3. In 2015-16 I was a consultant general Paediatrician at the COCH NHS Foundation Trust Hospital with special interests in epilepsy and childhood disability. My duties covered general Paediatrics (inpatients and outpatients) and Neonatology (inpatient and outpatient), as well as holding clinics for children with disability and those with epilepsy. I held no additional managerial position during that period although I had been the Paediatric lead clinician between 2000 - 2004 and the Paediatric Clinical Director between 2004 - 2009.

4. I retired from full-time medical practice in June 2019 but returned part-time for 2 months pending my successor taking up her post. In 2020 I worked as a volunteer Paediatric clinical advisor to the NHS 111 service during the COVID pandemic but I have not undertaken clinical work since then. I relinquished my GMC registration on 02/09/20.

PART 2: GENERAL ISSUES

Organisation of the Neonatal Unit and Paediatric Department (including the managerial structure and how morbidity and mortality on the NNU was considered)

5. The neonatal unit (NNU) formed part of the Paediatric Department, which comprised the NNU, a Paediatric inpatient ward for patients up to 16 years of age, a Paediatric outpatient clinic providing clinics for children and young people up to 16 years of age, including clinics for babies who had been on the NNU and required hospital clinic review. Between June 2015 and June 2016, the NNU was designated a level 2 unit and provided care for babies over 27 weeks gestation, including short-term ventilation support. There were three intensive care cots, three high dependency cots, 10 special care cots on the NNU plus four transitional care cots on the maternity ward (for babies remaining with their mothers but requiring some neonatal nurse support).

6. All of the Paediatric doctors (consultants and trainee doctors – the latter also being known as 'junior' doctors) worked on the neonatal unit and the Paediatric ward, although only the consultants and more experienced trainee doctors (also known as Registrars), held clinics in the Paediatric outpatients. Nursing staff worked exclusively on either the Paediatric ward, or on the NNU, or in Paediatric outpatients.

7. The Paediatric ward included a Paediatric assessment unit where patients referred from General Practitioners (GPs), or from the Emergency Department (ED), were assessed with some being discharged the same day and others being transferred to a bed on the ward for more prolonged assessment and treatment. Intermittently (perhaps roughly once in two weeks), one or more Paediatric doctors would be asked to attend the ED to assist in assessing and treating seriously ill children and young people. If the ED was particularly busy and patients were waiting many hours to be assessed, Paediatric doctors would be asked to assess patients up to 16 years of age in the ED, but would only do so if not pre-occupied with work in the Paediatric department.

8. There were broadly two types of managers within the hospital: clinical managers and administrative managers. First, I shall discuss the clinical managers. Clinical managers had some managerial responsibilities but also maintained a clinical role with the exception of the two most senior clinical managers in the hospital, the Medical Director (Ian Harvey) and the Director of Nursing (Alison Kelly) who rarely, if ever, undertook direct clinical care of patients due to their heavy managerial responsibilities although they had extensive previous experience of providing patient care. At a departmental level, there was a nurse manager on the Paediatric ward, Sister Anne Martyn (after 2016 her surname changed to McGladden), who also covered the outpatients, and a separate nurse manager on the NNU, Sister Eirian Powell.

9. These departmental nurse managers sometimes assisted in the care of patients, and had considerable previous experience of doing so, although most of their time was occupied with managerial responsibilities, as far as I was aware. There was also a lead nurse for children's services, who in 2015-16 was Sister Ann Murphy, who offered support to the two nurse ward managers and ensured children's nursing guidelines, as well as child safeguarding procedures, were followed in all specialties outside Paediatrics and Neonatology that also dealt with some patients under 16 years of age (this particularly applied to the ED and to certain surgical specialties such as ENT, Ophthalmology and Orthopaedics).

10. The departmental clinical manager was the lead clinician in Paediatrics, who in 2015-16 was Dr Ravi Jayaram. His managerial role was to represent Paediatric doctors within the management structure of the hospital. This required Dr Jayaram to attend

management meetings within the hospital, meet weekly with our departmental administrative managers, attend a Clinical Governance meeting with our Obstetric colleagues every 1-2 months, and to represent our department at meetings outside the hospital concerned with the provision of Paediatric services. In 2015-16, and for several years either side, Dr Jayaram was heavily involved in discussions about possible re-organisation of the Paediatric and Maternity services under the regional Sustainability and Transformation Plan. Alongside these managerial duties, Dr Jayaram maintained the same clinical responsibilities and workload as the rest of us Paediatric consultants.

11. In 2015-16 Dr Stephen Brearey was the consultant neonatal lead for our department. This was more of an additional clinical role, rather than a managerial role, that Dr Brearey undertook alongside the same clinical responsibilities as the rest of us consultant Paediatricians. This role involved attending meetings of the regional neonatal network, ensuring NNU medical guidelines and policies were updated and that new ones were introduced (although all consultants contributed to producing and updating guidelines), and attending monthly meetings with the Paediatric and neonatal risk and patient safety facilitator and NNU nurse manager (or her deputy). These regular meetings were known as 'risk management meetings' or sometimes 'neonatal clinical incident group' meetings because clinical incidents were reviewed. A death would be reviewed as a serious clinical incident. Non-fatal unexpected collapses would only be reviewed if reported as clinical incidents. These monthly meetings were arranged around the availability of Dr Brearey, the NNU nurse manager and the patient risk and safety facilitator.

12. Prior to the NNU risk management meetings, Dr Brearey undertook a mortality review of any recent death by reviewing the nursing and medical records (often the NNU nurse manager assisted him), sometimes in discussion with the responsible consultant for that baby. In addition to reviewing recent deaths, these meetings reviewed clinical incidents that nursing and medical staff had reported where procedures or practices had not been followed correctly either due to human error or problems with equipment or other resources. Some harm might have occurred to a patient because of a clinical incident but more often no actual harm had occurred. When available, other Paediatric consultants could attend these risk management meetings. Although summaries of these meetings were not circulated to all consultant Paediatricians, any lessons learnt

that ought to influence future clinical practice were discussed by Dr Brearey informally amongst the consultant Paediatricians and also formally when neonatal deaths were discussed at Neonatal Mortality review meetings or the Maternal and Neonatal (sometimes called the Perinatal) Morbidity and Mortality review meetings. I received copies of some of the individual mortality summaries from Dr Brearey prior to attending the hospital's internal investigation of NNU deaths in July 2016 which I exhibit as **Exhibit JMG1**. **[INQ0102739, pp. 1-17]**

13. Every 1-2 months a Maternal and Neonatal morbidity and mortality meeting (sometimes referred to as a perinatal meeting), would be held attended by all available Paediatricians (consultants and trainees), Obstetricians, midwives and neonatal nurses, at which neonatal deaths or unusual neonatal cases were discussed, as well as stillbirths or unusual maternity cases and any rare maternal deaths related to pregnancy or childbirth. Due to the number of NNU deaths in 2015-16, and the limited time to discuss all of these during the 1-2 monthly Maternal and Neonatal meetings, it was necessary to arrange several Neonatal Mortality meetings that were only attended by the Paediatric doctors (consultants and trainees), and some neonatal nurses.

14. Dr Brearey, like us other consultant Paediatricians, also informally discussed various clinical matters and concerns at any time of the week with the rest of us consultant Paediatricians in our offices (we all shared offices along the same corridor), or in the adjacent corridor. These conversations could be held individually or in groups, although were not documented. Whilst the departmental nurse manager posts were permanent positions, the lead clinician in Paediatrics and the lead consultant for Neonatology roles were held by one of the consultant Paediatricians for several years (there was no fixed duration for these roles). Most of the consultants in the department would have the opportunity to undertake these roles at some stage during their consultant career. The professional and personal relationships between all the consultant Paediatricians was very good as were the relationships the consultants had with our nursing colleagues, particularly the nurse managers within the department.

15. In 2015-16, Dr Jayaram was our Paediatric department lead clinician and represented our department (including the NNU), within the hospital managerial structure and at meetings requiring a Paediatric representative outside the hospital (for example with the Primary Care Trust or committees planning integrated healthcare across Cheshire

and Merseyside). Dr Brearey took main responsibility for procedures and practices on the NNU and was supported by, and liaised regularly with, the rest of us consultant Paediatricians. All of the paediatric consultants were responsible for patient care and safety on the NNU, and in the rest of the Paediatric department, when we were the consultant of the week or the on-call consultant out of hours. The consultant Paediatricians, with senior nursing colleagues and managers, were also responsible for ensuring that policies and practices within the department promoted patient safety.

16. The second type of manager within the hospital, I refer to as administrative managers. The most senior of them was the Chief Executive Officer who in 2015-16 was Mr Tony Chambers. Other senior administrative managers were the Finance Director and various senior managers whose titles regularly changed and who were responsible for the operational running of the clinical services and of the estate functions of the hospital. These senior administrative managers collaborated with clinical managers with the two most senior clinical managers, the Medical Director and the Director of Nursing, working most closely with the other senior executive administrative managers.

17. A few years prior to 2015, the management structure of the hospital was re-organised. Previously, clinical services were divided into 3 directorates: Medicine, Surgery and Women & Children. Each directorate had a directorate administrative manager plus one or more assistant managers, a Clinical Director (a consultant doctor with some managerial responsibilities), and a Directorate nurse manager. A few years prior to 2015, this structure was changed and the clinical specialties were divided into two divisions: Urgent Care and Planned Care. Essentially this involved the creation of a Medical and Surgical division on the basis that the former had a higher proportion of urgent admissions and the latter had a greater proportion of planned admissions (although most specialties, whether medical or surgical, managed both types of admission and also catered for both urgent and planned outpatient attendances). .

18. An unfortunate consequence of creating two divisions of clinical specialties was that Paediatrics (including Neonatology), was placed in a separate division to Obstetrics. These two specialties work closely together since Obstetricians and midwives are responsible for the care of a mother and her baby prior to birth and Paediatricians are responsible for the care of the baby after birth. Complications with a pregnancy often impact the care of a baby after birth and issues arising in a baby after birth may have

implications should the mother have future pregnancies. To mitigate this administrative division, the departmental Paediatric manager and her assistant also provided administrative managerial support to the Obstetric department. Also, the Paediatric lead clinician and the lead nurse for children's services continued to meet Obstetric colleagues at the 1-2 monthly Clinical Governance meetings and the Paediatric and neonatal risk and patient safety facilitator was also the risk and patient safety facilitator for Obstetrics.

19. The consultant Paediatricians and the ward manager, or sometimes another senior nurse from the Paediatric ward and from the NNU met, usually with a departmental manager for an hour each Monday lunchtime for an informal discussion about the working of the department. We referred to these meetings as 'senior Paediatrician' meetings although, as described, these were not limited to Paediatricians. The senior Paediatrician meetings were not minuted although, as the Paediatric lead clinician, Dr Jayaram generally listed the topics discussed and circulated this list by email around the consultant Paediatricians (although I did not save those emails).

20. One of the Monday monthly meetings was a more formal departmental meeting. Minutes were taken by a departmental secretary and circulated to attendees afterwards. This monthly meeting was attended by consultant Paediatricians, sometimes a middle grade Paediatrician (to gain experience), the departmental nurse managers (or their deputies), departmental administrative managers, a finance advisor, an Information Technology (IT) specialist, several children's nurses with specialist roles, and the departmental pharmacist.

21. The monthly departmental meeting was chaired by the lead clinician in Paediatrics, Dr Jayaram, and usually began with the finance advisor and the IT specialist for the department presenting information about monthly patient activity levels and associated finances. After discussing these presentations, Dr Jayaram provided information about any relevant initiatives within the department or health region, then the nurse managers and consultants were invited to raise items for discussion. This meeting did not discuss patient morbidity or mortality which was covered in separate meetings (which, for the NNU, comprised the monthly NNU risk management meetings and the 1-2 monthly Maternal and Neonatal morbidity and mortality review meetings, or occasional Neonatal mortality review meetings, as previously described).

Paediatric medical staffing and cover within the department

22. I was one of seven consultant general Paediatricians working at COCH from June 2015 to June 2016. As part of our general Paediatric training, all of us consultants were also trained in Neonatology (the management of newborn babies), and we all provided consultant support to the NNU. Each of us had additional special interests in Paediatrics (mine are described in paragraph 3, other colleagues had special interests in respiratory medicine, cardiology, diabetes, medical education, rheumatology, and psychological medicine). The other 6 consultant Paediatricians were Drs Jayaram, Brearey, Saladi Doctor AJ, Doctor ZA and Newby. Dr Newby left during that year to be replaced by Dr Holt.

23. The provision of medical cover in the Paediatric department, at consultant and trainee doctor level, was similar to other medium-sized district general hospitals that included a level 2 NNU. However, some comparable departments had more consultants and by 2015 we had wanted to increase the number of consultants in order to provide two consultants of the week, one covering the Paediatric ward and the other the NNU. Despite this desire to increase consultant numbers, I think it was not until 2016 that a formal business case to increase to nine consultant Paediatricians was presented within the Urgent care division which was approved, I believe during 2016, and the additional consultants were appointed in 2017.

24. Consultant cover for the NNU was provided on weekdays by the consultant of the week with each Paediatric consultant undertaking this role once every seven weeks. The consultant of the week duty began on a Monday morning and this consultant was responsible for the medical care of patients on the Paediatric ward and NNU from 08:30 to 16:30 each weekday. An on-call consultant was responsible for patient care from around 16:30 (but sometimes up to an hour later if completing an afternoon clinic with the consultant of the week covering in the meantime), until 08:30 the next morning. At weekends, the on-call consultant was responsible for patient care on the Paediatric ward and NNU for 24 hours at a time. The consultant of the week undertook the role of on-call consultant on a Friday night and for 24 hours on a Sunday, and the other consultants took it in turn to be the on-call consultant overnight on weekdays (usually

only once each week, unless several consultants were away), with one of them being the on-call consultant for 24 hours on a Saturday.

25. In 2015-16 the complement of 'junior' (non-consultant) trainee doctors assigned to the Paediatric department comprised seven Tier 2 trainee doctors who had undertaken two years of basic (called Foundation) training in general medicine and surgery followed by between two and seven years of training in Paediatrics. Tier 2 doctors were also known as middle grade doctors and were formerly called, and sometimes still referred to as, registrars. There were also nine Tier 1 doctors, two being Paediatric trainees (doctors who had undergone up to 2 years of training in Paediatrics after their Foundation training), six were trainees with a similar duration of previous training who intended to become GPs and were gaining experience in Paediatrics for 6 months, and a Foundation year doctor. One additional Foundation doctor worked in the department but undertook on-call duties as part of the adult medical rota rather than within the Paediatric department.

26. Most trainee doctors joined our department for between six and 12 months, although some of the GP or Foundation trainees only worked with us for four months. We were not always able to fill all of the trainee posts, which was a problem shared with other hospitals given that trainee posts were recruited regionally. Intermittently during 2015-16, and continuing afterwards, the consultant Paediatricians took turns to 'act down' and cover vacant middle grade posts on-call, with another consultant being the consultant on-call, which added to our on-call workload. I believe many other district hospital Paediatric consultants had to likewise intermittently cover the middle grade rota.

27. The medical working day started at 08:30 with a 30 minute patient 'handover' session where the consultant of the week and the trainee Paediatric doctors discussed all the patients on the Paediatric ward then those on the NNU. The middle grade and Tier 1 trainee doctors who had been on duty overnight presented each patient guided by a printed list, distributed to all those at the handover, that gave each patient's name, diagnosis and/or problem list, results of important investigations and those needing to be undertaken, plus any other actions that were required. Nurses did not usually attend these doctor-run patient handover sessions but held their own patient handover

session, separately on the Paediatric ward and on the NNU, about an hour earlier when their daytime shift began.

28. Following the morning handover, the consultant of the week would undertake a ward round on the Paediatric ward, sometimes with a middle grade Paediatrician and usually with several less experienced trainee Paediatric doctors, whilst one (sometimes two), middle grade Paediatricians led ward rounds on the NNU, accompanied by several of the less experienced trainee doctors. At the end of the Paediatric ward round, the consultant and trainee doctors who had conducted that round would join the nurse in charge that day on Paediatric ward to discuss each patient. Following this discussion, the consultant Paediatrician then attended the NNU to sit with the trainee doctors who had undertaken the NNU ward round, and the neonatal nurse in charge that day, to discuss each neonatal patient (or if the NNU round hadn't finished, the consultant would help complete that round before discussing patients with the trainee Paediatricians and nurse in charge). The consultant would usually then see any neonatal patient about whom there were particular concerns.

29. On Wednesdays and Sundays, this same pattern of ward rounds occurred except the consultant of the week began by leading the ward round on the NNU, with the middle grade Paediatricians conducting the ward round on the Paediatric ward. If there was a patient causing marked concerns either on the Paediatric ward, the NNU or occasionally in the ED, this patient would be seen before commencing the ward rounds or, depending on the urgency, before starting the handover session. During the rest of the day, the consultant would see patients about whom trainee doctors or nurses had concerns on the Paediatric ward or NNU.

30. On two lunchtimes each week, the consultant of the week held a short outpatient clinic where up to three patients referred urgently by Family doctors would be seen. The consultants who were not the consultant of the week held outpatient clinics and undertook administrative and training duties, as well as participating in the on-call rota overnight.

31. In 2015-16 the on-call consultant overnight would usually leave the hospital around 6 pm if there were no special concerns about patients on the Paediatric ward or NNU (although some consultants stayed later in their offices to complete administrative work, such as checking on patient results and organising investigations as well as

completing clinic letter dictation). The consultant overnight would routinely phone the middle grade Paediatrician on-call at 22:30 to receive a report on the Paediatric ward and NNU patients, although stable patients were not discussed.

32. At any time during the evening or night the middle grade doctor on-call could phone the consultant on-call for advice or to ask the consultant to attend to review a patient (although sometimes the consultant might decide to attend to review a patient when only asked for advice). If the middle grade Paediatrician on-call was pre-occupied helping to manage a seriously ill patient, then the Tier 1 doctor, any of the nurses, midwives or sometimes the hospital telephonists would phone the on-call consultant to request that consultant's urgent attendance from home.

33. From 17:00 until 21:00 (at which time there was a further handover session between the trainee doctors on duty), there was one middle grade doctor and two Tier 1 doctors on duty, in addition to the on-call consultant. Each Tier 1 doctor worked either on the Paediatric ward or the NNU although both could work on the same side temporarily depending on the relative workloads in the two areas. These doctors provided medical support to the Paediatric ward, NNU and occasionally attended the ED when requested.

34. Cover for the NNU included attending high risk deliveries on the labour ward and responding to any concerns about babies on the postnatal ward (and, during the daytime, all newborn babies were routinely examined either by a trainee doctor or specially trained midwife). Between 21:00 and 09:00, one middle grade and one Tier 1 doctor would be resident in the hospital covering the Paediatric ward and NNU, supported by the on-call consultant Paediatrician at home (but available to attend the hospital to assist in assessing and treating patients when necessary). The weekday on-call Paediatric cover between 17:00 and 21:00 applied from 08:30 to 21:00 at weekends, with the same cover overnight as on weekday nights.

35. The consultant Paediatrician worked a 1 in 7 on-call rota and would undertake a normal working day before and after having been on-call overnight. The trainee doctors worked shifts and so either worked during the day or the night with periods of night shifts occurring every few weeks and lasting for 3 or 4 consecutive nights. On a weekday there would be one middle grade and two Tier 1 doctors off duty because they were working the night shift. On the day before a new period of night shifts, the

number of trainee doctors off duty would double as one overnight team was completing a final shift and another team was about to start a period of nights. The complement of junior doctors would often be further depleted due to study leave and annual leave. This meant that typically on a weekday there would be one (occasionally two) middle grade doctors, and two Tier 1 doctors working on the NNU and the same number on the Paediatric ward with a middle grade doctor assisting in clinic and another working in the community (as part of the Community Paediatric team).

The culture and atmosphere on the NNU in 2015-2016 and changes after June 2016.

36. I do not believe that the administrative re-organisation that placed Paediatrics and Obstetrics into separate Divisions affected the general running of the NNU, nor compromised identifying concerns over neonatal deaths and collapses at a Paediatric departmental level. However, I feel that bringing these concerns to the attention of more senior medical clinical managers was initially more difficult than would have been the case when there had been a Women and Children directorate with its own Clinical Director. Previously, the Clinical Director for Women and Children met other senior managers at the hospital Board Management meetings as well as regularly meeting the Medical Director alongside the other Clinical Directors.

37. Once the two divisions were created, there was no longer a Paediatric Clinical Director and instead the lead clinician in Paediatrics liaised with the managers in the Urgent Care division but it was my impression that this relationship was relatively remote and the Paediatric lead clinician no longer met regularly with the Medical Director. Even so, once both the Medical Director, as well as the Director of Nursing, became aware of concern about deaths on the NNU, I do not think that the divisional administrative structure affected how these concerns were then managed.

38. The relationship between Paediatric consultants and neonatal nurses was good in 2015-16. The NNU was busy at that time but in my experience the NNU had been as busy or busier in earlier years but not for several years leading up to 2015-16. Staffing levels were below that recommended, by the RCPCH and the British Association of

Perinatal Medicine, on both the nursing and medical side although this had been longstanding and applied to many other NNUs. The increased number of deaths and collapses on the NNU caused stress amongst neonatal nurses and consultant Paediatricians (as well as the trainee Paediatricians) during 2015-16. After June 2016, the number of cots on the NNU was reduced and the gestational age for admission to the NNU was raised, with the result that staffing levels immediately improved and the workload reduced.

39. Despite the reduced workload, I detected a somewhat tense atmosphere between us consultant Paediatricians and our neonatal nursing colleagues which I assumed was due to the possibility of deliberate patient harm having been raised by us consultants. However, the neonatal nurses remained courteous and professional. I occasionally witnessed neonatal nurses crying, away from the patient area, because of the possibility that a colleague might have harmed patients. I do not believe that this staff distress adversely affected the quality of care on the NNU, nor that parents of babies on the NNU were aware of the unhappiness amongst the staff.

40. Although concern over possible deliberate patient had been raised amongst us consultant Paediatricians in 2015-16, I did not feel it appropriate to discuss these concerns with nursing colleagues on the NNU because these were instead being raised (with the agreement of all of us consultants), by Dr Brearey with the NNU nurse manager and senior hospital managers. After June 2016, I consciously refrained from discussing the possibility of deliberate patient harm with neonatal nursing colleagues in view of the various investigations in progress beginning with the hospital's internal investigation, then the RCPCH and Hawdon reviews and, finally, the police investigation.

Safeguarding, procedures following the death of a baby, and 'speaking up'

41. I received training in child protection as a trainee doctor in Paediatrics. I attended annual update safeguarding training sessions given by the Children and Young People's safeguarding team at COCH (which I think began sometime between 2000 and 2010), and I read the reports about serious safeguarding failures involving Victoria Climbie and Peter Connelly. This training was orientated towards recognising and investigating child abuse either in children presenting to hospital, or suspected within a