.

Date	Source	Event/Action
23 June 2015	Email from Coroner	Coroner's Notification received. Coroner requests a report from the consultant involved in care.
30 June 2015	Email	Inquest Notification acknowledged and Post-Mortem (PM) requested.

30 July 2015	Email	Dr Jayaram report disclosed to Coroner's Officer by Hill Dickinson ("HD")
3 August 2015	Email	To Coroner's Officer advised that PM can take up to 6 months and will not be available any time soon. (December 2015)
1 September 2015	Email	Dr Saladi Report disclosed to HM Coroner by HD.
3 September 2015	Email	HD informs Coroner's Officer that there are no further reports to follow and no RCA investigation.
30 December 2015	Email from Coroner	Coroner's Officer requested a copy of the medical records
30 December 2015	Email	Email request for medical records acknowledged and clarification sought as to whether maternity records were also required.
30 December 2015	Email from Coroner	Coroner's Officer confirms both maternity and baby records are required.
12 January 2016	Correspondence by post & email.	Medical records posted to Coroner, email sent to Coroner's Officer to confirm that this has been done and that they should arrive tomorrow.
22 April 2016	Email	Dr Davies Report disclosed to Coroner
20 January 2016	Phone Call Note S Drive Folder	Coroner's Officer notifies HD that the inquest has been set down for 23 March 2016. No witnesses identified yet by Coroner. Coroner's Officer informed that the Coroner has requested a maternity report covering the pregnancy and birth. HD advised report will be requested ASAP.
28 January 2016	Email	Coroner's Officer informs HD that she has discussed the inquest case with Mr Rheinberg and that he requires reports from all doctors involved (8 junior doctors in total). Mr Rheinberg also believes that COCH should consider completing a SUI Report due to the complications in long line and catheter insertion. Inquest set down for 23 March 2016 so grateful if issues could be addressed ASAP.

29 January 2016	Email	From Mum to Coroner with family concerns and apology for delay in getting them to Coroner's Officer
29 January 2016	Email	Email from Coroner's Officer with parents concerns to be addressed.
19 February 2016	Phone Call Note S Drive and Paper File.	HD call with Coroner's Officer. Coroner's Officer had asked for an update on whether there was going to be a SUI Report. HD explained that this was being reviewed by the Trust and that an update would be provided next week. HD updated Coroner's Officer updated that reports had been requested from most of the (8) junior doctors but some were out of the country on annual leave and HD couldn't therefore guarantee when reports would be received by the Coroner. HD also still trying to contact a couple of doctors who no longer worked at the Trust. Coroner's Officer asked for an update ASAP and if there may be problems meeting the deadline to notify her as soon as possible.
1 March 2016	Email	To HD from Coroner's Officer. Case discussed with Mr Rheinberg who has reluctantly agreed to withdraw the case from 23 March 2016. Mr Rheinberg would still like copies of the COCH reports and SUI ASAP.
22 April 2016	Email	Signed Reports disclosed to Coroner via email from HD - Dr Davies, Dr Jayaram, Dr Beech, Dr Brunton, Dr Holt, Dr Lambie, Dr Wood. HD updated that 3 final reports are being followed up from junior doctors and would be sent over as soon as they are received.
28 June 2016	Email	Dr Harkness report disclosed to Coroner's Officer.
11 August 2016	Email & Postal Correspondence	Email from Trust's legal team to Coroner's Officer to inform that 3 reports have been posted today - Dr Harkness, Dr MacCarrick and Dr Ogden.
11 August 2016	Email	Email from Coroner's Officer thanking for following up and advising that HM Coroner had enquired about the reports early that day.

12 August 2016	Email	Letter in from HM Coroner dated 11 August 2016 expressing concern re recent correspondence (of late) not being responded to. Statements requested by 22 August 2016: • Dr Harkness • Dr Theresa Mccormick • RCA/SUI Report • Statement Interviews produced in relation to the production of the SUI/RCA Medical Notes (? previously disclosed in January 2016) Witness summons received.
12 August 2016	Email	From Stephen Cross to Mr Rheinberg. Confirming reports sent by post on 11th August 2016. Informing that the medical records had previously been disclosed via recorded delivery on 12th January 2016.
16 August 2016	Email	Trust's legal team to Coroner's Officer. I&S I&S I&S Non-availability provided for other witnesses. Requesting clarification of other witnesses' attendance required.
18 August 2015	Email	Coroner's Officer to Trust's legal team re Dr Beech read only evidence may be possible. Request to obtain non-availability for Dr Ogden as work on setting down the inquest date will commence next week.
18 August 2015	Email	Trust's Legal Team email to Coroner's Officer, non-availability dates provided for witnesses.
18 August 2015	Email	Email from Coroners Officer confirming inquest date to be 18 August 2015.
22 August 2016	Postal Correspondence	Notice of resumed Inquest to be held 10 October 2016 from HM Coroners Officer. Witnesses notified.

27 September 2016	Phone Call Note	Trust's legal team phone call with Coroner's Officer, MT. Coroner's Office urgently requiring the SUI report expected 23 August 2016 Family solicitor suggesting withdrawal of inquest hearing. Author of the SUI report will be called to the inquest and possibly others who contributed.

Email from me (17 May 2016)

297. On 17 May 2016 I sent an email to Claire Raggett in which Child A was mentioned **[INQ0008474]**.

298. To the best of my knowledge, the inquest meeting relating to Child A between Ruth Millard and Stephen Cross was booked to take place at 9:00am on Thursday 19 May 2016. I did not attend that meeting and am unable to provide any further information in relation to that meeting.

299. I do not hold a copy of the meeting notes.

Email from me (19 May 2016)

300. On 19 May 2016, I sent an email to David Harkness in which Child A was mentioned **[INQ0008928]**.

301. I sent this email to Dr David Harkness to introduce myself as handling the inquest, due to Heidi Douglas leaving the department, and to follow up on his overdue report for the Coroner.

Serious Incident Panel meeting on 2 June 2016

302. A legal report was prepared for the SI Panel meeting on 2 June 2016 **[INQ0008504]**.

303. The entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witnesses	Current Position
I&S **Child D** DOB PD/06/2015	22 June 2015	Neonatology	The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust. Letter of Claim received 25.05.2016 Expert Reports to be obtained by Hill Dickinson. **Negligence alleged:** 1.0 antiobiotics not prescribed on 18

			with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.				June at 36 weeks + 6 days gestatition contrary to Trust policy and recognised opinion. 2.0 Once [redacted] was born, failure to identify risk factors – respiratory distress, feeding difficulties, need for rescue breaths. 3.0 Failure to transfer to neonatal immediately

304. The report highlights that the latest update in relation to Child D was that a Letter of Claim had been received on 25 May 2016 and that expert reports were to be obtained by Hill Dickinson. The report details the allegations of negligence made against the Trust by the Claimant's Solicitors.

305. My usual process was to notify the panel of any updates to cases detailed on the report. I am unable to recall what was discussed at this meeting due to the passage of time, but it would have been usual process for me to have provided an update based on the text highlighted in red in that a Letter of Claim had been received and to have read out the allegations of negligence.

306. I have been asked to provide a summary of the entry for Child A. There are no updates on the report dated 2 June 2016 to that of an earlier report dated 25 April 2016.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Current Position
I&S **Child A** [redacted] DOB: PD /06/15	8 June 2015	Neonatology	Twin babies born by PD .06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. I&S A post mortem was carried and the cause of death is 1a) Unascertained. **Potential Claim received 18.02.2016** To be reported to the NHSLA for Inquest funding.	0	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby [redacted]'s

			Maternity report received from Dr Davies to be sent to Coroner. Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI.*** ***Coroner has recommended consideration be given to a SUI Report.*** ***Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.***			care found to be acceptable. **Duty of Candour to be considered** following Neo-natal Review. 05.04.2016 RM to review OSR report & NNU Review and chase action plan 22/04/2016 Reports submitted to Coroner. Update email to RM requesting confirmation of reports to be disclosed and action plan. Coroners Officer has asked for a reports to be sent to Coroner by w/c 2 May 2016.

307. The matters outstanding on the report dated 2 June 2016 related to seeking confirmation that Duty of Candour with the family had taken place. I would be seeking assurance so that I could update the Coroner.

308. I was also seeking confirmation of any reviews or incident reports that were to be disclosed to the Coroner together with any associated Action Plans, all of which had been required to be disclosed by 2 May 2016.

309. Where I reference "*22/04/2016 Reports submitted to Coroner*", this was my comment to update the SI panel in relation to the individual witness reports that were disclosed to HM Coroner via email on 22 April 2016.

310. Due to the passage of time, I do not recall if Child A was discussed at the meeting held on 2 June 2016. It would be usual process for me to have raised the matters highlighted in red as set out above.

Child N (3 and 15 June 2016)

311. On 3 June 2016, Child N experienced a sudden and unexpected deterioration **[INQ0000579 at page 16]**. Letby has been convicted of the attempted murder of Child N in relation to this.

312. I was not notified of this deterioration at the time as it was not linked to an inquest or claim investigation. It would not be usual process to notify legal services of a patient's deterioration which would have been for the clinical and risk teams to investigate. I do not recall being informed of any deteriorations or incidents relating to Child N.

313. On 15 June 2016, Child N experienced a sudden and unexpected deterioration **[INQ0000579 at page 33]**. The jury did not return a verdict in relation to Child N in relation to this occasion. I was not notified of this deterioration at the time as it was not linked to an inquest or claim investigation. It would not be usual process to notify legal services of a patient's deteriorations which would have been for the clinical and risk teams to investigate.

314. I do not recall being informed of any deterioration or incidents relating to Child N.

Death of Child O (23 June 2016)

315. On 23 June 2016 Child O suddenly and unexpectedly deteriorated and died **[INQ0001344, pages 13 to 17]**. Letby has been convicted of the murder of Child O.

316. I was notified that this death was to be subject to a coroner's inquest investigation by email from Coroner's Officer Christine Hurst on 1 July 2016.

317. I was on I&S leave from 4 July 2016 to 29 December 2016 and was not involved in any discussions in relation to this death. From my review of emails, this incident was taken to the SI Panel meeting on 4 July 2016, but I was absent on I&S leave and did not attend this meeting.

Death of Child P (24 June 2016)

318. On 24 June 2016 Child P suddenly and unexpectedly deteriorated and died **[INQ0001453, page 17]**. Letby has been convicted of the murder of Child P.

319. I was notified that this death was to be subject to a Coroner's inquest investigation by email from Coroner's Officer Christine Hurst on 1 July 2016.

320. I was on I&S leave from 4 July 2016 to 29 December 2016 and was not involved in any discussions in relation to this death. From review of emails this incident was taken to the SI Panel meeting on 4 July 2016, but I was absent on I&S leave and did not attend this meeting.

Child Q (25 June 2016)

321. On 25 June 2016 Child Q suddenly and unexpectedly deteriorated **[INQ0001522, page 18]**. The jury did not return a verdict in relation to Child Q.

322. I can confirm that I was not notified of this deterioration at the time. It would not be usual practice to notify myself or legal services of a patient's deterioration. I was on I&S leave from 2 July 2016 to 29 December 2016 and was not involved in any discussions in relation to the deterioration.

Serious Incident Panel meeting (29 June 2016)

323. A legal report was prepared for the Serious Incident Panel meeting on 29 June 2016 **[INQ0008527]**. I can confirm that I was the author of the report dated 29 June 2016. The report covers the period 9 June 2016 to 29 June 2016. The SI Panel meeting was held on 30 June 2016 and I sent apologies for this meeting.

324. The entry for Child D is below:

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witness	Current Position
I&S Child D [redacted]) DOB PD 06/2015	22 June 2015	Neonatology	The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+36 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Coroner Instructing Independent Medical Expert. Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust. Letter of Claim received 25.05.2016 Expert Reports to be obtained by Hill Dickinson. **Negligence alleged:** 4.0 antiobiotics not prescribed on 18 June at 36 weeks + PD gestatition

			*The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner, Coroner's Officer unable to confirm timescale for Expert Report.				contrary to Trust policy and recognised opinion. 5.0 Once [redacted] was born, failure to identify risk factors – respiratory distress, feeding difficulties, need for rescue breaths. 6.0 Failure to transfer to neonatal immediately

325. The report highlights that the latest update in relation to Child D was that a Letter of Claim had been received on 25 May 2016 and that expert reports were to be obtained by Hill Dickinson. The report details the allegations of negligence made against the Trust by the Claimant's Solicitors.

326. I was not in attendance at this meeting and do not know if Child D was discussed.

Downgrading of the NNU from Level 2 to Level 1 (July 2016)

327. In July 2016, the hospital's NNU was downgraded from Level 2 to Level 1 **[INQ0014414]**.

328. I do not recall my understanding of the reasons for this or the circumstances in which it was decided and by whom. I was on I&S leave from 1 July 2016 to December 2016 and was not involved in discussions or decisions such as this.

Serious Incident Panel meeting (4 August 2016)

329. A legal report was prepared for the SI Panel meeting on 4 August 2016 **[INQ0008587]**. The update in relation to Child D is detailed below. I was on I&S leave from July 2016 to 29 December 2016 and was not the author of this report. I can see that the report updates the SI Panel that the expert report had been received from the Coroner and a copy of it was attached to the report. The report also updated the SI Panel that an email had been received on 1 July 2016 from Hill Dickinson regarding the family's request that the Coroner obtained an extra report. I have been unable to locate this email request to assist any further in relation to this point.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Witness	Current Position
I&S **Child D** [redacted] DOB: PD/06/2015	22 June 2015	Neonatology	The Baby was born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12	0	I&S Level 2 Investigation I&S	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician.

			minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner,			(Head of Midwifery) Dr Newby (Paeds)	Reports and Level 2 sent on 1 Dec 2015 Expert Report instructed by HM Coroner received 21.06.2016. Dr Ian Mercow Medical Report Coron Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust. Letter of Claim received 25.05.2016 Expert Reports to be obtained by Hill Dickinson. **Negligence alleged:** 7.0 antiobiotics not

							prescribed on 18 June at 36 weeks + PD gestatition contrary to Trust policy and recognised opinion. 8.0 Once [redacted] was born, failure to identify risk factors – respiratory distress, feeding difficulties, need for rescue breaths. 9.0 Failure to transfer to neonatal immediately Email received on 1 July 2016 from Hill Dickinson regarding family request to Coroner for extra report

330. I was on I&S leave from July 2016 to 29

331. December 2016 and was not the author of this report. The update in relation to Child A is detailed below.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Current Position
I&S **Child A** [redacted] DOB: PD/06/15	8 June 2015	Neonatology	Twin babies born by PD.06.2015 by planned caesarean section at 34 weeks. Twin one female twin two male. Neonatal death of twin 1 unexpectedly on 08/06/15 at COCH. I&S A post mortem was carried and the cause of death is 1a) Unascertained. **Potential Claim received 18.02.2016** To be reported to the NHSLA for Inquest funding. Maternity report received from Dr Davies to be sent to Coroner.	0	OSR Review I&S	**Inquest not yet set** : (no witness list yet). Dr Jayaram (Paeds) Dr Saladi (Paeds) Dr Davies (Obs & Gynae) PM sent to Saladi and Jayaram 29 Dec 2015 Coroner has been notified that a SUI investigation is not to be undertaken. Review of Mothers care found to be acceptable. Review of baby [redacted]'s care found to be acceptable. **URGENT & OUTSTANDING** **Duty of Candour to be considered** following Neo-natal Review.

			Coroner has requested reports from all Drs involved in paediatric care afforded to the patient (8in total - ST1-ST6) only 1 still employed by COCH). 6/8 reports received. Family questions raised & answered by Dr Jayaram. Family are instructing Legal Representation. ***Format of NNU investigation thought to be equivalent of a SUI. Coroner has recommended consideration be given to a SUI Report. Coroner notified that we are unable to meet deadline of 23 March 2016 for all reports and investigations. Coroner's Officer has again asked about the level of investigation.***			05.04.2016 RM to review OSR report & NNU Review and chase action plan 22/04/2016 Reports submitted to Coroner. Update email to RM requesting confirmation of reports to be disclosed and action plan. Coroners Officer has asked for a reports to be sent to Coroner by w/c 2 May 2016. SPC – need to speak to Coroner by the end of the week (05.08.16)

332. The update relates to Stephen Cross speaking to the Coroner by the end of the week (5 August 2016). I was absent from the Trust at this time and an unable to provide any further detail to that noted on the report.

333. The summary for Child O and Child P is below.

Opened date	Hospital Number	Ref	Date of Death	Description	Linked Complaints	Linked Incidents	Specialty
06/07/16	**Child P** [redacted] (Baby)	I&S	24/06/15	Baby 1 of triplets born by C-Section at 33+2weeks on PD/06/16. Born in good condition and subsequently deteriorated. No cause of death – awaiting full histology and post mortem *No reports requested yet as awaiting results of a meeting – with SPC	0	ID: I&S	Neonatology/Paeds/ Obs and Gynae
06/07/16	**Child O** [redacted] (Baby)	I&S	23/06/16	Baby 2 of triplets born by C-Section at 33+2weeks on PD/06/16. Born in good condition and subsequently deteriorated. COD: (awaiting full post mortem) 1a) Fresh bleeding into abdominal cavity due to b) Rupture of sub-capsular haematoma of liver	0	ID: I&S	Neonatology/Paeds/ Obs and Gynae

				c) To be established by full histology *No reports requested yet as awaiting results of a meeting – with SPC			

334. I was absent from the Trust and did not write this report. The entry states that: "*no reports have been requested yet as awaiting results of a meeting"* and that this matter was with Stephen Cross.

335. A file note written by my Inquest Assistant on 6 July 2016 details the following:

"FILE NOTE

06/07/2016 14:00

[redacted] *INQUESTS*

Meeting with SPC on 06/07/2016, not to go for reports until given the go ahead, following meetings in the next few weeks.

Any correspondence Re these inquests → notify SPC."

Serious Incident Panel meeting (11 August 2016)

336. A legal report was prepared for the SI Panel meeting on 11 August 2016 **[INQ0008594]**.

337. A summary of the entry for Child D is below but I was on I&S leave from July 2016 to 29 December 2016 and was not the author of this report.

Hospital Number & Inquest Ref	Date of Death	Speciality	Description	Complaint	Incident	Current Position

I&S **Child D** [redacted] DOB PD /06/2015	22 June 2015	Neonatology	The Baby was born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is: 1a)Pneumonia with acute lung injury *The mother has previously requested a copy of her maternity records and of the baby's records - these were sent to her. Family statement circulated to Dr Newby and Dr Davies CC. Julie Fogarty. Dr Newby has prepared a response. Questions answered by Julie Fogarty. File with Coroner,	0	I&S Level 2 Investigation	Family have instructed solicitors. Dr Davies (Obs and Gynae) Julie Fogarty (Head of Midwifery) Dr Newby (Paeds)	Unexpected Death. Reports received from Head of Midwifery. Consultant Obstetrician Consultant Paediatrician. Reports and Level 2 sent on 1 Dec 2015 Expert Report instructed by HM Coroner received 21.06.2016. Dr Ian Mercow Medical Report Coron Copy medical records sent to Coroner. Reported to NHSLA and Inquest funding granted – Joanna Trewin from Hill Dickinson representing Trust. Letter of Claim received 25.05.2016 Expert Reports to be obtained by Hill Dickinson. **Negligence alleged:** 1.0 antiobiotics not prescribed on 18 June at 36 weeks + PD days gestatition contrary to Trust policy and recognised opinion. 2.0 Once [redacted] was born, failure to identify risk

							factors – respiratory distress, feeding difficulties, need for rescue breaths. 3.0 Failure to transfer to neonatal immediately Email received on 1 July 2016 from Hill Dickinson regarding family request to Coroner for extra report

338. I was on I&S leave when this report was updated. The report provides an update that an email had been received on 1 July 2016 from Hill Dickinson regarding a family request to the Coroner for an extra report to be obtained, as was updated on the legal report from 4 August 2016.

339. The words, "*Coroner's chasing a response 10.08.16*", have been added into the update for Child A.

340. Child O and Child P do not appear to be on the report that I have access to dated 11 August 2016.

Serious Incident Panel meeting (17 August 2016)

341. A legal report was prepared for the SI Panel meeting on 17 August 2016 **[INQ0008520]**.

342. I was on I&S leave from July 2016 to 29 December 2016 and was not the author of this report. There do not appear to be any updates from the legal report from 11 August 2016 in respect of Child D.

343. In the final column the following information has been added in, in respect of Child A;

"Letter received from Mr Rheinberg to SPC on 12/08/16. Requesting a copy of the statements from Dr D Harkness, Dr T MacCarrick, Dr S Ogden, SUI and Medical records. No SUI — OSR to be agreed at SUI. Medical records already sent. Inquest will be set for October — non-availability will be sent by 22" August 2016."

344. Child O and Child P do not appear on the legal report, but I am unable to comment on why that was.

Serious Incident Panel meeting (7 September 2016)

345. A legal report was prepared for the SI Panel meeting on 7 September 2016 **[INQ0008601].**

346. I was on I&S leave from July 2016 to December 2016 so I cannot explain why part of this report appears blank or whether there was there anything to report in relation to any of the children named on the indictment. To assist as best I can, I have reviewed the document, and it would appear to be a formatting error.

347. The report only appears to detail new claims notified to the Trust, inquests opened, and inquests held during that period.

348. A legal report was prepared for the SI Panel meeting on 9 January 2017 **[INQ0008606]**.

349. Part of this report appears blank. I have been asked to explain this. I am unable to provide an accurate explanation as I was on a phased return to work following I&S leave week commencing 9 January 2017. I understand that the report was prepared by Helen Andrews, Legal Assistant. I am unable to reliably comment as to why there are blank rows in the table within the report, this is likely due to Helen's skills in editing Microsoft Word tables. From review of the inquest files, there does not appear to have been anything to update in relation to the inquest investigations at this meeting.

Serious Incident Panel meeting (14 February 2017)

350. A legal report was prepared for the SI Panel meeting on 14 February 2017 **[INQ0008608]**. Although dated 14 February 2016, I have been asked if that is the

correct date. It is my understanding that a SI Panel Meeting did not take place on 14 February 2017. My Report for the SI Panel meeting, held on 17 February 2017, is saved as 'SUI Incident Report 14.02.2016', the 2016 is a typographical error and this should read 14.02.2017. On opening this report, I have updated the date of the report in the header to 17 February 2016. This is a typographical error and should read 17 February 2017. It is likely that I started to prepare the report on 14 February 2017 and finalised it on the morning of 17 February 2017 to ensure that it was up to date for the meeting later that day.

351. The entry for Child D is below:

Patient Details	Speciality	Description	Complaint	Incident	Claim	Inquest
Inquest ref: I&S **Child D** DOB: PD/06/2015 PD DOD: 22/06/2015		Baby born at COCH on PD/06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is given as : 1a) Pneumonia with acute lung injury *Expert Opinion: **Mr Pickersgill**	0	Unexpected death Level 2 I&S	**Letter of Claim received** 25.05.2016 Negligence alleged: 1. Antibiotics not prescribed on 18 June at 36+6 weeks gestation contrary to Trust policy and recognised opinion. 2. Once [redacted] was born,	Coroner: Mr N Rheinberg Witnesses called/Reports disclosed:- •Julie Fogarty, Head of Midwifery, •Dr Elizabeth Newby, Consultant Obstetrician •Dr Joanne Davies, Consultant Paediatrician •Level 2 Investigation •Medical Records

		1 Treatment followed good practice for management of a term rupture of membranes. By definition on presentation membranes were pre-term and in line with RCOG recommendations should have been prescribed with oral erythromycin but accepts that this is a contentious area. 2. Difficult to confirm if outcome would have been different for baby in that she probably would have survived after PD days of oral erythromycin. **Dr Mecrow:** 1.Dr Mecrow agrees that [redacted] died from bacterial sepsis as a result of pneumonia and this was contracted by her at or shortly before her delivery; 2.Post-natal management was appropriate and Dr Mecrow is not critical of any aspect of it; 3.Dr Mecrow says that [redacted]'s sudden deterioration and collapse were wholly unexpected and unpredictable; 4.Dr Mecrow said that from a non-specialist obstetric point of view he could not advise			failure to identify risk factors – respiratory **Letter of response denies a breach of duty.** Inquest funding granted – Joanna Trewin from HD representing Trust. • distress, feeding difficulties, need for rescue breaths. • Failure to transfer to transfer to neonatal immediately. Family meeting to be arranged.	Mother's witness statement circulated to Dr Newby and Dr Davies CC Julie Fogarty. Dr Newby has prepared a response to family questions *Expert reports instructed by the Coroner from: Dr Mercow, Consultant Paediatrician Dr Pickersgill, Obstetrician & Gynaecologist. Both called to attend the Inquest. Looking to set down the inquest March – May 2017, non-availability obtained and passed to Hill

		the Court whether antepartum or intrapartum antibiotic treatment of [redacted]'s mother was appropriate. However, he states that earlier treatment with antibiotics post-natally is unlikely to have made any difference to the outcome, even if this was to have been indicated. **Expert reports instructed by Hill Dickinson:-** Ms Edwards (Expert Midwife) Dr Wagstaff (Consultant Neonatologist).				Dickinson. Pre-inquest meeting to be arranged.

352. The entry in relation to Child D on the legal report for 14 February 2017 summarises the background to the incident following birth on 20 June 2015, the Post-Mortem cause of death. It also summarises the findings of the Coroner's experts' reviews and states that the Trust's legal representatives, Hill Dickinson, have instructed expert midwifery and neonatologist reports on behalf of NHS Resolution.

353. The report confirms that a letter of claim from the family's legal representatives has been received and summarises the allegations of negligence. It confirms that the Trust's response at that time denied a breach of the duty of care. The report informed the SI Panel that the Trust was legally represented and had been granted inquest funding by NHS Resolution. It recorded that the Trust were to arrange a family meeting to consider the Trust's investigations.

354. The report also provided an update on the position with the inquest investigation detailing witnesses called, confirming that Mum's statement has been circulated to witnesses and that the Coroner's experts were being called to give evidence at the inquest hearing which the coroner was looking to set down between March and May

2017. It also explained that non-availability had been obtained from witnesses and sent to Hill Dickinson and that a pre-Inquest witness support meeting would be arranged.

355. I sent apologies to the SI Panel meeting held on 17 February 2017. In my covering email, I detailed the following in relation to inquest monitoring (see attached as **Exhibit SHL18**):

"Inquest Monitoring

Child D - *Child D - Neonatal*

Sian to update Legal Services on any developments in setting the family meeting – no legal representation to be present at this meeting.

Legal Services currently arranging an internal Pre Inquest Meeting with Hill Dickinson in attendance."

356. My request at this meeting was to be updated by Sian Willians, Deputy Director of Nursing, in relation to progress with setting a meeting with the family to discuss the Trust's investigations.

357. The summary of the entry for Child O and Child P is below:

Patient Details	Specialty	Description	Complaint	Incident	Claim	Inquest
Child O & P Inquest Ref:		Sudden collapse of triplet.		Unexpected death: Level 2 Investigation I&S	No claim at present.	No Inquest at present. Coroner to decide whether inquest required.

358. The summary above confirmed the position in relation to the Coroner's inquest investigation in that the Coroner had not yet confirmed to the Trust whether an inquest investigation would be opened with a hearing set down.

359. I was not in attendance to the meeting and am unable to confirm whether Child o or Child P were discussed, but I can confirm that I had not flagged any updates in relation to the inquest investigation to be discussed at this meeting.

Serious Incident Panel meeting (17 February 2017)

360. A legal report was prepared for the Serious Incident Panel meeting on 17 February 2017 **[INQ0008256]**. Although dated 17 February 2016, I have been asked if the correct date is 17 February 2017. I can confirm that I was the author of this report. I can confirm that the date of the report should have read 17 February 2017 and that the 2016 entry is a typographical error.

361. The entry in relation to Child D is below:

Patient Details	**Speciality**	**Description**	**Complaint**	**Incident**	**Claim**	**Inquest**
Inquest ref: I&S **Child D** DOB: PD/06/2015 PD DOD: 22/06/2015		Baby born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation	0	Unexpected death Level 2 I&S	**Letter of Claim received** 25.05.2016 Negligence alleged: 1.Antibiotics not prescribed on 18 June at 36+6 weeks gestation contrary to Trust policy and	Coroner: Mr N Rheinberg Witnesses called/Reports disclosed:- •Julie Fogarty, Head of Midwifery, •Dr Elizabeth Newby, Consultant Obstetrician •Dr Joanne Davies,

		breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. A post mortem has been carried out and the cause of death is given as : 1a) Pneumonia with acute lung injury *Expert Opinion: **Mr Pickersgill** 1 Treatment followed good practice for management of a term rupture of membranes. By definition on presentation membranes were pre-term and in line with RCOG recommendations should have been prescribed with oral erythromycin but accepts that this is a contentious area.			recognised opinion. 2.Once [redacted] was born, failure to identify risk factors – respiratory **Letter of response denies a breach of duty.** Inquest funding granted – Joanna Trewin from HD representing Trust. • distress, feeding difficulties, need for rescue breaths. • Failure to transfer to transfer to neonatal immediately. Family meeting to be arranged.	Consultant Paediatrician •Level 2 Investigation •Medical Records Mother's witness statement circulated to Dr Newby and Dr Davies CC Julie Fogarty. Dr Newby has prepared a response to family questions *Expert reports instructed by the Coroner from: Dr Mercow, Consultant Paediatrician Dr Pickersgill, Obstetrician & Gynaecologist. Both called to attend the Inquest.

		2. Difficult to confirm if outcome would have been different for baby in that she probably would have survived after PD days of oral erythromycin. **Dr Mecrow:** 1.Dr Mecrow agrees that [redacted] died from bacterial sepsis as a result of pneumonia and this was contracted by her at or shortly before her delivery; 2.Post-natal management was appropriate and Dr Mecrow is not critical of any aspect of it; 3.Dr Mecrow says that [redacted]'s sudden deterioration and collapse were wholly unexpected and unpredictable;				Looking to set down the inquest March – May 2017, non-availability obtained and passed to Hill Dickinson. Pre-inquest meeting to be arranged.

		4.Dr Mecrow said that from a non-specialist obstetric point of view he could not advise the Court whether antepartum or intrapartum antibiotic treatment of [redacted]'s mother was appropriate. However, he states that earlier treatment with antibiotics post-natally is unlikely to have made any difference to the outcome, even if this was to have been indicated. **Expert reports instructed by Hill Dickinson:-** Ms Edwards (Expert Midwife) Dr Wagstaff (Consultant Neonatologist).				

362. At this time, I would highlight any updates/matters for attention to my report in red. In the case of Child D, I was highlighting that a family meeting was still to be arranged

and that the Coroner was looking to set the inquest hearing down between March 2017 and May 2017. Non-availability was being sought from all witnesses and dates would be passed to our legal representative at Hill Dickinson to liaise with the coroner. A Pre-Inquest support meeting was to be arranged for all witnesses.

363. I was not in attendance to the Serious Incident Panel Meeting held on the morning of 17 February 2017 and therefore do not know whether Child O or D were discussed at the meeting. In my covering email, I have requested an update from Sian Williams as to whether there has been any progress in setting the family meeting and have confirmed that there is to be no legal attendance at that family meeting (see **Exhibit SHL18** above). **INQ0102364**

364. Please see below a summary of the entry for Child O and Child P:

Patient Details	Speciality	Description	Complaint	Incident	Claim	Inquest
Child O & P Inquest Ref:		Sudden collapse of triplet.		Unexpected death: Level 2 Investigation **I&S**	No claim at present.	No Inquest at present. Coroner to decide whether inquest required.

Serious Incident Panel meeting (7 March 2017)

365. A legal report was prepared for the SI Panel meeting on 7 March 2017 (See **Exhibit SHL19 and SHL20**) **INQ0102364**

366. I can confirm that I was the author of this report. At that time, I would highlight any updates to my report in red. Below is the update in respect of Child D.

Patient Details	Speciality	Description	Complaint	Incident	Claim	Inquest

Inquest ref: I&S **Child D** DOB: PD/06/2015 **PD** DOD: 22/06/2015		Baby born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. A post mortem has been carried out and the cause of death is given as : 1a) Pneumonia with acute lung injury *Expert Opinion: **Mr Pickersgill** 1 Treatment followed good practice for management of a term rupture of membranes. By definition on presentation membranes were pre-term and in line with RCOG recommendations should have been prescribed with oral erythromycin but accepts that this is a contentious area. 2. Difficult to confirm if outcome would have been	0	Unexpected death Level 2 I&S	**Letter of Claim received** 25.05.2016 Negligence alleged: 3. Antibio tics not prescribed on 18 June at 36+6 weeks gestation contrary to Trust policy and recognised opinion. 4. Once [redacted] was born, failure to identify risk factors – respiratory **Letter of response denies a breach of duty.**	Coroner: Mr N Rheinberg Witnesses called/Reports disclosed:- •Julie Fogarty, Head of Midwifery, •Dr Elizabeth Newby, Consultant Obstetrician •Dr Joanne Davies, Consultant Paediatrician •Level 2 Investigation •Medical Records Mother's witness statement circulated to Dr Newby and Dr Davies CC Julie Fogarty. Dr Newby has prepared a response to

		different for baby in that she probably would have survived after PD days of oral erythromycin. **Dr Mecrow:** 1.Dr Mecrow agrees that [redacted] died from bacterial sepsis as a result of pneumonia and this was contracted by her at or shortly before her delivery; 2.Post-natal management was appropriate and Dr Mecrow is not critical of any aspect of it; 3.Dr Mecrow says that [redacted]'s sudden deterioration and collapse were wholly unexpected and unpredictable; 4.Dr Mecrow said that from a non-specialist obstetric point of view he could not advise the Court whether antepartum or intrapartum antibiotic treatment of [redacted]'s mother was appropriate. However, he states that earlier treatment with antibiotics post-natally is unlikely to have made any difference to the outcome, even if this was to have been indicated.			Inquest funding granted – Joanna Trewin from HD representing Trust. • distress, feeding difficulties, need for rescue breaths. • Failure to transfer to transfer to neonatal immediately. Family meeting to be arranged.	family questions *Expert reports instructed by the Coroner from: Dr Mercow, Consultant Paediatrician Dr Pickersgill, Obstetrician & Gynaecologist. Both called to attend the Inquest. Inquest set for 25 May 2017. Pre-inquest meeting to be arranged.

		Expert reports instructed by Hill Dickinson:- Ms Edwards (Expert Midwife) Dr Wagstaff (Consultant Neonatologist).				

367. For this meeting, I provided an update that the inquest date had now been set for 25 May 2017 and that a pre-inquest support meeting with staff was to be arranged. This information was important to the members of the SI Panel in ensuring that meetings and reviews are completed in good time for the inquest hearing.

368. Due to the passage of time, I do not recall whether Child D was discussed at the SI Panel meeting, but my usual process would be to raise the points highlighted in red for consideration and action.

369. A summary of the entry for Child O and Child P is below.

Patient Details	Specialty	Description	Complaint	Incident	Claim	Inquest
Child O & P Inquest Ref:		Sudden collapse of triplet.		Unexpected death: Level 2 Investigation **I&S**	No claim at present.	No Inquest at present. Coroner to decide whether inquest required.

370. Child O and Child P are detailed on the report as the Coroner had opened an inquest investigation in relation to the deaths and this was to remain on the report for monitoring of progress with the coroner's investigation. There were no changes made to this report from earlier reports. My reports would always include cases that required monitoring for decisions and updates or in relation to trends.

Serious Incident Panel meeting (14 March 2017)

371. A legal report was prepared for the Serious Incident Panel meeting on 14 March 2017 **[INQ0008612]**. Although dated 7 March 2017, I have been asked whether the report was for the meeting on 14 March 2017.

372. I can confirm that I was the author of this report, my records show that I last edited the report on 9 March 2017 at 14:45.

Patient Details	**Speciality**	**Description**	**Complaint**	**Incident**	**Claim**	**Inquest**
Inquest ref: I&S **Child D** DOB: PD 06/2015 PD DOD: 22/06/2015		Baby born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15.	0	Unexpected death Level 2 I&S	**Letter of Claim received** 25.05.2016 Negligence alleged: 5. Antibio tics not prescribed on 18 June at 36+6 weeks gestation contrary to Trust policy and recognised opinion. 6. Once [redacted] was born, failure to identify risk	Coroner: Mr N Rheinberg Witnesses called/Reports disclosed:- •Julie Fogarty, Head of Midwifery, •Dr Elizabeth Newby, Consultant Obstetrician •Dr Joanne Davies, Consultant Paediatrician •Level 2 Investigation •Medical Records

		A post mortem has been carried out and the cause of death is given as : 1a) Pneumonia with acute lung injury *Expert Opinion: **Mr Pickersgill** 1 Treatment followed good practice for management of a term rupture of membranes. By definition on presentation membranes were pre-term and in line with RCOG recommendations should have been prescribed with oral erythromycin but accepts that this is a contentious area. 2. Difficult to confirm if outcome would have been different for baby in that she probably would			factors – respiratory **Letter of response denies a breach of duty.** Inquest funding granted – Joanna Trewin from HD representing Trust. • distress, feeding difficulties, need for rescue breaths. • Failure to transfer to transfer to neonatal immediately. Family meeting to be arranged bearing in mind the Inquest date. Who will present Lesson	Mother's witness statement circulated to Dr Newby and Dr Davies CC Julie Fogarty. Dr Newby has prepared a response to family questions *Expert reports instructed by the Coroner from: Dr Mecrow, Consultant Paediatrician Dr Pickersgill, Obstetrician & Gynaecologist. Both called to attend the Inquest. Inquest set for 25 May 2017. Pre-inquest meeting to be arranged.

		have survived after PD days of oral erythromycin. **Dr Mecrow:** 1.Dr Mecrow agrees that baby died from bacterial sepsis as a result of pneumonia and this was contracted by her at or shortly before her delivery; 2.Post-natal management was appropriate and Dr Mecrow is not critical of any aspect of it; 3.Dr Mecrow says that babies sudden deterioration and collapse were wholly unexpected and unpredictable; 4.Dr Mecrow said that from a non-specialist obstetric point of view he could not advise the Court whether			Learning Report. Will Head of Midwifery cover Midwife Care and a Senior Lead deliver the report? Consider an overall generic statement with individual cases at the end.	

		antepartum or intrapartum antibiotic treatment of [redacted]'s mother was appropriate. However, he states that earlier treatment with antibiotics post-natally is unlikely to have made any difference to the outcome, even if this was to have been indicated. **Expert reports instructed by Hill Dickinson:-** Ms Edwards (Expert Midwife) Dr Wagstaff (Consultant Neonatologist).				

373. I can confirm that I have made an error in not updating the date of the report in the report header from 7 March 2017 to 14 March 2017.

374. Due to the passage of time, I am unable to recall if the SI Panel Meeting went ahead on 14 March 2017, but I have been unable to locate any emails relating to a meeting on this date either in my inbox or my sent box.

Serious Incident Panel meeting (28 March 2017)

375. A legal report was prepared for the Serious Incident Panel meeting on 28 March 2017 **[INQ0008614]**.

376. I can confirm that I was the author of this report. My report is dated 28 March 2017, and the meeting was held on 30 March 2017.

377. A summary of the entry for Child D is below:

Patient Details	Description	Incident	Claim	Inquest
Inquest ref: I&S **Child D** DOB: PD 06/2015 **PD** DOD: 22/06/2015	Baby born at COCH on PD 06/15. Mother had spontaneous rupture of membranes at 36+6 on PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S I&S on 22/06/15. **A post mortem cause of death is given as :** 1a) Pneumonia with acute lung injury ***Coroner's Expert's Opinion:** **<u>Mr Pickersgill</u>** 1 Treatment followed good practice for management of a term rupture of membranes. By definition on presentation membranes were pre-term and in line with RCOG recommendations should have	Unexpected death Level 2 **I&S**	**Letter of Claim received** 25.05.2016 ***Negligence alleged:*** 1. Antibiotics not prescribed on 18 June at 36+6 weeks gestation contrary to Trust policy and	Coroner: Mr N Rheinberg Inquest set for 25 May 2017. Witnesses called/Reports disclosed:- •Julie Fogarty, Head of Midwifery, •Dr Elizabeth Newby, Consultant Obstetrician •Dr Joanne Davies, Consultant Paediatrician •Level 2 Investigation •Medical Records *Experts instructed by the Coroner Both called to attend the Inquest.

	been prescribed with oral erythromycin but accepts that this is a contentious area. 2. Difficult to confirm if outcome would have been different for baby in that she probably would have survived after PD days of oral erythromycin. **Dr Mecrow:** 1.Dr Mecrow agrees that baby died from bacterial sepsis as a result of pneumonia and this was contracted by her at or shortly before her delivery; 2.Post-natal management was appropriate and Dr Mecrow is not critical of any aspect of it; 3.Dr Mecrow says that babies sudden deterioration and collapse were wholly unexpected and unpredictable; 4.Dr Mecrow said that from a non-specialist obstetric point of view he could not advise the Court whether antepartum or intrapartum antibiotic treatment of [redacted]'s mother was appropriate. However, he states that earlier treatment with antibiotics post-natally is unlikely to have made any difference to the outcome, even if this was to have been indicated. **Expert reports instructed by Hill Dickinson:-** Ms Edwards (Expert Midwife)		recog nised opinio n. 2.Once [redacted] was born, failure to identify risk factors – respiratory distress, feeding difficulties, need for rescue breaths. 3.Failure to transfer to transfer to neonatal immediatel y. **Letter of response denies a breach of duty. However consideratio n to be given to settling prior to the Inquest.**	

	Dr Wagstaff (Consultant Neonatologist).		Inquest funding granted – Victoria McManus from HD representing Trust. Family meeting date to be confirmed bearing in mind the Inquest date. Who will present Lesson Learning Report? Will Head of Midwifery cover Midwife Care and a Senior Lead deliver the report? Consider an overall generic statement with individual	

			cases at the end.	

378. The action to focus on in relation to this inquest investigation at that time was the inquest date that had been set for 25 May 2017 and the outstanding actions that required clarification for the Coroner. I have flagged the actions for this inquest on the covering email sending my report to the SI Panel as **Child D** – *Lesson Learning for Inquest/family meeting date?".* (See **Exhibit SHL21**) **INQ0102364**

379. The actions I needed to be addressed were to be informed of the date of the meeting with the family, to seek clarification as to the appropriate witness to present the Lesson Learning Report at the inquest hearing and to seek clarification as to whether an overall generic statement would be written for the Coroner.

380. Due to the passage of time, I am unable to recall if Child D was discussed at the meeting but my usual practice at the time of the meeting would be to raise the matters highlighted in red. On the report. The red text highlights an outstanding action or an update.

381. The entry for Child O and Child P is below:

Patient Details	**Specialty**	**Description**	**Complaint**	**Incident**	**Claim**	**Inquest**
Child O & P Inquest Ref:		Sudden collapse of triplet.		Unexpected death: Level 2 Investigation **I&S**	No claim at present.	No Inquest at present. Coroner to decide whether inquest required.

382. Child O and Child P are detailed on the report as the Coroner had opened an inquest investigation in relation to the deaths which was to remain on the report for monitoring

of progress with the Coroner's investigation. There were no changes made to this report from previous reports.

Inquest preparation action plan (7 April 2017)

383. An inquest preparation action plan was prepared in relation to Child D on 7 April 2017 **[INQ0008761]**. I can confirm that I am the author of this document. The document is a copy and paste of the summary notes of the Trust's pre-inquest meeting for witnesses Julie Fogarty, Dr Davies and Dr Newby on 13 April 2017 with our legal representative from Hill Dickinson. This was a draft document and was not circulated or taken forward. The summary notes had previously been circulated to Alison Kelly and Mr Ian Harvey on 14 March 2017.

384. The final entry is "*Having regard to the outcome of the meeting between Counsel and the with the [sic] Consultant Paediatricians*." I do not recall where this final entry came from as it was not part of the advice obtained from Hill Dickinson. This does not appear to be a reference in this case, and it may have been a template from a previous inquest. This was a draft document, not used after being created, not forwarded or taken forward.

385. I do not have any knowledge of a meeting between Counsel and with the Consultant Paediatricians relating to this case.

Serious Incident Panel meeting (30 May 2017)

386. A legal report was prepared for the SI Panel meeting on 30 May 2017 **[INQ0008619]**. I can confirm that I was the author of this report, I did not attend the meeting held on 31 May 2017 due to being away on 2 weeks' annual leave.

387. The entry for Child D is below:

Patient Details	Description	Incident	Claim	Inquest
	Baby born at COCH on PD 06/15. Mother had spontaneous rupture of membranes			

Inquest ref: I&S **Child D** DOB: PD 06/2015 PD DOD: 22/06/2015	at 36+6 PD June 2015. Failed induction of labour. Baby delivered by c-section. After 12 minutes of age the baby was floppy and required inflation breaths and was later taken to NNU. The baby died I&S on 22/06/15. **A post mortem cause of death is given as :** 1a) Pneumonia with acute lung injury ***Coroner's Expert's Opinion:** **Mr Pickersgill** 1 Treatment followed good practice for management of a term rupture of membranes. By definition on presentation membranes were pre-term and in line with RCOG recommendations should have been prescribed with oral erythromycin but accepts that this is a contentious area. 2. Difficult to confirm if outcome would have been different for baby in that she probably would have survived after PD days of oral erythromycin. **Dr Mecrow:** 1. agrees that baby died from bacterial sepsis as a result of pneumonia and this was contracted by her at or shortly before her delivery; 2.says Post-natal management was appropriate, not critical of any aspect of it; 3. says that babies sudden deterioration and collapse were wholly unexpected and unpredictable; 4. said that from a non-specialist obstetric point of view he could not	Unexpected death Level 2 **I&S**	**Letter of Claim received** 25.05.2016 ***Negligence alleged:*** 1. Antibiotics not prescribed on 18 June at 36+6 weeks gestation contrary to Trust policy and recognised opinion. 2.Once [redacted] was born, failure to identify risk factors – respiratory distress, feeding difficulties,	Coroner: Mr N Rheinberg Inquest set for 25 May 2017 **ADJOURNED.** Witnesses called/Reports disclosed:- •Julie Fogarty, Head of Midwifery, •Dr Elizabeth Newby, Consultant Obstetrician •Dr Joanne Davies, Consultant Paediatrician •Level 2 Investigation •Medical Records *Experts instructed by the Coroner Both called to attend the Inquest.

	advise the Court whether antepartum or intrapartum antibiotic treatment of [redacted] mother was appropriate. However, he states that earlier treatment with antibiotics post-natally is unlikely to have made any difference to the outcome, even if this was to have been indicated. **Expert reports instructed by Hill Dickinson:-** Ms Edwards (Expert Midwife) Dr Wagstaff (Consultant Neonatologist).		need for rescue breaths. 3. Failure to transfer to transfer to neonatal immediately. **Letter of response denies a breach of duty. However consideration to be given to settling prior to the Inquest.** Inquest funding granted – Victoria McManus from HD representing Trust. Family meeting held 16/05/2017 Who will present Lesson	

			Learning Report? Will Head of Midwifery cover Midwife Care and a Senior Lead deliver the report? Consider an overall generic statement with individual cases at the end.	

388. I can confirm that there were no changes made to the SI Panel Report dated 30 May 2017 in respect of Child A from the previous report dated 23 May 2017 (see **Exhibits SHL22 and SHL23**). It includes a summary of the incident, the Post-Mortem cause of death, summaries of the Coroner's experts opinions and names of experts instructed by Hill Dickinson. It also provides a summary of the allegations of negligence detailed in the Letter of Claim, the Trust response and inquest funding status. INQ0102364

389. It confirms that a family meeting was held on 16 May 2017, asks who the appropriate witness will be to present the lesson learning report at the inquest hearing, if there will be a joint approach to this and finally asks how the Coroner is to be updated in relation to the Trusts position, an action following legal advice.

390. This column confirms that name of the Coroner undertaking the inquest investigation. It communicates that the inquest was set for 25 May 2017, but that this date has been adjourned with the inquest to be set down at a later date. It provides a list of witnesses called to attend the inquest or who have submitted reports to the coroner and that the experts instructed by the Coroner are being called to give evidence.

391. I was not in attendance to the SI Panel Meeting held on 31 May 2017 due to annual leave. In my covering email I do not highlight any new matters to discuss in relation to this inquest investigation in addition to those already being considered.

392. The summary of the entry for Child O and Child P is below:

Patient Details	Specialty	Description	Complaint	Incident	Claim	Inquest
Child O & P Inquest Ref:		Sudden collapse of triplet.		Unexpected death: Level 2 Investigation I&S	No claim at present.	No Inquest at present. Coroner to decide whether inquest required.

393. It describes that there had been a sudden collapse of a triplet but the Coroner had not yet decided at this time whether a full inquest investigation with a hearing was to take place.

Involvement and knowledge (July 2016 to April 2017)

394. I have been asked to set out my involvement and knowledge about the rise in the NNU mortality rate from June 2015 to June 2016. I was informed by Stephen Cross that the Trust was an outlier in terms of mortality figures, that investigations were taking place and to escalate any inquest investigations notified by the Coroner, or claims relating to the Women's and Children's Division, to Stephen Cross and the SI Panel. I do not recall the date that I was given this information.

395. I was notified of incident reviews via the SI panel and of M&M meetings taking place in relation to three deaths. I was not party to any discussions regarding Letby, other than the briefing I received on 30 June 2016 and I emailed Ruth Milliard about.

396. I was aware that concerns had been raised and that those concerns were being addressed by reviews and by the Director of Nursing and Medical Director.

Contact with the police

397. I was not involved in any discussions about referring suspicions and concerns about Letby to the police.

Reflections

398. I was not involved in discussions between the paediatricians and the Trust's Executives. I can't comment on what was known when and the details of what actions were taken. It is my understanding that various investigations both internally and externally to the Trust were undertaken.

399. It is very difficult for me to have a view on any errors I may think might have been made handling the suspicions and concerns raised in respect of Letby as I do not, and did not, have enough information to form a view. I was not involved in any discussions about this.

400. I do not feel able to express a view on whether if the babies had been monitored by CCTV the crimes of Letby could have been prevented or whether systems, including security systems relating to the monitoring of access to drugs and babies in NNUs, would have prevented deliberate harm being caused to the babies named on the indictment.

401. I have been asked what recommendations I think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff. I believe that CCTV for vulnerable patients could be an option in the future though this may be perceived as intrusive to families and patients. I also think that staff that have genuine concerns regarding suspected criminal activity should be empowered to report their concerns directly to police. I believe that suspicions regarding potential crimes should be passed to the police to investigate.

Any other matters

402. There is no other evidence that I can give from my knowledge and experience which is of relevance to the work of the Inquiry.

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

Request for documents

404. All relevant documents have been exhibited to this statement.

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: 24 June 2024