Witness Name: Professor Simon Kenny
Statement No.: [XXXX]
Exhibits: [XXXX]
Dated: [XXXX]

THIRLWALL INQUIRY

WITNESS STATEMENT OF PROFESSOR SIMON EDWARD KENNY

I, Professor Simon Edward Kenny, will say as follows: -

1. I qualified as a Bachelor of Medicine and Surgery with Honours from the University of Birmingham in 1990. I was awarded a Fellowship of the Royal College of Surgeons of England in 1995. I received a Doctor of Medicine from University of Liverpool in 2001. I was awarded Intercollegiate Fellowship in Paediatric Surgery in 2002 and obtained my Certificate of Completion of Specialist Training in the same year. I was made an Honorary Fellow of the American Academy of Pediatrics in 2004. I trained in general surgery in Toowoomba, Australia, and then on the Merseyside Surgical Rotation including a one-year attachment to the Countess of Chester Hospital in 1993-1994 prior to commencing my paediatric surgical research and training at Alder Hey Children's NHS Foundation Trust in 1995. During my training, I spent one year at the Royal Melbourne Children's Hospital (Australia, 2000-2001). I was appointed as a Consultant Paediatric Surgeon / Urologist at Alder Hey Children's Hospital in 2003 and remain in post. This role involves provision of emergency and elective surgery for children up to 18 years of age and covers Cheshire and Merseyside in addition to wider areas of the Northwest and North Wales. Part of this role is to provide neonatal surgical services. I was appointed a Clinical Director for the Surgery, Cardiac, Anaesthesia, Theatre and Critical Care Clinical Business Unit in 2009 and remained in this post until October 2016. I was allocated 2 Programmed Activities (8 hours) per week for this role. This role provided clinical leadership and oversight of the activities of the Clinical Business Unit including internal governance as well as interacting with external bodies such as the neonatal operational delivery network. My clinical line manager was the Medical Director. 2015 was a busy year as Alder Hey was moving from its old site into a new 'Hospital in the Park' and implementing a new Electronic Patient Record system. In October 2016 I resigned from this role on my appointment as National Clinical Lead for paediatric surgery in the 'Getting It Right First Time' programme initially funded by the Department of Health but latterly as part of NHS England. The reason for resignation was to avoid any potential conflict of interest. I remain in this position. Within

this role I created data packs to explore variation in outcomes between hospitals providing children's general surgery and urology and visited over 80 hospitals, writing a national report published in 2020. In addition, I was appointed as National Clinical Director for Children and Young People in NHS England in 2019. I remain in post. This role has clinical leadership responsibilities for delivering the 2019 NHS Long Term Plan commitments as part of the NHS England Children and Young People's Transformation Programme. The role also carries clinical responsibilities around all NHSE activities that involve children and young people. I am also chair of the Women's and Children's Programme of Care within Specialised Commissioning. This Programme includes the Neonatal Transformation Programme and is responsible for commissioning of Service Specifications – for example the Neonatal Service Specification. I have also had clinical oversight of the last procurement of the National Neonatal Audit Programme. Between 2003 and 2020 I was also the Chair of the Clinical Outcomes Committee for the British Association of Paediatric Surgeons and have a particular interest in long term outcomes for children requiring surgery. I have an Honorary Professorship at the University of Liverpool. I am still actively involved in surgical and clinical practice including neonatal surgery.

2. I attended some of the Cheshire and Merseyside Neonatal Network Board, Steering Group and Clinical Effectiveness Meetings as part of the team representing Alder Hey Children's Hospital. As evidenced by the minutes, mortality and adverse incidents were presented in various ways in these meetings. At the time, the model of care for babies requiring surgical intervention was under review and this was the focus for my attendance at these meetings. However, in both the Steering Group and Clinical Effectiveness meetings critical incidents and mortality data were shown. The data came from several sources – there was mortality and incident data returned by individual units, and periodically data from MBRRACE and NDAU. The individual unit level data returns were difficult to interpret as they were not benchmarked and there was no means by which outlier status could be identified. With the benefit of hindsight, on page 17 of the ODN Quarterly Network report annual mortality at Chester was high at 3.8 deaths per 1000 live births which was nearer to mortality at Arrowe Park (5.1) and Liverpool Women's (4.7) vs Whiston (0.5) and Ormskirk (0.8). This, however, was one page of a 17-page document in a meeting with a packed agenda and there was no benchmarking to indicate outlier status. MBRRACE / NDAU data was benchmarked, but, as I recall, unit level data was not available at these meetings. As reflected in the minutes and from my recollection, the overall picture was reassuring. I note that at the Cheshire and Merseyside Neonatal Steering Group meeting on 10th October 2016 Item 8 included a 'response to NHS England following EMBRRACE(sic) report' I recollect that at least one

meeting I asked why it wasn't possible to see unit level MBRRACE data and being told that it was due to data governance concerns and that data sharing agreements would need to be in place. Not being able to see benchmarked unit level outcomes limited the effectiveness of these meetings. One of the issues around MBRRACE data was timeliness – for example I received emails from MBRRACE requesting review of neonatal mortality for 2015 in November 2016. So, there was locally collected timely data which was not benchmarked and nationally benchmarked data with a significant time lag. No real time data was available. There were also specific issues with surgical neonatal data as at the time it had been identified by MBRRACE and NNAP that babies who required surgery at Alder Hey and Manchester were not being included in data returns as both units did not use 'Badger', the neonatal electronic information software. Instead, both centres were using their own electronic patient records and, until 2015, paper notes. In 2015 there were ongoing discussions around this and both Manchester and Alder Hey were asked to provide outcome data on babies with 3 neonatal surgical conditions: oesophageal atresia, necrotising enterocolitis, and gastroschisis. Realising that we needed to integrate data from Alder Hey, in 2016 we signed a contract with Badger to provide neonatal electronic patient records for babies admitted to Alder Hey with surgical problems. This was implemented in 2017 to allow neonatal surgical data to be collected for national audit purposes. This development also enabled us to see babies care records from episodes of care prior to their transfer to Alder Hey which has been very helpful. Further to these meetings, individual adverse events and mortality for neonates requiring surgical intervention were also discussed in the monthly morbidity and mortality meetings of the Department of Paediatric Surgery but babies discussed in one forum were not clearly identifiable in the other as reporting in network meetings was anonymised. A neonatologist was present at the Department of Paediatric Surgery morbidity & mortality meetings and by 2016/17 we held regular 6 monthly joint morbidity and mortality meetings with the neonatology department at Liverpool Women's Hospital – the organization that we most often work with. Further to this, any neonate who died at Alder Hey would be discussed by the Hospital Mortality Review Group.

3. Despite the caveats described around lack of visibility of benchmarked neonatal unit outcome data the meetings were generally helpful as I was aware (as described above) that the outcomes for babies with surgical disease were not that visible and was keen to address this as well as ensure that babies requiring surgery had an experience that matched those of babies who didn't. As stated above, a lot of the focus was on the neonatal surgical review and there were issues around roles and responsibilities of the neonatal transport team for babies arriving at Alder Hey who needed surgery. At the time

there was a model where the transport team would continue to care for the baby on arrival in theatre until the baby could be taken into theatre. This was causing disruption to the transport team workflow, and it was useful to have the support of the neonatal operational delivery network in working through solutions.

4. In 2015 Alder Hey Children's Hospital was a 'standalone surgical neonatal unit' commissioned by NHS England against draft neonatal surgical specification B (england.nhs.uk). Up until this time, the care of babies requiring surgery had been provided by the neonatal surgeons themselves who provided care on the Neonatal Surgical Unit. Babies who needed to be ventilated or dialysed were cared for on the Paediatric Intensive Care Unit. Most babies admitted to Alder Hey were 'Level 3' according to the neonatal service specification. Level 3 indicates babies who require intensive care support. During 2015 plans were being enacted for the surgical neonatal unit to be supported by consultant neonatologists – with a vision of a single service between Liverpool Women's Hospital and Alder Hey. In the autumn of 2015, the first 3 neonatologists who were going to be attending Alder Hey had been identified and contracts issued. Since then, the neonatal workforce has expanded to provide 7-day consultant and advanced nurse practitioner cover, and building has commenced on a new neonatal surgical unit that will allow parents to sleep by their babies. We routinely received babies with postnatally diagnosed congenital malformations from the Countess of Chester Hospital and premature babies with surgical disease. Typically, a referral would come from the on-call consultant paediatrician to the duty consultant paediatric surgeon and if transfer was indicated a conference call would be set up with the transport team via the cot bureau. If the referral was for a surgical review and it was not definite that a ventilated preterm baby would require surgery, the on-call neonatologist at Liverpool Women's Hospital would attend the conference call - it was agreed that those babies would be transferred to the level 3 neonatal unit at Liverpool Women's Hospital. It was concerns about the potential need for multiple transfers of unwell neonates to and from Alder Hey that has led to the building and staffing of a new surgical neonatal unit at Alder Hey Children's Hospital. On occasions, babies would be transferred to the Level 3 neonatal unit at Arrowe Park Hospital, but this was not ideal for babies with surgical disease as if they developed surgical problems, they would require onward transfer. When the episode of surgical care was complete, babies who had Level 1 or 2 critical care needs would be transferred back to the Countess of Chester.

The culture and atmosphere of the NNU at the Countess of Chester Hospital in 2015-2016

5. Since my appointment in 2003 I have conducted regular urology clinics at the Countess of Chester Hospital. These are held approximately 6 times per year. These clinics are collaborative, in that they are held in the presence of members of the consultant paediatric team at the Countess. These clinics are valuable, in that they mean that families do not need to face the cost and inconvenience of travel to Alder Hey in Liverpool but also allow sharing of clinical information on children with urological conditions to provide effective treatment and links to local continence and safeguarding teams. It is also valuable continuing professional development for paediatricians to learn more about urological presentations in children which reduces the need for referral to tertiary paediatric urology.
6. During those clinics, I met all the consultant paediatricians who were also providing neonatal care.
7. I have no recollection of ever visiting the neonatal unit, but I may have done at some point in the last 21 years to review the babies if there was a particular surgical issue at the same time.
8. My recollection of events and timings in 2015 and 2016 around the culture and atmosphere of the NNU are subject to the vagaries of time and memory.
9. I had always been impressed by the level of dedication and clinical knowledge of the consultants I met. Dr Brearey had been one of the most diligent attenders of neonatal network meetings.
10. The Countess of Chester neonatal team were notable in that they have always been proactive about written policies about neonates and regularly contacted us to update surgical and urological guidance.
11. At some point in 2015-2016 during these clinics Dr Brearey raised concerns with me over noted increases in neonatal death rates and was struggling to identify a clear cause.
12. I remember having several conversations with him about this and during one of these conversations he mentioned that he had mapped out which staff had been on the unit at the time of sudden collapses and that there was a single staff member who was always present when they occurred. I agreed with him that this was both unusual and concerning and encouraged him to concern these concerns with the medical director.
13. I am not sure whether it was by text message, phone call, or at the next clinic that I learned that a Royal College review was being held. This provided me with some assurance that matters were being looked at. I was also aware that the individual was not involved in direct patient care thereafter which was reassuring pending the review outcome.

14. Over the course of 2016-17 it was clear that what had been previously good relationships between the paediatric consultant workforce and the hospital management had deteriorated and that there was stress and conflict evident. I remember Dr Brearey telling me that the nurses had 'drawn the wagons' around the nurse (later identified as Letby). This was to say that they were very protective of her. That said, the conduct of the consultant staff in my presence in clinic was always professional and I did not see a qualitative reduction in the standard of clinical work. At this time, I was also conducting satellite clinics in Ysbyty Gwynedd Bangor and Arrowe Park Hospital. During my career, I have conducted similar clinics in Whiston hospital, Wrexham Maelor Hospital, Warrington General Hospital, Glan Clwyd Hospital, Leighton Hospital, Ormskirk Hospital and University Hospital North Midlands. The only notable difference was the willingness of the consultants to do the clinic together with me whereas in other centres I was often left to do the clinic alone and deal with different information technology systems, etc by myself. I always saw this as a sign of the dedication and professionalism of the Countess of Chester paediatricians and a positive cultural aspect of the Department.
15. Given the subsequent events from 2016 to the present day, I have witnessed remarkably professional behaviour from all the paediatricians at the Countess of Chester who have maintained a strong patient centred focus despite the intense pressure that they have been under. I did not personally witness any impact on the quality of care offered by the consultant team. My observations are restricted to the interactions I have had in the Outpatients Dept.
16. During the period 2015-2016, together with the other members of the paediatric surgical team at Alder Hey, I was involved in the care of several of the babies who were involved in the Letby case.

Involvement in the care of children named on the indictment.

17. In the first, **Child I**, according to the statement of Dr Palanasami, I was contacted by Dr Dewhurst when I was Consultant Paediatric Surgeon on call. As detailed above, if there were concerns that a baby might require surgery then they were transferred to Liverpool Women's Hospital. As the main Level 3 neonatal unit regionally, both the doctors and nurses had more experience of seriously unwell babies, including those with possible surgical pathology. I have no specific contemporaneous notes of this discussion, but I remember the conversation with Dr Dewhurst and being reassured that he felt that there was no immediate surgical pathology. This clinical presentation is not uncommon, and fortunately most babies do not require surgery. As detailed below, I was subsequently involved in a tabletop review of **Child I**.

18. I was also involved in the care of **Child N** when he was admitted to the Paediatric Intensive Care Unit at Alder Hey Children's Hospital following a cardiorespiratory arrest at the Countess of Chester Hospital on the 18th June 2016. He had abdominal distension following this and at 0145hrs was reviewed by Dr Salim, Surgical Registrar, who felt that his abdomen was not distended and that no change in management was indicated. I reviewed him at 0845 on 20/6/2016 and had no specific concerns. The specific issues I was watching out for involved the consequences of potential reduced blood flow through the intestine during the period of cardiac arrest. When the heart stops pumping then there is a reduction in oxygen and nutrient supply, particularly to the intestine. The reduction in supply may lead to ischaemia – in which the cells must switch energy supplies and work inefficiently, creating lactic acid, or, in extreme cases, infarction – characterised by cell death and necrosis, resulting in a perforation of the bowel. He was reviewed by the duty surgical registrar the following day and by myself on 22nd June 0845hrs by which time I was happy with him. At 1400hrs I was part of a discussion between high dependency consultant, infectious disease, and myself in which we agreed to stop antibiotics. By 23 June 2016 he had improved enough for discharge back to Chester but remained on the High Dependency at Alder Hey until 27 June 2016 when a cot became available.

Involvement in reviewing the care of children named on the indictment.

19. With regards to **Child I,** I was invited to a 'table-top' review meeting of the care of Child I on 26 February 2016. I think that this was both because I had been involved in original discussions with Dr Dewhurst and because I was Clinical Director at Alder Hey. The review was held by Cheshire and Merseyside Neonatal Network. I am not sure who instigated it. This was the only 'table-top' review that I think I had been involved in and it was essentially a discussion around the decision making to do with the transfers that had been involved. From memory the case was presented orally and possibly by Powerpoint prior to the discussion. I have seen the minutes and action points from the discussion and from memory this was a fair recollection of the discussion. I cannot remember if there was any discussion of the cause of the collapse. My focus was around the circumstances that had led to a transfer to Arrowe Park where it would be difficult to give surgical input as there were no formal arrangements for surgical review there. I am not sure whether this discussion was before or after Dr Brearey had relayed his more general concerns about neonatal mortality at the Countess of Chester.
20. We had already discussed the case of **Child I** at the Department of Paediatric Surgery Morbidity and Mortality Meeting on 20th January 2016. I obtained the postmortem result prior to this discussion because of the history of intermittent abdominal distension, and I

was keen to ensure that potential surgically correctable pathology had not been missed. I have no recollection of being suspicious of the reasons behind the collapse. The following is what is recorded in the minutes (APH: Arrowe Park Hospital; AP: Action Point).

21. ***Discussion of Neonatal Mortality case:*** *baby was not cared for at AH, phone advice given at some stage, do not currently document these episodes. Baby was transferred to APH but not sure of reason (e.g., was it for surgical review or for general review in higher level neonatal unit) nor whether there was surgical advice prior to transfer. If thought to be a surgical problem, then T/F to LWH more appropriate as we have a regular commitment to give surgical advice at the Women's but not at APH and cannot provide a sustained service at APH. Note subsequent PM for this baby cause of death = prematurity, pathology in brain, lung, heart.* ***AP:*** *To discuss documentation / dictation re such infants at consultant meeting.*

22. I was also asked to review the case of **Child G** by the police and reviewed the case notes from 2015, submitting a report that concluded that her symptoms were not due to Hirschsprung's disease on 22 March 2020.
23. I am not aware that I had any further involvement in investigation or review of any of the other deaths or collapses of babies named in the indictment.

Increased neonatal deaths at the Countess of Chester Hospital NNU

24. As detailed above [10], I am uncertain as to when I became aware of the increased number of neonatal collapses and deaths at the Countess of Chester Hospital NNU but it was sometime in 2015-16 and was a verbal communication of general concern by Dr Brearey.
25. From memory, my main discussions were with Dr Brearey and Dr Jayaram. The discussions were mainly speculative – initially around potential causes. I have a recollection of Dr Brearey asking me whether I had ever seen a baby suddenly collapse. I do not remember the exact clinical details but remember saying no whilst qualifying my response with the statement that I was a neonatal surgeon not a neonatologist. At some point we discussed the possibility of foul play – from memory this was at the time that Dr Brearey had produced the staff timetable analysis.
26. This information worried me, but I was reassured by the knowledge that there was to be an Invited Review and that the nurse in question was not directly caring for babies.
27. I do not think there was widespread knowledge at this point at Alder Hey. I was personally quite guarded at this point as I did not want to prejudice any potential police enquiry and was assuming that this would happen, potentially with covert filming etc.
28. My recollection may not be completely accurate, but I remember attending a clinic in Chester when the paediatricians had been briefed about the findings of the report and

that a further inquiry was being advocated with no mention of possible criminal actions. I remember Drs Jayaram and Brearey both being extremely upset and at this point I recollect suggesting that they approach the police directly. I remember telling them that this would constitute a Protected Disclosure under whistleblowing law that would protect them from adverse consequences. I also recollect saying that if I had been Medical Director and such concern had been raised that I would have gone directly to the police.

29. On 7th February 2017 Margaret Barnaby, Interim Chief Operating Officer at Alder Hey forwarded an email from Julie Maddocks (Director, Northwest Neonatal Network), that linked to a leaked report to the Sunday Times about the Invited Review and that an independent inquiry would be commissioned. On the 8th February, Ms Barnaby sent a copy of the Royal College of Paediatrics and Child Health Invited Review into the Countess of Chester Hospital NHS Foundation Trust.
30. I was therefore able to read the report myself and confirm that there was no mention of possible malfeasance or forensic/ police involvement. Again, my recollection may not be completely accurate, but remember a telephone conversation with Dr Brearey to reemphasize that they should contact the police directly. I also told Dr Brearey that the remedial actions recommended by the RCPCH report were not earthshaking – apart from the investigation into unexplained deaths the recommendations could likely to be made to all level 2 units in the network. From Dr Brearey's email this conversation would have appeared to have been the 8th or 9th February 2017.
31. At this time, I also discussed the issue with close surgical colleagues at Alder Hey, Miss Sarah Almond, Mr Matthew Jones and Mr Colin Baillie. They supported my actions. From memory we agreed that we would write a letter of support for the paediatric team at the Countess of Chester if required.
32. At some point I also raised my concerns with Louise Shepherd, Chief Executive at Alder Hey in case it might be necessary for an approach to the Countess of Chester. I think it was shortly after that conversation that I heard from the paediatricians at the Countess of Chester that the police were to be involved.
33. After the police involvement, I have been kept updated about progress when I have been attending clinic.
34. As detailed above [2,3,4] I attended network meetings in which mortality was discussed. I have no recollection of the increased mortality in Chester being directly discussed other than possibly a verbal reference to issues under investigation at the Clinical Effectiveness Group Meeting in May 2017 at the Longhouse in Chester . I remember overall network mortality being discussed and noting that whereas Cheshire and Merseyside had been almost at the upper exceedance of normality that overall mortality was more within the normal range.

35. I do not think that on the basis of the mortality data presented at the meetings which I attended that a discrete signal was visible for the Countess of Chester.
36. I did not have data prepared by MBRRACE-UK, the National Neonatal Research, NHS England or any other organisations about the mortality rate and number of serious adverse incidents on the Countess of Chester Hospital NNU.

Concerns and Suspicions

37. I may have interacted with Letby in a single instance at Liverpool Women;s Hospital when she was a student nurse. I only realised this when her photograph appeared in the press.
38. I have indicated above about how I came to be aware on concerns. At that point no names were used.
39. I did not use formal or informal means to report concerns for the safety of babies on the NNU or at the Countess of Chester Hospital. This is because I did not have access to the data and details that would have enabled me to report these concerns. Without this, all my information was secondary. I was also reassured, at least until around February 2017 that things were being investigated and responded to by the Countess of Chester Hospital management who presumably had far more information than I did. I saw my role as providing support and 'critical friendship' to the paediatricians at the Countess who had the knowledge and data to take matters forwards professionally.
40. In 2015/2016 the external scrutiny bodies with whom concerns could be raised would be: NHS England including the Cheshire and Mersey Neonatal Operational Delivery Network and the Specialised Commissioner for Neonatal Care, Andrew Bibby, the Care Quality Commission, the Child Death Overview Panels, and in this context the police.

Safeguarding of babies in hospitals

41. I have undergone safeguarding training level 3 which included case studies such as Beverley Allitt. This is part of my mandatory training and is held as a face-to-face teaching session with the safeguarding team at Alder Hey. Cases were reviewed and discussed. Actions to take include discussing any concerns with line manager in the first instance.
42. I have not had specific assistance from my professional body – the General Medical Council to assist me with safeguarding guidance or advice in the context of suspicion or abuse by a member of staff towards babies.

Reflections

43. There has been at least one case at Alder Hey where covert video surveillance in association with the police has been used to convict a parent who was inducing illness in their child. If such measures had been employed as soon as concerns were raised about unexplained deaths it is possible that some of the crimes of Letby could have been prevented. I am unconvinced that routine video recordings would prevent such crimes as they could be worked around. Letby was an extremely rare case. Introduction of video monitoring of babies needs to be carefully thought through as there may be unintended consequences. For example, when I tried to introduce video recording into operating theatres there was significant staff push back – staff were concerned about being recorded making mistakes or their conversations overheard. On the positive side, I think that parents should have open access to their baby and that should include the ability to freely access neonatal units without having to request access. In addition, if parents are not able to be with their baby, they should be able to access an instant video feed.
44. I do not know enough about all the cases to know whether systems to monitor access to drug cupboards could have prevented deliberate harm. I think that these systems are useful for several reasons and can be helpful. However, I suspect that drug doses in small babies of sufficient magnitude to cause harm can be obtained from part used vials which would negate much of the positive aspect of using these systems. They are however useful in documenting who has withdrawn specific medication so narrow the zone of suspicion down.
45. Recommendations which may keep babies in NNUs safe from criminal actions of staff include strengthened governance and commissioning guidance with clear lines of responsibility when concerns are escalated beyond organizations. Although less than a decade ago, data is much more available, and all relevant audits should report benchmarked data in near real-time to assist in early warning. Within Trusts, quality leads should focus on detection of signals of concern and have clear line of escalation to Board level. Trusts should have clear lines of communication with police and policies to inform police as soon as any signals of possible concern are identified. Trust Board members should have a statutory duty to report allegations of criminality to the police at the start of any investigation and to inform the lead commissioners at ICB level. Similar arrangements and policies should exist within Integrated Care Boards and external bodies to permit escalation from ICB level. There are a number of Childrens Operational Delivery Networks – neonatal, congenital cardiac, paediatric critical care and surgery in children. They have national coverage. These networks have a key role in delivering population-based care and also in this context for monitoring outcomes and escalating concerns. However, they have no legal standing in the Health and Social Care Act and any executive actions fall to Specialised Commissioners. Consideration should be given

to giving Operational Delivery Networks legal status and formal governance and commissioning responsibilities. This would have the effect of creating far clearer lines of responsibility. Since 2015, Child Death Oversight Panels have been consolidated and I believe that this makes it easier for them to detect trends – they should also have access to benchmarked mortality data. Since 2019, the National Child Mortality Database has been collating neonatal mortality data and now this data is available at ICB level which may also assist in early identification. Again since 2015 hospitals have been required to appoint Medical Examiners and from 2024 all bereaved parents will be contacted by the Medical Examiner and case review will occur in non-coronial cases, Medical Examiners should receive additional training in the forensic aspects of case review to detect possible criminality and should also have access to benchmarked mortality data so that individual cases can be seen in a wider context. Mandatory safeguarding training curricula should be reviewed to include clear policies on actions to take if any staff members have concerns about possible criminality. Systems & policies should be in place to install covert video surveillance. Parents are the best guardians of their children and should have open access to the neonatal ward at all times and be issued with passes to allow free movement. Any new neonatal unit that is being built should be designed to allow parents to sleep by the cot (we have done this at Alder Hey since 2015). The role of video monitoring of babies and drug cabinet controls should be considered – as discussed above.

Any other matters

46. I recall having a conversation with Dr Camilla Kingdon, President of the Royal College of Paediatrics and Child Health after she had met with Drs Brearey and Jayaram in July 2023. As National Clinical Director for Children I had frequent telephone conversations and meetings with Dr Kingdon. The conversation was very similar to the narrative that I present in this statement, which was to note what I considered exemplary behaviour by the paediatricians at the Countess of Chester and the challenges that they had faced in their concerns being raised. We spoke about the need to support doctors and health professionals who find themselves in this position.
47. In my role as the Chair of the Women's and Children's Programme of Care in Specialised Commissioning I was responsible for approving the revised Service Specification for Neonatal Critical Care (Neonatal-critical-care-service-specification-March-2024.pdf (england.nhs.uk)) and the Neonatal Critical Care Clinical Network Specification (Neonatal Critical Care Clinical Network Specification (england.nhs.uk). These were approved in part in the context of Letby, but I would welcome review of these documents as part of this Inquiry.

48. I also have commissioning responsibilities on behalf of NHS England for the National Child Mortality Database which is funded by NHS England via the Healthcare Improvement Partnership. Again, I welcome review of the commissioning of this audit programme.
49. I have not given any interview or otherwise made any public comments about the actions of Letby or the matters of investigation by the Inquiry.

Any other matters

50. I have no additional documents to disclose.

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.

Sign Personal Data

Dated: 29th May 2024