Witness Name: Julie McCabe
Statement No.: 1
Exhibits: JM01-JM07
Dated: 28 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JULIE MCCABE

I, Julie McCabe, will say as follows: -

My Statement

1. This statement has been drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. This statement is the product of drafting after communications between those external solicitors in writing and by video conference.

2. My current role at NHS England is Midlands Regional Deputy Director of Nursing & Quality, Professional and System Development. Between August 2014 and May 2019, I was Director of the North West Neonatal Operational Delivery Network ("NWNODN"). I no longer have direct access to the files of the NWNODN. I also no longer retain in my inbox the emails I would have sent or received during my time as Director of the NWNODN. Where possible, I have exhibited the relevant documents relating to my time as Director of the NWNODN. However, many of the policies and guidelines that were in place during 2014-2019 have since been updated or replaced.

3. As part of this process, my solicitors have searched the files provided to NHS England by the NWNODN for the documents the Inquiry have requested. My solicitors have also shown me the witness statement of my successor Director of the NWNODN, Louise Weaver Lowe, so that I could understand what background information she had already provided to the Inquiry and to avoid duplicated disclosure.

4. I have sought to set out below any additional evidence that I am able to provide from my knowledge and experience generally. I have not given any interviews or otherwise made any public comments about the actions of LL or the matters of investigation by the Inquiry.

5. I wish to express at the outset my sorrow for the parents and families of the babies who have lost their lives or been injured as a result of the crimes of LL. It is beyond comprehension that events of this nature could happen at an NHS hospital, a place where patients and families expect the highest standard of care. I cannot imagine the distress and suffering caused to the parents of the babies in this case and I offer my deepest condolences to the families.

6. I did not have a role in the running of the Countess of Chester Hospital ("the Trust"). As I have explained below, the role of the NWNODN was to support clinicians and NHS England in issues related to capacity flow and pathways. However, when I became aware that there was a suspicion of criminal activity at the Trust, I supported the pleas from the clinicians for the police to become involved and escalated the matter within NHS England. In summary, my evidence is as follows:

    a. During the period of 2015-2017 the NWNODN was developing and maturing as a Network, however, in many aspects, it was a national leader in areas such as benchmarking, monitoring and reporting demand for neonatal services and capacity to deliver care in the most appropriate places. The Network was ahead of the curve nationally, particularly in relation to data and how we were using it to try and support patient flow, improve pathways and workforce standards.

    b. I do not recall in detail the matters discussed at the various NWNODN meetings which I attended in 2015-2016, but the minutes which have been disclosed to the Inquiry would have been checked at the time for accuracy and they are consistent with my general recollection of events.

    c. In early 2016 the NWNODN Steering Group did receive data about the number of deaths within the neonatal unit at the Countess of Chester, along with all the other neonatal units within the region. However, I do not recall anyone raising any particular concerns with me at the time about the cause of these deaths or an increase in the rate of mortality generally.

    d. Clinical issues were not discussed in detail at the NWNODN meetings that I attended (namely, the Steering Group meetings), but were instead discussed by the Clinical Effectiveness Group, which reported into the Steering Group.

    e. I first became aware of concerns that clinicians at the Trust had about the increased mortality rate, and the involvement of a particular individual who worked in the neonatal unit, around the time the decision was taken to downgrade the unit

(early July 2016). I did not know the identity of the individual concerned at this stage and I did not understand the concerns to involve criminal activity.

f. I supported the decision taken in early July 2016 to downgrade the unit to allow the Trust the time and resources (due to staff having more capacity) to investigate the reasons for the increase in mortality and make improvements where necessary.

g. It became apparent to me in early 2017 that there were significant tensions between the clinicians at the Trust and some of the Executives. My impression was that the clinicians did not feel they were being listened to or that the Executive was taking the necessary actions to address their concerns.

7. I believe there are lessons to be learnt from these events, particularly in relation to matters of culture particularly openness and transparency, to improve patient safety.

Career and employment at NHS England

Background

8. I qualified as a Registered Nurse in 1986 from the Bolton School of Nursing. I then completed midwifery training at the Bolton School of Midwifery and qualified as a Registered Midwife in 1988.

9. I completed a BA Honours Degree in Health Studies from Bolton University in 2002 and in 2010 completed a MSC in Health Management from Manchester Metropolitan University Business School.

Roles

10. Set out below is my employment history:

Employment History	
February 2021 – Present day	Regional Deputy Director Nursing & Quality, Professional & System Development, **NHSE Midlands**
March 2020 – February 2021	Independent Nurse Joint Governing Body **NHS Shropshire Telford and Wrekin**
April 2019 – January 2021	Assistant Director Quality & Safety, NHS Wales
February 2014 – March 2018	Director North West Neonatal Operational Delivery Network Hosted by **Alder Hey Childrens Hospital NNS Foundation Trust**
June 2016 – March 2018	Programme Director - Cheshire and Merseyside Women's and Children's Partnership Acute services collaboration Hosted by **Alder Hey Childrens Hospital NNS Foundation Trust**
April 2013 to February 2014	Women and Children's Programme Lead – **NHS England**
January 2012 – April 2013	Assistant Director Greater Manchester Children, Young Persons and Families NHS Network Hosted by **NHS Wigan Wrightington and Leigh**
April 2003 – April 2013	Regional Manager for CEMACH and CMACE (Confidential Enquiry into Maternal and Child Health & Centre for Maternal and Child Enquiries) North West, Isle of Man, West Midlands, and Wales **Central Manchester and Manchester Children's University Hospitals NHS Trust.**
2010 –2018	Honorary Research Fellow for University of Manchester
2017 - 2019	Honorary Lecturer for John Moores University
September 2002 - March 2003	Regional CESDI/CEMD Manager for Merseyside Cheshire and the Isle of Man **Central Manchester and Manchester Children's University Hospitals NHS Trust.**
January 2000 - September 2002	Senior Midwife, Supervisor of Midwives, IPC Nurse, **Central Manchester and Manchester Children's University Hospitals NHS Trust.**

Operational Delivery Networks

11. Operational Delivery Networks ("ODN") were established by NHS England in 2014. Consequently, the period this Inquiry covers was a time when ODNs were still in their infancy. When I was appointed to the NWNODN, a large part of my role was to set up the functions, structure and processes of the Network.

12. During the period of 2015-2017 the NWNODN was developing and maturing as a Network, however, in many aspects, it was a national leader in areas such as benchmarking, monitoring and reporting. The Network was ahead of the curve nationally, particularly in relation to data and how we were using it to try and support patient flow, improve pathways and workforce standards. However, as noted above it was still developing and has since added further assurance to its processes for data

reporting of patient outcomes. The Network worked alongside NHS England commissioning colleagues and would attend meetings with senior commissioners.

13. The ODNs are not decision-making bodies. Rather, they seek to facilitate and support through recommendations. The role of the NWNODN is to coordinate patient pathways between providers over a wide area to ensure access and egress of specialist neonatal care. The NWNODN supported neonatal services in the region to meet national, local and Trust standards and optimise resources to improve services.

14. As outlined above, I left my position as the Director of the NWNODN in May 2019. In this section of the statement I will outline the role, structure and governance of the Network during my time as Director, providing documents where I am able. However, as a developing Network, much of what was relevant at that time has now been superseded. My solicitors have referred me to the witness statement of Louise Weaver Lowe, the current director of the NWNODN, which describes the following key governance documents for the Network:

    a. NWNODN Operational Policy **[INQ0018024]**
    b. NWNODN Governance Framework **[INQ0018021]**
    c. NWNODN Board Terms of Reference **[INQ0018014]**
    d. NWNODN Senior Management Team Terms of Reference **[INQ0018023]**
    e. NWNODN Data Group Terms of Reference **[INQ0018017]**
    f. NWNODN Programme Board Terms of Reference **[INQ0018015]**

Background to Operational Delivery Networks

15. In December 2012, the NHS England Commissioning Board published guidance "Developing Operational Delivery Networks: The Way Forward" **[INQ0018010]**. This built on previous guidance published in July 2012 "The Way Forward: Strategic Clinical Networks" **[Exhibit JM/01, INQ0106978]** which outlined the range and role of clinical networks in the new health system. The July 2012 paper set out that ODNs would be the network focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise.

16. The July 2012 paper establishes the way forward for ODNs as networks to be determined by clinical need as agreed between providers and commissioners. It sets out the route for the safe transfer from the previous national provider delivery networks which included adult critical care, neonatal critical care, burns and major trauma. ODNs were formally launched in April 2013.

17. This guidance sets out the following purpose of ODNs:

    a. Ensure effective clinical flows through the provider system through clinical collaboration for networked provision of services.

    b. Take a whole system, collaborative provision approach to ensure the delivery of safe and effective services across the patient pathway, adding value for all its stakeholders.

    c. Improve cross-organisational, multi-professional clinical engagement to improve pathways of care.

    d. Enable the development of consistent provider guidance and improved service standards, ensuring a consistent patient and family experience.

    e. Focus on quality and effectiveness through the facilitation of comparative benchmarking and auditing of services, with implementation of required improvements.

    f. Fulfil a key role in assuring providers and commissioners of all aspects of quality as well as coordinating provider resources to secure the best outcomes for patients across wide geographical areas.

    g. Support capacity planning and activity monitoring with collaborative forecasting of demand and matching of demand and supply.

<u>The North West Neonatal Operational Delivery Network</u>

18. The NWNODN serves a population of circa 7 million and has a birth rate of approximately 74,000 per annum. The 22 units that make up the NWNODN have a total of 474 cots and admit approximately 7,500 infants per year. The NWNODN is organised into three localities: Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria. The Operational Delivery Network Memorandum of Understanding 2015 **[INQ0018040]** sets out the principles of ODNs in the North West (not specific to neonatology).

19. The NWNODN is hosted by Alder Hey Children's NHS Foundation Trust. The role of the ODN "host" is to enable, oversee and performance manage the formal establishment of the ODN by way of establishing a facilitative, supportive framework to ensure clear lines of responsibility and reporting arrangements to provide assurance. The host provider is a member of the ODN internal governance processes but is not responsible for the compliance of other ODN member organisations. Accountability for this rests with the ODN Board and the Assistant Director of Specialised Commissioning in NHS England's North of England Specialised Commissioning Team.

20. The NWNODN team is overseen by the NWNODN Board and is accountable to NHS England Specialised Commissioning. Membership, participation in, and engagement with the NWNODN is formally required by the 20 Trusts providing neonatal services across the North West, as per the National Neonatal Service Specification. The NWNODN acts as a resource, coordinator and facilitator for all of the ODN's stakeholders to achieve a collaborative approach to safe and effective specialised services.

21. Provider organisations that deliver NWNODN services within the North West of England are collectively responsible for the delivery of ODN functions in partnership with the host organisation.

My Role in the North West Neonatal Operational Delivery Network

22. I was appointed as the Director for the NWNODN in February 2014. As Director my role was to provide overall leadership, strategic direction and management. My role was facilitative, to promote joint working and to help all stakeholders work together to provide safe, fair and effective specialised services. I worked closely with lead clinicians to provide leadership strategic direction and management of the Network. This included strategic planning, development of the annual work programme, operational, monitoring and optimising capacity within the Network, improving standards, support development and implementation of Network protocols and guidance and management of Network resources.

23. Part of my role as Director was chairing the neonatal network steering groups of the three localities which formed the NWNODN: Greater Manchester, Lancashire and South Cumbria and Cheshire and Merseyside.

24. The role of the Neonatal Steering Groups is to provide expertise, direction and advice to NHS England via the NWNODN, service providers and the wider NHS community to improve the quality, safety and effectiveness of neonatal care across the Network. The NWNODN Cheshire and Merseyside Neonatal Steering Group sought to provide assurance of the highest standard of care for babies and their families by monitoring performance across Cheshire and Merseyside to include activity, quality monitoring, benchmarking and audit. It also encouraged collaboration and sharing of best practice and learning across the Network.

25. The Neonatal Steering Groups review variation in clinical outcomes or other aspects of service quality or efficiency, define targets for improvement, choose appropriate clinical indicators for monitoring and develop strategies to achieve improvement. It would agree a common clinical governance structure with an improvement process to identify and rectify weak points on the pathway or within the Network and develop, review and ratify evidence-based standards of care, guidelines and pathways (developed or supported by relevant professional bodies) to promote standardisation of best practice and principles across Cheshire and Merseyside.

26. As set out in the 2015 NWNODN Cheshire and Merseyside Neonatal Steering Group Terms of Reference, core membership comprised of the appointed Chair, Neonatal Clinical Lead, Network Director and Quality Improvement Lead. They were joined by membership from across the NWNODN footprint and the Steering Group welcomed support from Specialised Commissioning, NHS service providers, Obstetric and Midwifery representation, user, carer and family representation, the voluntary sector and supporting networks **[Exhibit JM/02, INQ0106999]**.

27. The Steering Group met quarterly, and it made Network recommendations by consensus where possible. If a consensus could not be reached, a majority decision of the Group was sought. Exhibited is the Steering Group's Work Plan for 2015/16 **[Exhibit JM/03, INQ0106987]**.

28. As Chair of the Cheshire and Merseyside Neonatal Network Steering Group my duties included management and leading meetings, presenting the agenda and ensuring that all voices were heard. It was my responsibility to run meetings in a timely and effective way and to ensure actions were noted and carried out. As part of my role, I liaised with members of the Steering Groups who were senior clinicians

from neonatal services across Cheshire and Merseyside and also with NHS England Direct Commissioning colleagues.

29. I did not have any formal training for my role as chair of the Steering Group, however my experience developed over time through learning from colleagues and attending leadership courses.

30. The Neonatal Clinical Effectiveness Groups was a Neonatal Network sub group which report directly to the Steering Groups in each of the three localities in the Network. The Cheshire and Merseyside Clinical Effectiveness Group provided clinically driven governance and assurance framework in the locality. The role of the Clinical Effectiveness Group was to co-ordinate incident reporting across the Network as well as reviewing mortality cases across the network, sharing learning gained from these reviews where appropriate. It would disseminate and monitor the implementation of national and local evidence, guidelines and standards to ensure best practice across the Network. It would also respond to national alerts to ensure compliance with recommendations, provide assurance to the Steering Groups and provide strategic direction for the clinical audit programme **[Exhibit JM/04, INQ0106990]**.

31. Part of the role of the Clinical Effectiveness Group was to regularly review clinical service provision against recognised guidelines undertaking a gap analysis and implementing service improvements where applicable. All North West Neonatal Unit mortalities were peer reviewed at the Clinical Effectiveness Group, which provided a layer of assurance on top of the local review required for a neonatal death and identified and shared any lessons learnt. These peer reviews would be shared with the local Child Death Overview Panel to ensure all child death reviews have access to all information identified within mortality reviews. Exhibited is the Clinical Effectiveness Group's Work Plan for 2015/16 **[Exhibit JM/05, INQ0106983]**.

32. The core membership of the Clinical Effectiveness Group was the Network Neonatal Clinical Lead who was the Appointed Chair, the Neonatal Network Facilitator who was the Deputy Chair and a clinical and nursing lead for each provider Trust in the Cheshire and Merseyside Neonatal Network. Colleagues from other professional groups could be invited where appropriate. The Group made recommendations by consensus where possible, but where one could not be reached a majority decision

were sought. Decisions endorsed by the Group would be ratified by the Neonatal Steering Group. The Group met on a two monthly basis.

33. Alongside the Neonatal Steering Groups and Clinical Effectiveness Groups sat the NWNODN Data Group, which provided expertise, direction and advice on data. The 2014 Terms of Reference of the Group are exhibited **[Exhibit JM/06, INQ0106982]**. Information from the Group helped inform the three Neonatal Steering Groups and Clinical Effectiveness Groups, the NWNODN Senior Management Team, the NWNODN Board and the NWNODN Work Programme.

34. Part of the role of the NWNODN Data Group was to develop the NWNODN dashboard. This drew on deaths which were directly reported to MBRRACE-UK by Trusts. However, there was a delay in reporting and the data was not in real time. Exhibited is NWODN dashboard summary 2015 which draws on data from the 2013-14 period **[Exhibit JM/07, INQ0106985]**.

35. The core membership of the Data Group was the appointed Chair, Neonatal Clinical Leads, Network Director and data group nominations (as nominated by relevant clinical lead). The Data Group met quarterly.

Cheshire and Merseyside Neonatal Network Steering Group

36. The Inquiry have directed me to the minutes of four meetings of the Cheshire and Merseyside Neonatal Network Steering Group held in 2015 and 2016:

    a. 16 September 2015 **[INQ0101212]**
    b. 3 December 2015 **[INQ0101249]**
    c. 29 January 2016 **[INQ0101269]**
    d. 12 May 2016 **[INQ0101286]**

37. The Inquiry have asked me to confirm the accuracy of these minutes. I do not have specific recollections of these meetings, so am unable to confirm whether the minutes are an accurate record of what was discussed. However, the standard process was for an administrative member of staff to write up the minutes and then myself and the clinician lead would review them and confirm whether they were a correct summation. At the following meeting the minutes would be presented to the

Steering Group who would have the opportunity to say if they were an accurate reflection.

38. Looking at the minutes, there does not appear to be anything unusual, and the content suggests that it was business as usual matters that were being discussed. I do not believe that there was any discussion at these meetings about any increased neonatal mortality at the Trust. However, the ODNs were established in 2014 and we did not have sophisticated data reporting from the start. This was being developed and was part of the maturing process for the Network.

39. The Network was first made aware of the increase in the mortality rate at the Trust directly from the clinicians, which I believe was around the time that the decision was taken to downgrade the unit in early July 2016. This increase in mortality was corroborated further down the line by the data, but in the first instance it was flagged to us by the clinicians at the Trust. If we had been made aware on increased mortality through data reports, then I would expect that would have been discussed at the Steering Group. However, the more in depth conversation would be had at the Clinical Effectiveness Group, which was run by clinicians and had a more clinical focus.

Mortality data reports

40. During the period this statement covers we were developing and maturing as a Network, and I believe that mortality data was some of the later data we had access to as a network. In 2015-2017 we were primarily looking at data regarding patient flows, activity and workforce standards as set out in the National Service Specifications. Much of our role was related to the pathway monitoring function of the NWNODN. This would include assessing whether babies were being born or transported to the correct units and whether we had sufficient numbers of cots. At this time, much of what the Network was doing was ahead of other Neonatal networks across the country. We were one of the largest ODN's and monitoring data across a large geographical area which included Greater Manchester, Lancashire and South Cumbria and Cheshire and Merseyside.

41. The patient outcome data was difficult to compile and access, so we improved the methodology as we grew as a Network. During the Relevant Period we may have had the raw numbers, but at that stage the Network was not sophisticated enough to

be able to present that until we had a structure and function able to employ a data analyst and extract and use the data available to us. I am not sure at what point we started to use mortality data, but to my recollection it was after the concerns in relation to mortality at the Trust had been raised. As the Network matured, we were able to start looking at outcomes. This included NNAP data which provided us information on best standards of care on matters such as temperature at birth and breastfeeding rates. After the Network hired a data analyst, we were able to extract data from BadgerNet and prepare reports for the Steering Group to which the clinicians gave their input and provided a narrative.

42. The Inquiry has drawn my attention to the Cheshire and Merseyside Quarterly Data Report for the NWNODN meeting on 12 December 2015 **[INQ0101248]**. The Report does not contain mortality data from the Trust. The NWNODN would produce these reports to monitor network activity, patient flows and occupancy. The Report would therefore not contain mortality data from the Trust as, at this stage, the clinicians had not alerted us to the increased mortality and the data we were receiving was not yet sophisticated to pick up patient outcomes. At this stage our data collecting was primarily focused on pathways.

43. The Inquiry has also directed me to the North West Neonatal ODN Quarterly Data Report presented at the meeting of the Steering Group on 29 January 2016 **[INQ0101271]**. Page 15 of this reports shows that during the previous 12 months there had been 15 deaths at Arrowe Park, 8 deaths at the Countess of Chester, 21 deaths at Liverpool Women's Hospital, and 1 death at each of three other hospitals in the regions. I do not have a specific recollection of this meeting, so am unable to comment specifically on what was covered, but to the best of my recollection we did not discuss any increase in the mortality rate within the neonatal unit at the Trust or any specific concerns about the nature of these deaths.

44. The Inquiry has also asked me whether a mortality data report was available for the Steering Group meetings of 16 September 2015 and 12 May 2016. I do not have a specific recollection of one being so. As outlined above, access to mortality data was something that was being developed at the time and I cannot recall precisely when this was reported formally.

Events in June and July 2016

Emails regarding Child I

45. On 22 June 2016 I emailed Dr Nim Subhedar, the NWNODN Clinical Lead, requesting a discussion in relation to an email chain I had been copied into regarding Child I who died at the Trust on 23 October 2015 **[INQ0005753]**. In the email chain on 1 June 2016, Annemarie Lawrence, the Risk Midwife at the Trust, had emailed colleagues stating that the last communication was that the case had been reviewed internally at the table top meeting in Alder Hey Children's Hospital and that they were awaiting the post mortem. Annemarie also said that it was stated that they would forward the minutes of the thematic review when it was completed and requested that these be sent over as soon as possible.

46. Dr Stephen Brearey, a Consultant Paediatric at the Trust, requested that Dr Subhedar provide the minutes of the table top meeting about Child I. I was coped into an email from Simon Kenny, Clinical Director at Alder Hey Hospital, on 22 June 2016 as Dr Subhedar had not yet responded to the request and both Annemarie and Dr Brearey were chasing the minutes of the meeting. The email exchange was about getting the relevant documents so that the review could be finalised.

47. My request to Dr Subhedar for a discussion would not have been related to clinical details. Although I am a trained nurse, I am not a neonatologist. My role was in management, and I would not specifically talk to a clinician about the clinical details of a case. Rather my role was a supportive one to check in with clinicians, ensure good governance and make sure things were being reported in the right way.

Email from Dr Brearey dated 28th June 2016

48. The Inquiry has directed me to an email from Dr Stephen Brearey to Karen Townsend on 28 June 2016, proposing to have a conversation with me about changes to be implemented within the neonatal unit at the Trust **[INQ0003116]**.

49. I do not recall a specific discussion as a result of this email. However, during this period myself and Dr Subhedar were speaking to Dr Brearey. The two of them would have clinical conversations and I would be asking them how we could support as the Network. Through the Network we were doing benchmarking, facilitating mortality reviews and having conversations with NHS England. Around this time, we were

working closely with Roz Jones who was a senior commissioner who had joined the Steering Group and was the NHS England representative.

50. The first time I was alerted that the clinicians had concerns about a particular member of staff in connection with the increased mortality rate was during a conversation with Dr Subhedar and Dr Brearey. I do not recall a date for this conversation, but it was around the time the decision was taken to downgrade the unit. I was not made aware of the name of the member of staff and did not learn of her name until the arrest. In my role it would not have been professional to make enquiries about any concerns with the capability or performance of a particular employee. My understanding was that an individual had been moved from the unit and was going through a HR process at the Trust. Following her removal from the Neonatal Unit, I was subsequently informed that the mortality rate and number of collapses had reduced significantly.

Downgrading of the Neonatal Unit at the Trust

51. The Inquiry has referred me to an email on 5 July 2016 in which Dr Joanne Davies, Clinical Lead in Obstetrics and Gynaecology, wrote to Lorraine Burnett, Director of Operations at the Trust, making reference to babies who had died on the neonatal unit at the Trust. The email stated "Nim Subhedar and Julie Maddocks know all the facts and reasons for our concerns and feel 32/40 is appropriate (ie level 1 status)" **[INQ0004886]**.

52. I believe the facts that Dr Davies is referring to here related to capacity and patient pathways. Dr Subhedar and Dr Brearey would have considered the appropriate level of designation and we would have helped to facilitate this decision with NHS England. Level 1 entails minimal levels of high or critical care. At this stage it was appropriate to reduce the admissions criteria to allow for investigations to take place and free up clinical capacity for quality improvement. Dr Subhedar would have known the clinical case for the change in admissions criteria, while my role was in relation to the Network and how we could provide support. My involvement was high level and was to support recommendations made by clinicians and the Trust to NHS England.

53. I was also monitoring the effect on pathways and capacity elsewhere that the changes might have. When a pathway was changed, it was important to understand the effect on the rest of the Network. Consequently, part of my role was to have data

and information to inform whether the cot base needed adjusting and contractual changes were required elsewhere in the Network. If contractual changes were required it was not our role to make them, however we would provide information to NHS England and make recommendations.

54. On 5 July 2016 Lorraine Burnett sent me an email attaching the final proposal for neonatal provision and communications **[INQ0010363]**. At this time I was aware of the concerns about the increased mortality on the Neonatal Unit. The purpose of the email was to inform the Network about the communications around the designation of the Neonatal Unit and the reduction in admissions. The email also referred to the transfer of babies as a result of the change of admissions criteria and Lorraine was letting us know as our role as the Network was to monitor patient pathways.

55. The Inquiry has directed me to an email the following day on 6 July which refers to a conversation between myself and Lesley Patel, the Director of Nursing Specialised Commissioning (North) NHS England. I did not work directly with Lesley Patel, and do not recall any specific conversations with her, however as part of my role I would have likely updated her on the emerging concerns from the Trust and the redesignation of the Neonatal Unit. This would likely been the first time I spoke directly with Lesley about the issues at the Trust.

Steering Group Meeting 13th July 2016

56. The Inquiry has directed me to the North West Neonatal ODN Quarterly Data Report for Cheshire and Merseyside for the period of 1 July 2015 to 30 May 2016 **[INQ0101295]**. It indicated a total of ten deaths at the Trust in a 12 month period. I do not recall this report being presented at the 13 July 2016 Steering Group meeting.

57. The Inquiry have referred me to minutes of the Steering Group meeting on 13 July 2016 in which Dr Subhedar, Dr Brearey and myself were all in attendance **[INQ0101304]**. In this meeting there was a discussion as to the redesignation of the Neonatal Unit and the ongoing review into the neonatal mortalities. The minutes refer to the Trust reviewing the data to identify any missed factors. I was not aware what these specific factors were, but my understanding was that the Trust was carrying out internal processes and investigations into the concerns about the Neonatal Unit. The meeting was very professional and while we were aware that there were concerns with a particular member of staff (as noted above), we would not have spoken about

these concerns at this meeting. We were aware that the Trust was going through an internal process, and it was our role to support them where we could.

Risk Register

58. The Inquiry have referred me to a Risk Register which was held on behalf of the NWNODN and prepared on 12 December 2014, with the last update being 17 March 2015 **[INQ0101206]**. The Risk Register addressed risks across the Network and was not specific to individual hospitals. It would not have been updated to reflect the risks associated with the increased neonatal mortality rate at the Trust as its purpose was to identify Network and pathway risks. The Risk Register would therefore identify risks associated with staff shortages, data and IT issues, but would not include patient outcomes as the Network did not have a regulatory or performance function. If there was increased mortality at a particular hospital, we would expect that to be picked up by the individual hospital and monitored by regulators and commissioners.

Interview by the Royal College of Paediatrics and Child Health

59. On 2 September 2016, I was interviewed by the Royal College of Paediatrics and Child Health ("RCPCH"). The Inquiry has provided me with notes from this interview **[INQ0014605] [INQ0010197]**. I attended the interview with Colin Morgan who was the Consultant Neonatologist at Liverpool Women's Hospital. Colin was a member of the RCPCH and it was primarily a clinical conversation.

60. In the interview Colin highlighted that the Network needed to facilitate units being given sufficient trainees as there were less applicants and we were trying to support spreading them more evenly. In addition, Colin was of the view that some areas required enhanced trainee monitoring as there was insufficient levels of trained staff. Colin was Head of Deanery at the North West School of Paediatrics and the Network was trying to support him by facilitating conversations with units to ensure that we had an equal offer for all trainees.

61. Colin also stated that there had been some fragile services in relation to transport. There were issues with some babies not being born in the optimal place and needing a transfer after birth if a mother went into a unit that didn't have neonatal intensive

care services. This had meant that some of the local neonatal units would care for complex cases where intensive care was required. To optimise outcomes, babies need to be transferred to intensive care as soon as possible and Colin was reflecting on the fact that we had transport issues. I do not recall any other views Colin may have expressed during this interview.

Escalation of Concerns

62. The Inquiry have provided me with a paper prepared by Dr Subhedar for a NWNODN Board meeting on 12 September 2016 titled "Neonatal Mortality at the Countess of Chester Hospital" **[INQ0014639]**. The paper states the Dr Subhedar had previously acted as an external reviewer in 2015 but no major deficiencies in care or recurring themes were identified, though it was noted that it had not been possible to assign a clear cause of death in some cases despite a post-mortem examination. The paper states that the NWNODN Management review of mortality rates at the Trust benchmarked against other local neonatal units indicated that it was 1.5 – 2 fold higher than comparable units and appeared to be rising. The Network had access to the data from each Trust via BadgerNet, which was harvested from individual hospitals, allowing us to extract data to support the review.

63. The paper notes that I was to represent the NWNODN at the RCPCH review. During the review both Dr Subhedar and I worked closely with the clinicians. It was an invited RCPCH review commissioned by the Trust which we endorsed. The Trust invited the clinicians in, set out the rationale for the investigation and would have agreed the Terms of Reference with the clinicians. Dr Subhedar and myself discussed the review as he was part of it as a clinician and I was supporting from a management and Network perspective. These were ongoing conversations we were having at the time of the review.

64. The Inquiry have directed me to the Trust Neonatal Unit timeline, which indicates that a meeting was due to take place on 10 November involving Ian Harvey, the Medical Director at the Trust, Lorraine Burnett, the Director of Operations at the Trust, and myself **[INQ0002921]**. I do not recall if it was on this date, but I remember meeting Lorraine Burnett who provided an update for the Network and presented the concerns emerging from the Trust. The meeting was a few weeks before we received

the Dr Jane Hawdon and RCPCH Report so we would have been requesting an update.

65. The NWNODN was quite advanced in relation to other networks and one thing that we did well was work alongside NHS commissioning colleagues. The Trust would want to make sure that we, as the Network, were updated so that when there were conversations with NHS England commissioners, they had demonstrated that they were engaging with us.

66. On 1 December 2016 Dr Subhedar sent an email to Ian Harvey to which I was copied. Dr Subhedar said that "*In answer to your question, unexpected collapse without a clear cause is well recognised in neonatal units and we've had a couple of cases at LWH recently. However, I can't recall discussing any specific cases at network meetings where a baby has died suddenly and unexpectedly without a cause of death having been identified. However, as a Network we've only started collating reviewing deaths in a systematic way relatively recently and the process is still not completely robust.*"

67. As I was not a neonatologist, I could not comment on Dr Subhedar's clinical assertions, as it is not within my area of expertise. My expectation would be that these conversations took place in the Clinical Effectiveness Group or mortality reviews.

68. Regarding the robustness of the system for reviewing deaths, as I have said above we were developing as a Network at this time. Back in 2016 the system was not as robust as it is now, however, during the time covered by the events of the Inquiry, we were ahead of the curve nationally in terms of reviewing data and were building in more information to support flows and improve pathways and outcomes. Where necessary we would bring in external clinicians to look at mortality for the network and support recommendations on clinical areas. The Network was also able to provide learning opportunities and training around stabilisation and intensive care.

69. The Inquiry has provided me with a communications planning document from January 2017, which states that I was going to brief Simon Banks (NHS Halton Commissioning Group) on 6 February 2017 **[INQ0006378]**. By way of context, at that point we had an Acute Collaborative Vanguard. The vanguards were an NHS England initiative with the aim to transform and integrate health and social care

services. They were intended to be locally driven pilots, each contributing to the development of care model prototypes and with the aim of different providers working together towards the same aim.

70. I supported the Vanguard as a part time Programme Director working collaboratively with, maternity, paediatrics and neonatal services across Cheshire and Merseyside who had signed up to work together to ensure clinical sustainability of services, improve pathways and family engagement. What we were trying to do was look at how we could clinically sustain the number of units and where necessary centralise and consolidate specialised care. Simon Banks was the Senior Responsible Officer of the Vanguard at the time.

71. I cannot recall the conversation with Simon Banks, but the briefing would have been around what I knew at the time, including the background to reduction in admission criteria and the actions being taken at the Trust.

72. I have been referred to a note provided by Dr Subhedar of a meeting he attended on 28 February 2017 with Ian Harvey. The note states *"Nim Subhedar stated at our meeting that he too was concerned that the cause of death and/or deterioration remained unexplained in several cases. He supported Dr Hawdon's recommendation that* these *cases should undergo further detailed review. Nim also emphasised that the Network's position that the observed excess in neonatal mortality at COCH could not be explained merely as a consequence of medical or nursing workface deficits or increased activity and occupancy levels. Other network local neonatal units are working at similar levels of occupancy and staffing and COCH is not an outlier in this regard. Since these units are not reporting an excess in neonatal mortality, it suggests that there is a different explanation for our increased number of unexplained deaths".* **[INQ0006105]**.

73. I do not recall precise times or dates, but throughout this period Dr Subhedar and I were discussing what we could do as a Network. Dr Subhedar was looking at the concerns arising from the Neonatal Unit at the Trust from a clinical perspective and my role was to facilitate what information we could share with the Trust and what we could collate to help our understanding of the reasons behind the increase in mortality. This involved looking at mortality, activity, occupancy and nursing workforce.

74. I was aware that Dr Subhedar was meeting and talking to the paediatricians at the Trust and having regular telephone conversations to support as much as he could. This was about sharing his extensive expertise as a neonatal intensive care clinician who had experience on different neonatal units and was a member of the RCPCH.

Meeting on 27th March 2017

75. On 27 March 2017, I attended a meeting with Tony Chambers, Ian Harvey, Sue Hodkinson, Dr Ravi Jayaram, Dr Brearey and Dr Subhedar. For the reasons discussed below, this was the most difficult meeting I have attended in my career to date.

76. The meeting had been arranged as a clinical conversation between the clinicians at the Trust and the Chief Executive and Medical Director. Dr Subhedar rang me before the meeting and indicated that he would appreciate if I also attended in a supportive capacity. I understood from this that Dr Subhedar anticipated that it would be a difficult meeting. I also recall Dr Subhedar telling me that the clinicians were having a hard time with some of the Trust Executives. I was not directly part of internal conversations at the Trust, however my understanding was that there were issues between the clinicians and management, in particular concerning the Medical Director (Ian Harvey). The clinicians felt increasingly frustrated that they were not being listened to and actions were not being taken. As the clinicians expected the meeting to be difficult, Dr Subhedar wanted me to support from a management perspective and be an external witness.

77. The Inquiry has provided me with a note of the meeting, which indicates that I contributed the following words: "Given the information, on balance of probability, do you believe illegal activity has caused the deaths" **[INQ0003150]**. This was not a statement I made but rather a question I was putting to the clinicians. The clinicians responded by nodding their heads, indicating that they believed that this was the case.

78. It was not my role to support internal processes at the Trust or communications with the Executives. I went into the meeting expecting my role to be that of an observer and to make contributions on the functions of the NWNODN where necessary. However, I asked the question as it felt like the clinicians were saying to the

Executives that they had done everything they could to work out what was going on and that they now believed the worst. I felt that, from a professional perspective, I had to ask this question it was my professional duty and would ensure that my communications with the Chair of the Network Board and NHS England would not be based on hearsay or speculation.

79. There was a high level of anxiety at the meeting. I remember it being challenging and intense and there was a palpable sense of tension in the room. I remember the clinicians trembling, my recollection was that the clinicians felt like they were putting their careers on the line, but they were prepared to do this given the seriousness of the matter. They could not come up with a clinical reason as to why the babies had collapsed or died and they strongly suspected criminal activity. They believed that the Trust should do the right thing and contact the police.

80. After the clinicians confirmed that they suspected criminality, Tony Chambers said that if that was the case then they should call the police. This sounded like an ultimatum and that there were negative connotations to involving the police. The clinicians wanted the Trust to go to the police as an organisation, and although I think that they would have done so if that was the only option, they believed that the right thing to do was for the Executive to take this action.

81. The meeting concluded with what I thought was an agreement that Tony Chambers would do what was required internally to alert to Chair, the non-Executives and anyone else involved in escalation, which I presumed would include the legal team prior to contacting the police. Dr Subhedar and I walked away from this meeting assuming that this would be the next step. Following the meeting I took the decision to immediately update Roz Jones at NHS England and provided a summary of what had been said. I believed that the Trust had made the decision to bring in the police for a forensic investigation.

82. I informed Roz Jones that there had been an internal meeting at the Trust relating to additional cases that the clinicians felt required police involvement. The following day at the Lancashire and South Cumbria NWNODN locality meeting I took the opportunity to speak privately to Andrew Bibby outside of the meeting. Andrew was the Assistant Regional Director of Specialised Commissioning and I repeated to him what I had said to Roz.

83. Andrew Bibby was not aware of any action taken following the meeting. However he said he had spoken to the Trust, and they thought that the clinicians had gone maverick. I told Andrew very firmly that my impression from the meeting was that the clinicians had not gone maverick, but rather they were concerned about deaths and collapses to which they could find no clinical explanation. I said that they believed that the next step was to bring the police in, which was something that the Trust was going to action.

84. The next day I was called by the PA to Tony Chambers who told me to contact him urgently. I then received a call from Andrew Cannell, the NWNODN Board Chair, who told me not to take any calls from Tony Chambers and that I had done nothing wrong by updating NHS England, but to say that Tony was annoyed was an understatement. I told Andrew that I had not done anything wrong and had clearly escalated concerns as appropriate and according to professional standards and the Code of Conduct. Andrew said he'd reinforce this position and would speak to Tony Chambers. I did not personally end up speaking with Tony and I am unable to confirm what conversations took place, other than as described here.

85. At this stage Tony Chambers had not yet called the police and I can only assume that he was angry that I had escalated the matter to NHS England, who had contacted him asking why the police had not yet been brought in. Around this time I also got a call from Michael Gregory, Regional Clinical Director of Specialised Commissioning North, who was supportive, thanked me for what I had done and said that I had done nothing wrong. Chief Executives at Trust level are often very influential individuals and I believe Michael was providing reassurance that what I had done would not be career limiting. I reiterated that I was confident that I had made the right decision given the seriousness of the situation and my professional duties as a NMC registrant and in adherence to the NMC's Code of Professional Standards.

Further emails in April and May 2017

86. The Inquiry has provided me with an exchange of emails between Dr Subhedar and Dr Brearey on 7 April 2017 **[INQ0005848]**. The exchange was off the back of an email from Eirian Lloyd Powell on 3 April to Dr Brearey in which she was asking that, in view of Tony Chamber's commitment to returning the Neonatal Unit to a level 2,

whether he had spoken to the network with regards to exploring the possibility of a transitional phase whilst waiting for additional staff. The Neonatal Unit had been struggling to keep open with only two HD cots and no Transitional Care Unit. Eirian was proposing that in view of babies that needed to be repatriated, and to reduce pressure on the Neonatal Intensive Care Unit, the HD cot capacity should be increased from two to four to accommodate 15 babies. Dr Brearey then forwarded the email to Dr Subhedar as the Network lead on 4 April, asking whether he would be supportive of the proposal.

87. Dr Subhedar replied on 7 April copying me in following a conversation I had with him in which we agreed that the best way forward would be to look at activity and demand at the Trust, as we would for any other unit that requested a change to cost status or capacity. Dr Brearey replied with an update later that day, stating that the Trust had not taken any action yet. He relayed that Ian Harvey had asked for all of us to meet with a barrister so that they could better understand our concerns. The barrister was apparently being brought in to advise the Trust on how best to approach the police. I replied to Dr Brearey thanking him for the update and stating that the Network would continue to support in any way we could.

88. On 31 May 2017 Emma Kyte, Quality Improvement Lead Nurse at the NWNODN, sent an email to Dr Brearey and Dr Jayaram to which I was copied **[INQ0005885]**. The email provides data in relation to babies who collapsed at the Trust between 1 January 2010 and 31 December 2015 and includes the observation that the data for "*administration of adrenaline remains significantly high for 2015 even when compared to other drugs*". This was a clinical observation highlighting an anomaly in the administration of a particular drug. My role, and the reason I was copied, was to facilitate the provision of information that could support greater understanding of what was going on. I would not have commented clinically on the issues raised in the email. My role was to support the clinical conversations being had by senior nurses from a Network perspective.

89. On 20 July 2017, a peer review of the Trust's Neonatal Unit due to take place on 30 November was postponed **[INQ0003128]**. At this stage we were setting up a series of peer reviews across the Network. The Network would review providers in all three localities using clinicians from NWNODN networks and external clinicians to that provider. They would look at pathways, improvements, interventions and support.

The benefit of using external clinicians was that they could see things from different perspectives and could advise on best practice.

90. I do not recall the exact reasons that this particular peer review did not take place. However, this likely occurred because it would not have been an optimal time to visit when the Neonatal Unit had restrictions on admissions.

Reflections

91. As I have attempted to explain above, the NWNODN was at the forefront of ODN development nationally during the period covered by this statement. However, it had just started out and was maturing. As explained at paragraph 40 in 2015-17 we were primarily looking at data regarding patient flows and activity, which related to the pathway monitoring function of the ODN. Subsequent to the events of this Inquiry, the Network improved patient outcome data and have better access to mortality data.

92. The NWNODN's mandate is to develop and implement programmes of work to improve access to specialist resources, neonatal outcomes and patient experience. Its role is to monitor the neonatal clinical pathways, which ensure collaborative clinical decision making for babies and families. Even now with the benefit of hindsight, it would not have been the role of the NWNODN to intervene directly with internal processes at the Trust. Our role was to support clinicians and NHS England by providing any information or resources that we would enable decisions to be taken.

<u>Recommendations</u>

93. There are some things I believe could be done to improve patient safety and care.

94. For instance, I believe it is important to strengthen the voices of parents and families. I understand that the first phase of the introduction of Martha's Rule was implemented in April 2024 and providing this access to a rapid review from a separate care team will add a layer of assurance to families. In addition to having this second review, I believe families should also have their voices strengthened by being able to speak to anyone within a hospital setting that can provide them with the further information they are seeking, whether this be another nurse, the ward

manager, a doctor or in escalating concerns to Healthwatch or the Patient Advice and Liaison Service.

95. Another area that could be improved relates to the National Service Specifications that set out the service delivery models for optimal care and outcomes. The Specifications contain evidence based workforce standards that stipulate how services should be delivered, where they should be delivered and what staff should be delivering that care. However, we know that many providers are not complying with the Specifications for a variety of complex reasons. Greater support to Integrated Care Boards ("ICBs") across their geographical areas to ensure compliance with the Specifications can improve outcomes and keep babies on Neonatal units safe. For example, from a safety perspective, there is less opportunity for criminal actions to be committed if a unit is staffed in compliance with the Specifications with the appropriate number of nurses and Allied Health Professionals. A unit that is properly staffed will benefit from enhanced supervision and oversight, which contributes to safer care.

96. NHS England has recently delegated the commissioning of maternity and neonatal services to ICBs. As ICB's now hold Neonatal contracts, ODNs can play a key role in supporting ICB's help their providers ensure compliance with the National Service Specifications and monitor contracts against those standards. The need for collaborative working is particularly important as ICB's are still in their infancy, and some are not as developed as others. ODNs can take a whole system approach to provide ICB's with information that enables their providers to deliver safe and effective care, as well as providing an assurance function and coordinating provider resources to ensure the best outcomes for patients.

97. I also believe that NHS student training could be strengthened by including training about "thinking the unthinkable" with learning from the Allitt and Letby cases. While, for many, the idea that their colleagues could commit such unspeakable acts as those committed by Letby is hard to contemplate, being aware of criminal activity as a possibility is key to appropriate escalation. This training could involve providing guidance into the signs and traits that should raise suspicion among colleagues and trigger safeguarding processes.

98. Finally, the Inquiry may wish to explore the idea recommending the commissioning of an independent body that works with non-NHS healthcare experts to look at whether

current patient safety systems and processes sufficiently safeguard against criminal activities. Such a body could make recommendations on how those systems and processes can be adapted or whether additional processes would be beneficial. However, I understand that there would be practical difficulties and thought would have to go into how this might be effectively implemented.

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: Personal Data

Dated: 28/07/2024