THIRLWALL INQUIRY

Statement of David Hunter

Dated 20 June 2024

Personal Details

1. David HUNTER

Before I begin this statement I want to express my condolences to the families and friends of the murdered babies and express my sympathy to the family and friends of the babies who were harmed by the perpetrator.

Career and background

2. I left the Royal Air Force in 1975 having completed nine years of exemplary service. I joined Humberside Police in February 1975 and retired in August 2007 as a detective chief superintendent after completing 32 years of continuous exemplary service. Between then and March 2023 I was self-employed as an independent chair and author for public sector reviews. [See paragraph 5]

Police Career

3. I spent my time alternating between uniform and detective duties and served in both disciplines in most ranks. As a detective chief superintendent I was the Force's policy and sometimes operational lead for child and adult safeguarding and Multi-Agency Public Protection Arrangements [MAPPA].[1] MAPPA is the process through which the Probation, Police and Prison Services manage the risk posed primarily by dangerous and sexual offenders.

[1] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

4. I attended internal and external training and conferences for these three areas and represented Humberside Police on local and regional safeguarding forums, including Local Safeguarding Children Boards [LSCB] in Humberside. I considered myself experienced and competent in these matters and always willing to learn through reflection. The passage of time does not allow me to be precise on the dates of the training I received and conferences I attended. I think it is fair to say that the training and conferences were probably annual, or maybe biennial, events. I can say that the training and conferences continued after I left the police service. I recall making a presentation and participating in role play exercise for The Parole Board on risk management. I undertook similar training with the Home Office. I also attended Home Office sponsored training on Domestic Homicide Reviews including chairing skills.

Independent Reviewer

5. After my retirement from the police I was an independent reviewer for:

Child Serious Case Reviews [SCRs]

MAPPA Serious Case Reviews [MAPPA SCRs]

Domestic Homicide Reviews [DHRs]

Safeguarding Adult Reviews [SARs]

Child Serious Case Reviews

6. Serious case reviews were introduced in the first edition of Working Together, published on the same day as the Cleveland inquiry report in July 1988.[2] They were replaced by a new system of local child safeguarding practice reviews in 2018-19. Both types were commissioned in cases where a child had died or been seriously harmed and abuse or neglect was known or suspected. Additionally SCRs could be carried out where a child had not died, but had come to serious harm as a result of abuse or neglect.

[2] https://www.bmj.com/content/bmj/297/6642/190.full.pdf

Multi Agency Public Protection Arrangements Serious Case Reviews

7. Multi-Agency Public Protection Arrangements provide a statutory framework for assessing and managing the risk posed by certain sexual and violent offenders. MAPPA brings together the Police, Probation and Prison Services to form the MAPPA Responsible Authority for each MAPPA area. The MAPPA areas discharge their functions through local Strategic Management Boards. MAPPA serious case reviews are usually undertaken when an individual managed under MAPPA commits a serious further offence; generally murder, rape or their attempts.

Domestic Homicide Reviews

8. These were established under section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The purposes of domestic homicide reviews are to identify: learning about the way in which local practitioners and agencies work to safeguard victims and how agencies will respond to the learning. To improve: intra and inter-agency working and service responses for all domestic violence victims and their children, in order to prevent further domestic homicides.

Safeguarding Adult Reviews

9. The Care Act 2014 established Local Safeguarding Adults Boards [LSABs] and Safeguarding Adult Reviews. 'The overarching purpose of LSABs is to help and safeguard adults with care and support needs. The purpose of Safeguarding Adult Reviews is to identify and promote learning and to improve practice when an adult has been harmed and the review criteria are met.'[3] 'Safeguarding Adult Reviews need to be of good quality and need to be able to be shared to maximise the value of their learning.'[4]

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[3]https://www.traffordsafeguardingpartnership.org.uk/Safeguarding-Adults/Safeguarding-Adult-Review-SAR/Safeguarding-Adult-Review-SAR-Criteria.aspx

[4]https://www.scie.org.uk/safeguarding/adults/reviews/

Review Experience

10. Prior to retiring from the police I contributed to many child serious case reviews as a panel member and approved the police's written submissions. During my 16 years as an independent reviewer I completed over 100 reviews for about 20 different areas. Approximately half were Domestic Homicide Reviews with the remainder split fairly evenly between the other three review categories. I was never commissioned by Wirral Metropolitan Borough Council to undertake any type of review or other work. I had limited contact with some Wirral based agencies when undertaking reviews in neighbouring authorities. Amongst others, I undertook reviews for Liverpool, Sefton, Cheshire West and Chester Council, all of the ten Greater Manchester Metropolitan Boroughs and several Yorkshire based authorities.

The Process

11. The process of reviewing all types was similar. Terms of reference were established along with a review panel comprising: representatives from those agencies who had contact with the victim; additional independent members and people with detailed subject knowledge as needed. [For example alcohol addiction, debt management.] A key feature of all reviews was the involvement of the victims' families. The panel called for written reports from each agency involved with the victim and/or offender. These reports were analysed against the terms of reference, agencies policies, procedures and practice in the particular case. A written report was produced and submitted to the commissioning authority for approval. Some reviews had additional external scrutiny before open publication. In 2015/2016 MAPPA serious case reviews were not published.

My qualifications for the role of interim chair of Merseyside Death Overview Panel.

12. I was an experienced chair of police and inter-agency meetings and undertook internal and external voluntary chairing roles. For example I was chair of governors at a special school catering

for pupils with severe learning/physical disabilities and an independent lay hospital manager carrying out reviews of detention or community treatments orders for those patients detained under the Mental Health Act 1983 as amended. I had a good knowledge of the forensic approach to child deaths required by child death overview panels. I was a qualified Senior Investigating officer for serious and series of crime and undertook complex investigations, including suspicious child deaths. I retired from the police in August 2007. In July 2008 I was asked to be the interim chair of the joint Hull City Council and East Riding of Yorkshire Council, Child Death Overview Panel. I chaired eight panels between then and March 2010 at which time the authorities established separate child death overview panels and appointed permanent chairs.

Membership of Local Safeguarding Children Boards.

13. I represented Humberside Police on the four local safeguarding children boards whilst a serving police officer. I do not recall there being a Merseyside Local Safeguarding Children Board. I believe there were separate local safeguarding children boards for the five metropolitan boroughs: Knowsley, St. Helens, Sefton, Wirral, and the City of Liverpool, that made up Merseyside Metropolitan County. I was never a member of any of the five boards. I undertook child serious case reviews, domestic homicide reviews and adult safeguarding reviews for Sefton and Liverpool and presented the findings to the respective boards.

Child Death Overview Panels – General.

14. The Children Act 2004 provided the legislative framework for child death overview panels which became a statutory function on 1 April 2008. Child death overview panels were responsible for scrutinising the deaths of all children normally resident in their area to identify any learning and prevent child deaths, using an evidenced based approach.

Merseyside Child Death Overview Panel.

Independent Review of Merseyside Child Death Overview Panel 2015

15. An independent review of Merseyside Child Death Overview Panel, hereinafter referred to as The Panel, was undertaken during 2015. I have not been able to establish who commissioned it or its terms of reference. I have seen the June 2015 review report in draft form and do not know its history thereafter. From the content of the draft review report it seems the issues were; The Panel's interaction with the local safeguarding children boards concerning how The Panel's identification of modifiable factors [see footnote 8 page 9] would be taken forward by the local safeguarding children boards; improved presentation of statistics for The Panel's annual report and its reports to local safeguarding children boards; the frequency of The Panel's meetings and its membership. The draft report noted the attendance of two consultant neonatologists at The Panel meeting observed by the reviewer. There was no mention of The Countess of Chester Hospital or any hint or reference to the matters that are now known to have been happening there.

16. The draft review report dated 30 June 2015 pre-dates The Panel's consideration of an indictment baby's case on 23 March 2016.

17. The Thirlwall Inquiry could access the 2015 Independent review report of Merseyside Child Death Overview Panel through that body.

My Appointment to Merseyside Child Death Overview Panel

18. In December 2015 I was approached to see if I was interested in taking up an interim post as the independent chair of Merseyside Child Death Overview Panel. I'm unsure why I was asked other than I had completed several reviews in Sefton and Liverpool and knew people in local agencies. I recall the vacancy arose because the previous chairing arrangements within the Merseyside public health family ceased. I agreed to the request and informed The Panel Manger it was not a position I sought beyond the interim. A permanent chair was appointed in November 2016 at which point my tenure ended.

Overview [5]

19. At that time, Merseyside Child Death Overview Panel was a subgroup of Knowsley, Liverpool, Sefton, St. Helens and Wirral Local Safeguarding Children Boards. It had a statutory responsibility to review qualifying deaths of all children up to the age of 18 years. The Panel chair was accountable to the chairs of the five local safeguarding children boards and provided them with quarterly reports.

Qualifying Deaths

20. The Panel considered deaths occurring in children, aged from new-born to eighteen years, (excluding stillbirths and planned terminations of pregnancy carried out within the law) who were normally resident in their areas. This included babies of any gestation, irrespective of whether their birth was deemed viable, as it was felt there may be important lessons to be learnt within the antenatal and birth period.

Definitions [6]

Category	Age
Stillbirth	A baby born after 24 or more weeks completed gestation and which did not, at any time, breathe or show signs of life.
Early neonatal	The death of an infant aged under seven days.
Perinatal	A baby who was recorded as either a stillbirth or early neonatal death.
Neonatal	The death of an infant aged under 28 days.
Post-neonatal	The death of an infant aged 28 days to 1 year
Infant	The death of those aged under one year

Summary of Purpose, Functions and Procedures

21. The Panel had a protocol that governed:

[5] Full details of The Panel's purpose, functions and procedures are in The Merseyside Child Death Overview Panel Protocol May 2015.
[6] Source Office for National Statistics

the identification of deaths requiring its examination

the collection and submission of relevant data in a set format

liaison with other processes such as, criminal investigations, child safeguarding reviews and coronial investigations

the timetabling of cases for The Panel and reporting The Panel's determinations

22. The Panel used a sensitive, comprehensive and multidisciplinary approach to child death reviews. This enabled it to better understand how and why Merseyside children died. It used the findings to help prevent other deaths and improve the health and safety of children. Involving the family and not apportioning blame [for non-criminal matters] were seen as important.

Process

23. The overall process of what happened following a child's death involved a number of stages. This assumed that the immediate management of the death, including issuing a death certificate; implementation of the Merseyside Joint Agency Sudden Unexpected Death in Childhood [SUDiC] protocol; bereavement care etc. would take place within the relevant agencies.[7]

24. The Panel used three primary documents: Forms A, B and C.

Form A Notification of a Child Death

25. Paediatric liaison staff within hospitals across Merseyside and staff in other agencies e.g. children's hospice, Walton Centre, inputted initial notifications directly on to the Sentinel database[8].

[7] https://seftonscp.procedures.org.uk/assets/clients/10/Pan%20Merseyside%20Protocols/SUDiC%20Protocol%20May%202024.pdf

[8] The database used for all CDOP data collection is a web based system hosted by Vantage Technologies. All agencies involved in data inputting have been required to sign an information sharing agreement and comply with data sharing protocols.

This alerted The Panel's administration that a child death had occurred. Sentinel sent automatic emails to agencies requesting record checks.

26. If a child died in the community and was taken to a hospital it was the responsibility of the hospital paediatric liaison staff to inform The Panel's administrators. If a child death within the community was certified by a General Practitioner and the child had not been taken to the hospital thereafter the GP should inform the Practice Manager, who in turn was required to alert the relevant hospital for the area, or the hospital that has been providing the ongoing care during the condition leading to the death.

Form B Agency Report Form

27. If the child, or any family member, was or had been known, to an agency Form B would be completed on Sentinel and processed by The Panel's administrators. As there were a number of resources within Merseyside that offered services nationally the Sentinel system was used for all notifications. Deaths not under the remit of The Panel were notified to the relevant external child death overview panel and/or the relevant local safeguarding children board by The Panel's administrators.

Form B Combining Agency Form Bs

28. On receipt of agency reports The Panel administrators would combine all responses in one multi-agency Form B, anonymise it and make it available to The Panel members for consideration in advance of the meeting.

Form C Analysis Proforma

29. Form C was completed following discussion of the child's death at The Panel's meeting. That discussion was centred round whether there were any modifiable factors[9] that may assist with reducing similar deaths.

30. The Panel members had regard to four specific domains:

Factors intrinsic to the child;

Factors in the family and environment

Factors in the parenting capacity

Factors in relation to service provision

31. The Panel members agreed a number from 0-3 for each domain:

0: no information available

1: no factors identified or factors identified that are unlikely to have contributed to the death

2: factors identified that may have contributed to vulnerability, ill health or death

3: factors identified that provide a complete and sufficient explanation for the death

32. Additionally, The Panel was required to record each death against 1 of 10 nationally-set categories as follows:

Category 1: Deliberately inflicted injury, abuse or neglect

Category 2: Suicide or deliberate self-inflicted harm

Category 3: Trauma and other external factors

Category 4: Malignancy

Category 5: Acute medical or surgical condition

Category 6: Chronic medical condition

Category 7: Chromosomal, genetic and congenital anomalies

[9] Modifiable factors are those which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future deaths. For example smoking during pregnancy.

Category 8: Perinatal/neonatal event

Category 9: Infection

Category 10: Sudden unexpected, unexplained death

Completion of Form C

33. The completed Form C was collated and inputted into a Department for Education Child Death Data Collection form annually by local safeguarding children boards (Department for Education Form LSCB1). The analysis assisted with the identification of patterns and trends of child deaths and was made available to support the future considerations for service provision. The data was also used locally for the same purposes.

General

34. Forms A and B were sometimes submitted with incomplete data. I believed the root cause was that the level of detail required for their completion was not readily available at the time they were first submitted. For example; the employment status and occupation of both parents and other significant adults in the child's life. Gaps in information could be an obstacle to the analyses of cases. In my view the absent information was not ideal. However in most cases it did not impact on the analyses. Where missing details were thought to be important to The Panel's determinations, the case was deferred, the detail sought, and the case relisted for the next panel meeting.

Membership of The Panel

35. [Taken from The Panel's Annual Report 01.04.2015 to 31.03.2016] [10]

'The Panel had a core membership of:

[10] https://liverpoolscp.org.uk/scp/about-us/merseyside-child-death-overview-panel-cdop/print

Chair Independent

Manager & Administrator

Children's Social Care/Safeguarding

Merseyside Police

Education

Public Health*

Consultant Paediatricians

Lay members

Legal services

Named GPs

Merseycare

Local Safeguarding Children Board Business Managers

Safeguarding Nurse

Designated Nurses

Consultant Neonatologists

Consultant Obstetrician

*Since the resignation of the previous co-chairs, who were both public health representatives, there has been no public health involvement with the process. This issue has been raised in quarterly reports, and is being highlighted again in this annual report as it requires addressing.'

Frequency of Panel Meetings

36. Prior to June 2016, panel meetings were held monthly, alternating between neonatal and non-neonatal cases. I chaired both meetings.

Effectiveness of The Panel in Detecting Deliberate Harm

37. The Panel did not consider 'near miss' cases; only deaths. There were several processes in place designed to detect deliberate harm before a death was reviewed by The Panel. Neonatal

deaths were considered by neonatologists and their hospital teams who used their combined expertise and medical knowledge as an initial screening tool. For example the medical history of a particular child could have made it very likely, or inevitable, that they would die.

38. Some hospital and non-hospital deaths were referred to H.M. Coroner for consideration of a post mortem and this provided another level of scrutiny One indictment baby was such a case. Suspicions of deliberate harm could be shared with the police for a potential criminal investigation.

39. Local Safeguarding Children Boards had processes in place to identify when a child died or was seriously harmed as a result of abuse or neglect. In 2015 if such circumstances applied a child serious case review was likely to have been commissioned.

40. Several other agencies had processes in place that investigated the causes of child deaths. For example: The Health and Safety Executive, The Fire and Rescue Services and the Police.

41. If the death was being examined by police, HM Coroner or the local safeguarding children board [via a serious case review] The Panel did not consider it until the particular process was over.

42. Therefore, The Panel did not expect to be presented with a case where there was a suggestion of deliberate harm before the issue had been resolved. I recall that on one occasion The Panel discussed whether a child serious case review should have been considered and referred the matter back to the relevant local safeguarding children board. That was not an indictment baby I do not remember the outcome.

43. I now know that in 2016 The Panel looked at an indictment baby's death and did not identify anything that suggested deliberate harm. I will include more context later in my statement. [See paragraphs 53 onwards.]

The Panel's Liaison Network

Hospitals

44. My main point of contact with The Panel was its manager and administrator. I also had individual contact with local safeguarding children board managers or chairs as required. These contacts were around processes, funding, issues to do with the smooth running of The Panel and the requirements of local safeguarding children boards.

45. I had no direct contact with hospitals, including the Princess of Chester Hospital. The contacts were limited to hospital staff who attended The Panel. I would only have liaised directly with a hospital if there was an issue that The Panel Manager required support with.

Regional Links

46. I have extracted the following for The Panel's 2015/2016 Annual Report.

'Merseyside CDOP [The Panel] continues to be represented at the north-west CDOP meetings. A common dataset was agreed for all north-west annual reports to allow for the compilation of an overview report covering the north-west. This has been adhered to in the compilation of this report, as in previous years. Infant Mortality Workshop – regional initiative. There was also representation from Merseyside CDOP at the Infant Mortality Workshop planning sessions, relating to an event that took place later in 2016. The focus of the workshop was intended to be identifying best practice with an aim of reducing the number of infant deaths in the north-west, given we have a considerably high infant mortality rate.'

National Network:

47. 'Merseyside CDOP forms part of the national network group established by Nisar Mir, Consultant Paediatrician at Warrington Hospital. This group focused upon proposed changes to the documentation as one of the short-term goals and the development of a CDOP website as a longer term goal and both have been achieved, albeit the revised forms remain in draft awaiting consideration through the respective overseeing body. National Database Development Project Merseyside CDOP has also continued to represent CDOPs, by invitation, on the working group to establish if a national CDOP database is required. The necessity has been confirmed and is to progress with a tendering process beginning in 2016. The desired completion date for development is in 2017. The national database will be able to access Merseyside CDOP data through a 'sucking up' process that will not warrant input into two systems. Merseyside CDOP was the only panel represented from the beginning.'

Referrals from Countess of Chester Hospital 2015 and 2016

48. My understanding is that only one death was referred to The Panel by Countess of Chester Hospital in 2015 and 2016 and this was a baby on the indictment. I do not know the names of the other babies on the homicide indictments but am informed by The Panel administrators that those babies were not referred to The Panel. Without knowing the babies' names and cross checking them with all 2015/2016 referrals to The Panel I cannot be certain but accept what The Panel administrators say.

The baby named on the indictment referred to the Merseyside Panel

49. The Thirlwall Inquiry provided supporting papers to assist me prepare this statement; the following information was included. 'The Inquiry understands that you were present at, and Chaired, the Panel meeting which considered this baby on I&S.' My information from The Panel administrators is that this baby's case was examined on 23 March 2016. I have seen the minutes that confirm this. I am not aware that this baby was discussed at any other Panel meeting I chaired.

50. I have asked The Panel administrators for a copy of Form A which is the initial notification of this baby's death. This request has been denied on the grounds of confidentiality as the notification identifies this baby. The Panel's administrator confirms that it was received by the office on I&S I&S the day after this baby's death] having been completed by the Neonatal Practice Developmental Nurse at the Countess of Chester Hospital. I have asked The Panel's administrator, whether in their substantial experience, Form A was completed to a good standard and contained the required detail. The administrator felt it was of the standard expected given it was submitted a day after this baby's death.

51. Subsequently a combined Form B was completed as and when other details became available. For example the findings of the post mortem. The contributors to Form B were: Paediatric Unit Countess of Chester Hospital; Midwifery Service Countess of Cheshire Hospital; Wirral Community Health – health visitor service and a GP.

52. I can say that this baby's case was examined by The Panel on 23 March 2016 which included: two consultant neonatologists [neither were from the Countess of Chester Hospital], other clinicians, two lay members, the police and a solicitor. I was present as the independent chair. The information on Form B was comprehensive and sufficient to enable The Panel to complete its analysis and categorise this baby's death as a perinatal/neonatal event with no modifiable factors.

An indictment baby: **My Observations**

53. This baby was one of three Wirral cases looked at by The Panel on I&S. This baby's death was unexpected and the other two were expected. Form B included the result of this baby's post mortem held on I&S two days after the death. The cause of death did not raise any concerns that this baby had been, or may hve been, harmed.

54. The combined Form B was completed between I&S and I&S. One of the standard questions on Form B asked: 'Was there a formal internal review/ investigation?' The 'No' box was checked. It is not possible for me to say who or when that question was answered.

55. However, I have seen open source material that says by the time this baby's case was examined by The Panel on I&S, Dr Stephen Brearey head consultant on the neonatal unit at the Countess of Chester Hospital had raised his concerns about Lucy Letby with senior hospital staff on three occasions: 2 July 2015, 23 October 2015 and 8 February 2016.[11] These facts were unknown to The Panel. I believe this is a learning point and raises the questions of: if, when, how and who with, should the Countess of Chester Hospital have shared their concerns. There is also a case for the police, or any other agency, to inform child death overview panels if they are investigating or have suspicions about a qualifying death or deaths. That would prevent such cases being considered by the child death overview process. I am unaware whether any of The Panel attendees where this baby's case was discussed had any knowledge of the child safety concerns in The Hospital. Had I or The Panel Manager known of the concerns I am certain this baby's case would have been deferred. The record of The Panel's meeting on I&S is comprehensive and accurate.

Countess of Chester Hospital

56. This baby was the only case from the Countess of Chester Hospital looked at by The Panel during my tenure and I am not aware of this baby's case being discussed at any other meeting of The Panel. I did not know there was an increase in neonatal deaths at The Hospital and was never contacted by The Hospital for any purpose. I have never been invited to, or attended, any meeting at The Hospital. At no time while I was the interim chair of The Panel, did I hear from any source that The Hospital was concerned over the increase in neonatal deaths.

[11] https://www.theguardian.com/uk-news/ng-interactive/2023/aug/18/lucy-letby-timeline-attacks-babies-when-alarm-raised

57. My tenure with The Panel ended in November 2016 following the appointment of a permanent chair and I am therefore unable to help the Inquiry with matters postdating that time.

58. I was aware through the media of the Lucy Letby trial but did not connect the issues to The Panel's duties. This connection only came on 21 May 2024 when I received the Rule 9 letter.

The Panel's Annual Report 2016 [April 2015 to March 2016]

59. The Panel manager prepared the 2016 Annual Report with a little support from myself. I do not recall presenting it to any of The Panel's constituent local safeguarding children boards. The report did not mention any increase in the mortality rate at The Hospital as it considered only one case (as above) from there.

Other Matters

60. I did not see, receive, nor was I aware of any emails or other correspondence identifying a rise in the number of deaths at The Hospital.

Reflections

61. I have approached my statement in an open and transparent way as I believe it is important that if there is learning for either Merseyside Child Death Overview Panel or other such panels I should contribute to it without fear or favour. The families of all the babies subject to the Thirlwall Inquiry deserve no less.

62. The Panel only examined deaths of children resident in its five local authorities. The case above was the only case it considered that emanated from The Hospital, therefore it was not possible on that information alone to identify any issues within The Hospital's neonatal unit.

63. I said earlier in my statement [paragraph 55] that I believe The Panel and any other Child Death Overview Panels reviewing deaths from The Hospital, should have been aware of the total numbers of deaths. Had that happened The Panel would have seen the increase and asked for further details before deciding on whether to review that baby's death.

64. It is clear that at the time The Panel reviewed that baby's case in I&S that The Hospital's medical head of the neonatal unit already raised his concerns. I am unaware of how far they were shared within and without The Hospital. I believe they should have been shared with The Panel.

65. Not knowing about the increase denied The Panel vitally important information relevant to its role as an independent scrutineer. In brief The Panel was fettered for want of this detail.

66. At the time of my interim chairing I lived in East Yorkshire and while I travelled to Merseyside for The Panel meetings and other work I was not resident in the area. My network of professionals local to Merseyside was sufficient for my purposes. Had I resided in Merseyside I am sure my network would have been wider. Whether this in turn would have enabled me to pick up on the concerns within The Hospital cannot be known for certain. Perhaps chairs of such bodies should live more locally. However that may be seen as hampering their independence.

67 I am not aware of the current processes with The Panel and whether the systems for alerting child death overview panels of hospitals suspicions have changed.

68. The above case was the only one from The Hospital that The Panel considered. It was accompanied by a good level of data that enabled The Panel to discharge its responsibility cautiously and diligently. The Panel based its conclusions on the data available and there was nothing raised to suggest other relevant information was available. I do not know if it was deliberately withheld to avoid compromising any investigations or if no one made the connection between The Panel's work and the emerging suspicions at The Hospital.

69. While this baby's death was unexpected, there was not a hint of anything untoward. The post mortem provided a clear cause of death. Nevertheless, I now know that this baby was the victim of a homicide, something which I or The Panel never suspected or discussed at the time.

70. Apart from the Rule 9 letter, I have not been approached by anyone else to comment on the actions of the perpetrator nor will I do so, if so approached.

71. In conclusion I cannot see how it was reasonably possible for me or The Panel to suspect that this baby's death resulted from deliberate harm by a nurse. That alone means there must be learning somewhere in the child death overview process.

Statement of Truth

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

Signed

PD

20 June 2024