Witness Name: Neena Modi
Statement No.: [XXXX]
Exhibits: [XXXX]
Dated: 08-07-2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF NEENA MODI

I, Neena Modi, will say as follows:

1 Personal details

1.1 I am a clinical academic, Professor Neonatal Medicine at Imperial College London and Honorary Consultant at Chelsea and Westminster NHS Foundation Trust. I am Vice-Dean (International), Faculty of Medicine, Imperial College London and Non-Executive Director, Chelsea and Westminster NHS Foundation Trust and Imperial NHS Trust. I lead a multidisciplinary neonatal medicine research group focussed on improving the health and life-long wellbeing of infants born preterm or sick. I have published over 350 peer reviewed original research papers, chapters in textbooks, reports, and other publications. My academic roles include leadership of the UK National Neonatal Research Database (NNRD), International Neonatal Research Database (eNewborn), and the current National Institute for Health Research, Imperial Biomedical Research Centre "*Pregnancy and Prematurity*" theme. I have held several professional leadership roles. I am president-elect of the European Association of Perinatal Medicine, and past president of the Neonatal Society (2012-2015), Academic Paediatrics Association of Great Britain and Ireland (2014-2015), UK Royal College of Paediatrics and Child Health (2015-2018), UK Medical Women's Federation (2020-2021) and British Medical Association (2021-2022).

1.2 I qualified in medicine from the University of Edinburgh in 1976. I hold the following professional degrees: MB; ChB; MD; FRCP; FRCPCH; FFPM; FMedSci. I am a Fellow of the Royal College of Physicians (London), Fellow of the Royal College of Paediatrics and Child Health, and Fellow of the Academy of Medical Sciences. I am a member of the British Medical Association. I specialised in neonatal medicine. Following training positions in NHS hospitals in Edinburgh (Royal Infirmary; City; Western General; Royal Hospital for Sick Children), London (University College), and Liverpool (Liverpool Maternity; Alder Hey) I was appointed Senior Lecturer/Consultant in Neonatal Medicine at the Royal Postgraduate Medicine School (Hammersmith Hospital and Queen Charlotte's and Chelsea Hospital) in 1987. The Royal Postgraduate Medical School was subsequently incorporated into Imperial College London. I

moved to Chelsea and Westminster Hospital in 2003 as honorary consultant, with my primary appointment remaining with Imperial College London.

2 Royal College of Paediatrics and Child Health president's role

2.1 I was elected president of the Royal College of Paediatrics and Child Health by membership ballot and served in this role from April 2015 to March 2018. The role of the president is to provide professional leadership. The president is chair of Council, supervises vice-president portfolios in education, training, health services and research, and fronts the profession's responses to the principal issues of the day. Examples of my contributions during my tenure as president include overseeing creation of a new independent Board of Trustees, consulting with the membership to strengthen policies on the issue of RCPCH interactions with industry, initiating a major study, the "*State of Child Health in the UK*", and providing professional leadership to trainees during a challenging period of disputed contract negotiations with Government.

3 RCPCH Invited Review Service

3.1 The RCPCH has an "invited review service". The nature of this service is set out in "The Guide to Invited Reviews (August 2016) [INQ0010214]". In brief, the term "Invited reviews" included responding to a request by a healthcare organisation to consider concerns about an individual's clinical practice, incidents requiring a clinical investigation, patient safety concerns, workload, skill-mix and job planning issues, service delivery, and service reconfiguration.

3.2 As president, I had no role in the Invited Review service. The service was confidential, and the outcomes of reviews were not made known to me nor circulated within the RCPCH. During my tenure as president, there was no formal procedure for escalation by the Review Team to the president or other officer. The Invited Reviews Manager (Sue Eardley) reported to the Divisional Director (Jacqueline Fitzgerald) who in turn reported to the RCPCH CEO (Judith Ellis).

4 Countess of Chester Invited Review

4.1 I believe I must have become first aware of the Countess of Chester invited review in 2016. I was not involved in any aspect of the review, nor did I see the final report until it was provided to me by the Inquiry's solicitors. From memory, the only person to ever mention the Countess of Chester review to me personally was RCPCH CEO, Professor Judith Ellis. My recollection of conversations with Judith was that these raised no alarms, was "*for information*" and left me with the impression that everything was being done appropriately.

To my best recollection, I did not discuss the review with any other member of staff, nor was I aware of the concerns raised by the paediatricians at the Countess of Chester during the review as to potential foul play/criminality in respect of neonatal mortality and their request for police involvement. I do not recall any discussion at RCPCH Council on 27.10.16 about the Countess of Chester Invited Reviews. Also, to my best recollection, I did not at any time receive a formal debrief on the Countess of Chester review, nor did I see the closeout internal form dated 24.01.17 [INQ0010172] that was prepared following the review. It was not standard practice for the president to receive any such debriefs or closeout forms.

4.2 With hindsight, and upon reading the RCPCH Countess of Chester Report as provided to me by the Inquiry's solicitors, it is my opinion that the RCPCH Invited Review Team should have sought advice from the RCPCH registrar about the advisability of continuing with the Review. Also with hindsight, it is my opinion that the Invited Reviews programme should have had a process for escalation of problematic issues.

5 Communications with Dr Stephen Brearey

5.1 On 06.02.18 my personal assistant at the RCPCH passed an email to me from Dr Stephen Brearey, dated 05.02.18 [INQ0017466], stating that he felt the Countess of Chester paediatricians and affected parents could have been supported by the RCPCH "*in a more positive way*". I believe this was the first communication to me directly from the Countess of Chester regarding the RCPCH Review. I immediately emailed the Invited Reviews manager, Sue Eardley, asking for her comments [INQ0012746_0002]. She replied later that day (06.02.18 at 11.57) [INQ0012746_0001], explaining the review was confidential, expressing disappointment that Dr Brearey had not contacted her before writing to me, and stating "… *we do not I would suggest have an obligation to support them beyond providing an independent review of the service and their concerns*". Judith Ellis wrote the same day (06.02.18 at 19.40) to Sue Eardley and Jacqueline Fitzgerald asking then to provide me with factual details. Sue Eardley responded to Judith Ellis and Jacqueline Fitzgerald (06.02.18 at 21.55) with a lengthy suggested response, and again on 07.02.18 at 1802 with a shorter suggestion; I was not copied into these emails. Judith Ellis replied to Sue Eardley on 08.02.18 at 10.01, saying she would run it past me. Presumably following this discussion with Judith Ellis, I emailed Dr Brearey on 08.02.18 at 18.00 [INQ0017466_0002] asking "*Did you have something specific in mind when you referred to "supported by the college in a more positive way*"? He replied on 08.02.18 at 18:58 [INQ0017466_0001] as consequence of which I emailed Judith Ellis and RCPCH Registrar Mike Linney (08.02.2018 at 19:28) saying "…*there is clearly a real problem here, a cry for help which we cannot ignore. Who led our review? Might we discuss please*". On 09.02.18 at 15:00 [INQ0012734_0001] Judith Ellis emailed RCPCH staff Melissa Milner,

Jacqueline Fitzgerald, Graham Sleight, David Howley and Sue Eardley, and RCPCH registrar Dr Mike Linney, copying me, in which she set out a series of actions and stating "*Neena has today spoken to Stephen Brearey in Chester*". I presume, given the comment by Judith Ellis, that I did have a phone call with Stephen Brearey, but I have no recollection of this. I did however write to Stephen Brearey on 20.02.18 [INQ0017465] advising "… *you and your colleagues to seek assistance with reconciliation. We suggest you write to the Chair of the Trust Board of Directors and the Lead Governor, copied to Professor Ted Baker, CQC, Chief Inspector of Hospitals, and if you wish, to the RCPCH Registrar, summarising your concerns about the senior leadership of the Trust and the distressing impact that their past and ongoing actions are having on the morale of staff*". I do not recall any further communications with Dr Brearey. I demitted office on 14.03.18 and had no further knowledge of the review of the RCPCH Invited Reviews process.

5.2 To my best recollection, I did not have any direct discussion with Sue Eardley about her proposed replies to Dr Brearey's email nor any other aspect of the Invited Review. I do not recall ever having a discussion with the Review Team lead, Dr David Milligan, nor with Jacqueline Fitzgerald or Graham Sleight. My discussions were with CEO, Professor Judith Ellis. I did not agree with Sue Eardley's comment "… *we do not I would suggest have an obligation to support [the paediatric team] beyond providing an independent review of the service and their concerns*". I presume that this view was reinforced when I received Stephen Brearey's second email and why I used the phrase "*there is clearly a real problem here, a cry for help which we cannot ignore*".

6 Other matters

The Rule 9 letter invites me to include in my statement other matters that I consider relevant to the Inquiry's Terms of Refence. I refer to Section C, paragraph 29 of the Terms of Reference (*What changes should be made to improving the quality of care and safety of babies; what further changes should be made to the current structures, culture or professional regulation to improve the quality of care and safety?*). It is my opinion, based on my experience of having worked in neonatal intensive care in tertiary referral centres for almost 40 years that plausible alternative explanations exist for certain of the deaths and sudden deteriorations of the babies at the Countess of Chester, but the cases were not investigated adequately at the time and subsequently, and this may have had an impact on the exploration of causality during the trial. The care and safety of babies would be improved if steps were taken to ensure that neonatal teams and all others involved, are aware of approaches to investigating unexpected occurrences, and that specialists who are not only appropriately qualified, but also appropriately experienced, are consulted by all parties.

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 of its truth.

PD

Signed:

Dated: July 8th, 2024