Witness Name: [XXXX]
Statement No.: 02
Exhibits: [XXXX]
Dated: 13 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Dr Joanna Garstang

I, Dr Joanna Garstang, will say as follows: -

Professional Background

1. I have detailed my professional background in my first statement dated 20 March 2024.

2. Background information on NHS Safeguarding and Accountability Frameworks and Child Death Review.

2.1. My comments on the NHS Safeguarding and Accountability Frameworks (SAAF) are based on the perspective of Child Death Review (CDR), as this is my area of expertise. The majority of the NHS SAAF relates to child and adult safeguarding, and I do not consider myself the appropriate expert to address the NHS SAAF suitability for safeguarding.

2.2. CDR is a holistic process, considering full causes of death, modifiable factors, learning and support for families. CDR is also an important element of safeguarding, in that it requires the rapid multi-agency investigation of all sudden, unexpected deaths, so that any safeguarding issues can be discussed urgently with police and social care as a matter of routine. These multi-agency investigations commence at the time of death so enable prompt gathering of evidence and accounts from professionals and families.

2.3. CDR requires that all child deaths, including those considered to be expected and medically explained, are also independently scrutinised by multi-agency Child Death

Overview Panels (CDOP); this is a further opportunity to identify safeguarding concerns although this will be some months after the death.

2.4. These CDR processes were statutory at the time of the events at Countess of Chester (HM Government, 2013), although the guidance has since been updated (HM Government, 2018).

2.5. I have considered the 2019 NHS Safeguarding and Accountability Framework (SAAF) (NHS England and NHS Improvement, 2019) [INQ0014715]. It states in section 2.1 'The purpose of this document is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations.' As such, it does not set out new policies or priorities but details the accountability and assurance framework for safeguarding within the NHS.

2.6. CDR has been detailed in Working Together to Safeguard Children since 2006; (Working Together is the comprehensive multi-agency statutory guidance for safeguarding children). The legal basis for both child safeguarding and CDR are in the Children Act (2004). It should follow that the NHS SAAF includes CDR, as an integral part of child safeguarding, even though the majority of child deaths relate to underlying health issues and not safeguarding.

2.7. The NHS SAAF therefore should be the accountability process for the Child Death Review (CDR) Statutory and Operational Guidance (HM Government, 2018) and Working Together (HM Government, 2023).

3. Previous versions of NHS Safeguarding and Accountability Frameworks

3.1. Previous versions of the NHS SAAF include: Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework (NHS Commissioning Board, 2013) and Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (NHS England, 2015). As in the 2019 NHS SAAF, these

documents do not set out new policies or priorities but details the accountability and assurance framework for safeguarding within the NHS.

2013 NHS Safeguarding and Accountability Framework

3.2. The majority of the 2013 NHS SAAF relates to safeguarding rather than CDR. On page 11 it details that "Both CCGs (Clinical Commissioning Groups) and the NHS CB (NHS Commissioning Board – now NHS England) are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This includes specific responsibilities for looked after children and for supporting the Child Death Overview process, to include sudden unexpected death in childhood.'

3.3. On page 12, it states that the CCG is responsible for securing the expertise of a designated paediatrician for unexpected death in childhood.

3.4. Other than the brief mention of CDOP and designated paediatrician as detailed above; there is almost no mention of CDOP or Sudden Unexpected Death in Childhood (SUDIC) in the 2013 NHS SAAF. The vast majority of the document refers only to safeguarding and it is not clear if CDOP or SUDIC is included in this or not. For example, on page 16 it refers to the NHS CB 'clinical lead for safeguarding' and on page 32 NHS CB 'Provides specialist safeguarding advice to the NHS'. In reality, these clinical leadership roles and specialist advice only relate to safeguarding. At present, there is still no clinical CDR leadership and specialist CDR advice available from NHS England.

3.5. In 2013, Child Death Overview Panels (CDOP) were a sub-committee of Local Child Safeguarding Practice Boards (LSCB). There was therefore oversight of CDOPs by LSCBs; however, on page 20 of the 2013 NHS SAAF it states 'Each Board partner retains their own existing line of accountability for safeguarding.' This would suggest that the NHS was accountable for the NHS elements of CDOP and SUDIC.

3.6. The limited reference to CDOP and SUDIC in the 2013 NHS SAAF is concerning and confusing. This could be interpreted as the NHS SAAF did not apply to CDOP and SUDIC apart from the two specific details listed above, or they were considered as core elements of child safeguarding so did not require listing separately.

2015 NHS Safeguarding and Accountability Framework

3.7. There are only two mentions of CDOP or SUDIC in the 2015 NHS SAAF. The first is on page 18, where Child Death Review (CDR) is listed as a statutory review. It further states that 'All NHS agencies and organisations that are asked to participate in a statutory review must do so. The input and involvement required will be discussed and agreed in the terms of reference for the review but broadly this will involve meeting regularly with colleagues and attending panels or review group meetings throughout the investigative phase. Health commissioners will provide a panel member, provide oversight of health involvement at panel meetings, ensure that recommendations and actions are achievable, and disseminate learning across the NHS locally'. This could imply that NHS organisations must participate in CDR but not they do not have responsibility for leadership.

3.8. The second mention is on page 21, referring to employing or securing the expertise of a designated paediatrician for unexpected deaths in childhood.

3.9. The limited reference to CDOP and SUDIC in the 2015 NHS SAAF is concerning and confusing. This could be interpreted as the NHS SAAF did not apply to CDOP and SUDIC apart from the two specific details listed above, or they were considered as core elements of child safeguarding so did not require listing separately.

2019 NHS Safeguarding and Accountability Framework

3.10. The 2019 NHS SAAF was published after the Child Death Review Statutory and Operational Guidance (HM Government, 2018). The responsibility for CDR had been transferred to the Department of Health and Social Care from the Department

for Education, so this document should have been clear on the accountability for CDR, or another accountability framework for CDR published. However, similar to the 2013 and 2015 NHS SAAF, CDR gets few mentions.

3.11. On page 7, the 2019 NHS SAAF lists relevant legislation and statutory guidance. The CDR statutory guidance is omitted.

3.12. On page 15, the 2019 NHS SAAF refers to the Designated Paediatrician for Sudden Unexpected Deaths in Childhood (SUDIC); this term was now outdated having been replaced by Designated Doctor for Child Death in the 2018 CDR statutory guidance.

3.13. On page 16, the 2019 NHS SAAF does refer to the CDR statutory guidance, but only for CCGs to establish CDOP, and not for provider trusts to conduct CDR meetings or to ensure that Joint Agency Response (JAR) investigations take place when required. These key elements of CDR are not mentioned. (Joint Agency Response is a term introduced in the 2018 CDR guidance for deaths requiring rapid multi-agency investigation including SUDIC).

3.14. On page 24, the 2019 NHS SAAF details the CQC role specific for safeguarding, this does not include CDR.

3.15. On page 26, the 2019 NHS SAAF details multi-agency safeguarding arrangements including local Child Safeguarding Partners. There is no mention of the Child Death Review Partners, namely the CCG and Local Authority, who hold statutory responsibility for ensuring CDR processes.

3.16. The limited reference to CDOP, JAR or SUDIC in the 2019 NHS SAAF is very concerning, given that CDR was primarily a health responsibility after the publication of the 2018 CDR statutory guidance. Again, this could be interpreted as the NHS SAAF did not apply to CDR apart from the limited mentions above, or they were considered as core elements of child safeguarding so did not require listing

separately. In my experience, there is little accountability if NHS organisations do not follow CDR guidance, perhaps because CDR does not seem part of the 2019 NHS SAAF.

4. 2024 NHS Safeguarding and Accountability Framework

4.1. As in all the previous NHS SAAFs, the 2024 version makes little mention of CDR. Section 3 lists relevant legislation and statutory guidance; the CDR statutory guidance is not included.

4.2. In section 4.1, there is a table detailing how regional safeguarding teams will underpin the NHS England operating framework via their regional safeguarding work plans. The table refers to Child Death Overview Process as shown in Figure 1. Using 'Child Death Overview Process' rather than 'Child Death Review' gives the impression that only the CDOP function is included in the SAAF and not the whole of CDR, which involves the Joint Agency Response (JAR), SUDIC and provider led CDR Meetings.

Operating framework for NHS England regions	How will it be delivered? Workplan/delivery plan functions
Translate national strategy and policy to fit local circumstances, ensuring local health inequalities and priorities are addressed	Provide support, leadership and guidance on the development of NHS Safeguarding policies and procedures for safeguarding
Agree 'local strategic priorities' with individual ICSs	Use and monitor the allocated funding to develop safeguarding practice and expertise within the region, in line with nationally agreed priorities
Provide oversight to ICBs and agree oversight arrangements for place-based systems and organisations	Be the conduit for the evolving assurance of ICBs via: · the NHS Safeguarding heat maps · the multi-agency safeguarding arrangements · child death overview process · joint targeted area inspections · thematic reports from the National Child Safeguarding Review Panel · safeguarding adults boards (SABs) · chair networks

Figure 1 Table from section 4.1 2024 NHS SAAF

4.3. Section 4.3 states that: 'The SAAF governance processes will replicate ICB guidance and the ICB executive chief nurse will be accountable for the statutory commissioning assurance functions of NHS Safeguarding as per the agreed timelines with the regional chief nurse. These programmes will include: …child death overview process'. As in my previous comment, this could imply that the SAAF only relates to CDOP and not all statutory elements of CDR.

4.4. Section 4.3 also refers to the statutory safeguarding partners but makes no mention of the statutory child death review partners.

4.5. Section 9.3 does refer to the CDR statutory guidance but only mentions the requirement to set up CDOP and not to any other statutory CDR activities such as JAR, SUDIC or provider led CDR meetings.

4.6. There is no mention of a Designated Doctor for Child Death, however the whole 2024 NHS SAAF only refers to Designated Professionals and does not mention Designated Doctors for Safeguarding or Looked After Children individually either.

5. Are NHS Safeguarding and Accountability Frameworks fit for purpose?

5.1. As I have indicated already, I am not the appropriate expert to say if the NHS SAAF is fit for purpose for assuring safeguarding. My comments are made from the point of view of whether the NHS SAAF is fit for purpose for assuring CDR practices, although CDR is an important element of safeguarding.

5.2. I do not think the NHS SAAF is fit for purpose now or previously for assuring CDR practices. There are few mentions of CDR throughout all the versions, as a result it is not clear if the wider assurances processes around safeguarding are supposed to include CDR or not. Where CDR is mentioned, the information given only relates to the CDOP function which suggests that other statutory elements of CDR such as JAR, SUDIC and provider led CDR meetings are not included in the SAAF.

5.3. The JAR or SUDIC processes, are an important element of safeguarding practice, in providing rapid multi-agency investigation for all unexpected child deaths. Their lack of visibility in the NHS SAAF is of concern, as it could give the false impression that these are not statutory requirements, and ICBs or NHS trusts are not held accountable for JAR or SUDIC investigations.

5.4. In section 12 of my previous statement I referred to the lack of accountability and oversight for CDR nationally. The lack of visibility of CDR in all versions of the NHS SAAF has likely contributed to this, as has the lack of senior clinical leadership for CDR at NHS England.

5.5. Inspections by the Care Quality Commission (CQC) cover safeguarding. However, this does not appear to include CDR. The CQC Statement on role and responsibilities for safeguarding children and adults (Care Quality Commission, 2018b) and

Inspectors Handbook (Care Quality Commission, 2018a) make no mention of CDR, CDOP or SUDIC. There is therefore little accountability for NHS organisations that are not compliant with CDR statutory guidance.

5.6. I think that the NHS SAAF must either explicitly include all aspects of CDR, such as the JAR or SUDIC process, provider led CDR meetings and support for bereaved families; or a separate NHS SAAF for CDR should be created. I also think that CDR should be included in CQC inspections.

6. CDR processes for children who live in Wales

6.1. At the time of writing my first statement, I was not aware that some of the babies who died had home addresses in Wales. There are different CDR processes in Wales, and the 2018 CDR Statutory guidance only applies to England. This will have added further complexity to the situation at Countess of Chester.

Welsh Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

6.2. In Wales, the equivalent process to the JAR or SUDIC investigation is the Procedural Response to Unexpected Deaths in Childhood (PRUDiC)(National Safeguarding Service, 2023). There is no statutory basis to PRUDiC and the investigative process is less comprehensive than the English JAR. There is no equivalent to the Lead Health Professional or SUDIC paediatrician; there are no joint home visits by police and healthcare professionals following sudden infant or child deaths in the community.

6.3. The 2014 PRUDiC guidelines (Public Health Wales, 2014) included unexpected deaths of children who are inpatients at the time of collapse or death. In section 3.2 it states that: 'The PRUDiC applies to all unexpected deaths in children from birth until their 18th birthday, whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community.'

6.4. In section 3.3 it states 'If a baby dies within 24 hours of birth before discharge from hospital but with no immediate medical explanation apparent for the death, the

situation will be discussed by the Consultant Neonatologist and a Named Professional for Safeguarding Children. They will make a decision, informed by the circumstances surrounding the death and information available to them within health, as to whether the case should be regarded as an unexpected death and so fall within the PRUDiC.'

6.5. In section 3.7 it clearly states that PRUDiC should be started if there is uncertainty: 'Where professionals are uncertain about whether the death is unexpected, the death will be treated as unexpected and this procedure will be followed.'

6.6. The 2023 version of the PRUDiC guidelines includes sections on unexpected neonatal deaths and unexpected deaths on paediatric critical care units.

6.7. I am not sure of the cross-border arrangements in place for Welsh children and babies at Countess of Chester for the management of sudden unexpected deaths in 2015-17. However, it is clear a multi-agency investigation was expected either under the English SUDIC process or Welsh PRUDiC, and this would have enabled early discussion with police and social care as a matter of routine.

6.8. I understand that there are now regular meetings between English and Welsh paediatricians and CDR teams to enable effective cross-border investigation after child death.

Welsh Child Death Review

6.9. In Wales, there is no equivalent to CDOP. There is a public health led Child Death Review Programme (Public Health Wales, 2024), which looks at patterns and trends in deaths but does not conduct individual detailed case reviews as in the English CDR system. This is a public health programme rather than a statutory process. There are no Designated Doctors for Child Death.

6.10. I understand that in North Wales, a team of doctors had set up a CDOP project based on the English system, but again this was not on a statutory basis. I have not been able to find out any further information on this CDOP project.

6.11. The lack of CDOP equivalent in Wales is a weakness; there is no independent detailed oversight and scrutiny of child deaths. This limits identification of modifiable factors, potential safeguarding concerns, and learning from deaths. It would also make it much more difficult to spot a cluster of unexpected hospital deaths, regardless of the cause for these.

Statement of Truth

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

Signed: PD

Dated: 12 July 2024

References

2004. Children Act. England and Wales.

CARE QUALITY COMMISSION 2018a. Inspector's Handbook Safeguarding.

CARE QUALITY COMMISSION 2018b. Statement on CQC's role and responsibilities forsafeguarding children and adults.

HM GOVERNMENT. 2013. *WorkingTogether to Safeguard Children* [Online]. London: DfES. Available: https://webarchive.nationalarchives.gov.uk/ukgwa/20130802155605mp_/http:/media.education.gov.uk/assets/files/pdf/w/working%20together.pdf [Accessed].

HM GOVERNMENT. 2018. *Child Death Review Statutory Guidance* [Online]. London. Available: www.official-documents.gov.uk [Accessed].

NATIONAL SAFEGUARDING SERVICE 2023. Procedural Response to Unexpected Deaths in Childhood (PRUDiC). NHS Wales,.

NHS COMMISSIONING BOARD 2013. Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework.

NHS ENGLAND 2015. Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework.

NHS ENGLAND 2024. Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework.

NHS ENGLAND & NHS IMPROVEMENT 2019. Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework.

PUBLIC HEALTH WALES 2014. Procedural Response to Unexpected Deaths in Childhood.

PUBLIC HEALTH WALES. 2024. *Child Death Review Programme* [Online]. Available: https://phw.nhs.wales/services-and-teams/child-death-review/ [Accessed 2024].