Witness Name: Dr Lawrence Andrew Dixon
Statement No.: First
Exhibits: LAD1 to LAD7
Dated: 30 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR LAWRENCE ANDREW DIXON

I, Dr Lawrence Andrew Dixon, will say as follows: -

Career and background

1. I qualified in 1985 MB ChB Liverpool Medical School. I was previously a member of the Royal College of General Practitioners and also a member of the Royal College of Paediatrics and Child Health and held the Diploma in Community Child Health.

2. I originally trained for General Practice and then Paediatrics, obtaining a substantive post in Community Paediatrics in one of the predecessor organisations which now make up Betsi Cadwaladr University Health Board ("the Health Board"). Prior to this, as a junior doctor, I was predominantly based in Wirral, Chester and Runcorn for Trusts in England. Whilst working at the Health Board and its predecessors I was based at Wrexham Maelor Hospital.

3. I was the Assistant Named Doctor (also referred to as Lead Doctor in Safeguarding) in Wrexham and Flintshire from around 2009. From reviewing the minutes of the Flintshire and Wrexham Child Death Review Panel ("the CDRP"), I chaired my first meeting of the CDRP on 15 January 2015.

4. To my knowledge there was no specific training available at the time which was required in order to undertake this role. The role was undertaken based on the knowledge and experience I had gained, along with the qualifications referred to above.

Role and purpose of the Flintshire and Wrexham Child Death Review Panel ("CDRP") in 2015-2016

5. The CDRP is part of the All Wales Child Death Review Programme ("the Programme"). The Programme aims to identify and describe patterns of causes of child death, including any trends, and to recommend actions to reduce the risk of avoidable factors contributing to child deaths in Wales. All child deaths, where parents resided in Flintshire and

Wrexham, would be discussed at quarterly meetings of the CDRP but it was not the role of the Programme or the CDRP to investigate individual cases.

6. All child deaths, where the parents resided in Flintshire and Wrexham, would be discussed by the CDRP. As such, no specific decision would be made as to whether a particular case should be notified to, or considered by, the CDRP, irrespective of the cause or place of death.

7. When a child death occurred, the relevant hospital would generally contact a specific point of contact within the Community Child Health Department in Wrexham or Flintshire. This could be by way of a phone call or email with the details of the child. The information would not be received on any particular form.

8. This information was used to compile a list of all child deaths on a quarterly basis and this would be used to inform the CDRP meeting. For the reasons outlined above, there was no referral process and no specific information that would be provided.

9. Following receipt of this information, we would then do a 'cascade', via the Document for the Internal (BCUHB) Notification of a Child Death form, where we would inform all professionals involved with the child that we knew of, including the GP. I would request copies of the Health Board notes relating to the child, along with any other information given by other professionals, which I would then use to complete a form which would be sent to the Programme. It may be that a CDRP would not be held until some time after the submission of such a form.

10. CDRP discussions would be informed by the Health Board notes and information received from relevant professionals as opposed to a particular form. As noted previously, the purpose of the CDRP was to identify patterns and trends rather than to investigate specific cases. It would be expected that any issues or concerns regarding the medical treatment of a specific patient would be identified and investigated by the health care provider.

11. The CDRP would generally include members from the Health Board, the police, social services. Additional professionals could be co-opted as required for specific meetings / issues. It should be noted that the purpose of the CDRP is to identify regional patterns and trends and not to detect or investigate deliberate harm in specific cases. In my view this is an appropriate mix of professionals for such a panel.

12. I would liaise the Local Safeguarding Children Board and also with the Named Doctor who I understand liaised with the Regional Safeguarding Children Board ("the RSCB"). The RSCB would be provided with annual reports of the CDRP [**LAD1**]. I do not recall liaising

with other CDRP or CDOP about any particular child death as I do not recall any circumstances requiring such action.

13. The three CDRPs across the Health Board area would share their Annual Reports with one another and with the Named Doctor for Safeguarding Children. I don't recall there being any communication or relationship between Flintshire and Wrexham CDRP and any CDOP in England.

Countess of Chester Hospital

14. I have reviewed the CDRP minutes for 2015 and 2016 and identified 9 entries which make reference to the Countess of Chester. Of these patients, the minutes suggest that 5 died at the Countess of Chester. As noted above, there was no specific formal referral process as all child deaths, where the parents are resident in Wales, would be discussed. I am aware that three babies named on the indictment were discussed by the CDRP. It is not possible to independently confirm whether other babies named on the indictment were notified to the Flintshire and Wrexham CDRP as I have not been provided with the names or unique identifier of those children.

The CDRP's consideration of one of the babies named on the indictment

15. I understand that searches have been carried in the Health Board for patient case files relating to this baby. I am informed that no patient case files are held for this baby and they have never been registered on the Health Board's system as they were never a Health Board patient.

16. However, the Health Board have been able to source some hard copy documentation which has been retained in relation to this baby **[LAD2]**. The hard copy documents include a notification of birth, which contains handwritten annotations to suggest that notification of the death of this baby was provided by the Practice Development Nurse at the Neonatal Unit, Countess of Chester.

17. The information received has been compiled into the Document for the Internal (BCUHB) Notification of a Child Death Form. Page 2 of the form indicates the parties who were notified of the death of this baby by the Health Board and the date of this notification.

18. The Document for the Internal (BCUHB) Notification of a Child Death Form would have been used to inform the CDRP discussions, along with any additional input provided by other professionals who make up the CDRP. This information would have been sufficient for the purpose of the CDRP discussions.

19. I have been provided with a copy of the minutes of the Flintshire and Wrexham Child Death Review Panel of I&S [***INQ0001948***] by the Inquiry. The entry marked by the Inquiry as this baby states as follows: "**This baby** *was born at the Countess of Chester Hospital at* I&S *gestation where* **they** *died* [redacted] *after birth following complications. Not known to Social Services*". The document notes that professionals in attendance included representatives from Health, Police and Social Services.

20. Based on my review of the minutes of the Flintshire and Wrexham Child Death Review Panel of I&S [***INQ0001948***] provided by the Inquiry, it does not appear as though any further actions were taken or any external reviews initiated by the CDRP.

21. I chaired the CDRP meeting on I&S. My normal practice was to take the minutes of the meeting by hand and these were subsequently dictated and then typed up by my secretary. This is not a verbatim record of the discussion but is an accurate summary.

22. I understand that the only hard copy documents identified by the Health Board relating to this baby are the Notification of Birth with handwritten annotations and the Document for the Internal (BCUHB) Notification of a Child Death Form.

23. The Health Board have also conducted a search of my emails, as per my request. I understand that my email account was affected by a known NHS Wales IT issue which resulted in a number of email accounts of former employees being deleted due to the incorrect application of Office 365 retention rules. I am informed, however, that an 'on premises' server was in place until November 2020 and that searches have been conducted on this archive.

24. Searches of the server produced an email chain with Cheshire Police. On 28 November 2017, Janet Moore emailed Dr Lindsay Groves with a list of babies that were the subject of their enquiries and asked if there were any "*CDOP type documents*" which could be provided. Dr Groves forwarded the email to me and asked if I could respond to the request. The list of names provided by the police included this baby. Later the same day, I emailed Dr Groves and Janet Moore enclosing copies of the meeting minutes where the children (which included this baby) were discussed [**LAD3**].

25. The CDRP would not revisit a case at another CDRP meeting. There would be no need to do so unless further information was received. To my recollection there was never any cause to revisit a case at a subsequent CDRP meeting whilst I was Chair.

The CDRP's consideration of a second baby named on the indictment

26. I understand that searches have been carried in the Health Board for patient case files relating to this baby. I am informed that no patient case files are held for this baby and they have never been registered on the Health Board's system as they were never a Health Board patient.

27. However, the Health Board have been able to source some hard copy documentation which has been retained in relation to this baby [**LAD4**]. This consists of a copy notification of birth and the Document for the Internal (BCUHB) Notification of a Child Death Form. This indicates that the death was notified by telephone by Irrelevant & Sensitive, Health Visitor on Irrelevant & Sensitive.

28. Page 2 of the Document for the Internal (BCUHB) Notification of a Child Death Form indicates the parties notified of the death of this baby and the date of this notification.

29. The Document for the Internal (BCUHB) Notification of a Child Death Form would have been used to inform the CDRP discussions, along with any additional input provided by other professionals who make up the CDRP. This information would have been sufficient for the purpose of the CDRP discussions.

30. I have been provided with a copy of the minutes of the Flintshire and Wrexham Child Death Review Panel of Irrelevant & Sensitive [***INQ00012020***] by the Inquiry. The entry marked by the Inquiry as this baby states as follows: "*The child was born at* **I&S** *gestation at the Countess of Chester Hospital.* Irrelevant & Sensitive *The case was not previously known to Flintshire Social Services or Police*". The document notes that professionals in attendance included representatives from Health, Police and Social Services.

31. Based on my review of the minutes of the Flintshire and Wrexham Child Death Review Panel of Irrelevant & Sensitive [***INQ00012020***] provided by the Inquiry, it does not appear as though any further actions were taken or any external reviews initiated by the CDRP.

32. The minutes indicate that the physical meeting planned for Irrelevant & Sensitive had to be cancelled due to lack of professionals able to attend. It was therefore agreed that the review would be held via email. This is not a verbatim record of the discussions but is an accurate summary.

33. The only hard copy documents identified by the Health Board relating to this baby are the Notification of Birth and the Document for the Internal (BCUHB) Notification of a Child Death Form.

34. The Health Board have also conducted a search of my emails, as per my request. I refer to the IT issues mentioned above at paragraph 23. Searches produced the email chain

with Cheshire Police, which is described above at paragraph 24. The list of names provided by the police included this baby. The email I sent in response enclosed copies of the meeting minutes where the children (which included this baby) were discussed [**LAD3** above].

35. In addition, the search produced an email between the CDRP members in which a 'virtual death review meeting' was being trialled [**LAD5**]. On I&S, I emailed CDRP members asking them to indicate their involvement with the child or family and to provide any relevant information. On Irrelevant & Sensitive a response was received from Jayne Belton of Flintshire County Council advising that there was no PRUDIC (Procedural Response to Unexpected Deaths in Childhood) and that the case was not previously known to the Flintshire Social Services.

36. The CDRP would not revisit a case at another CDRP meeting. There would be no need to do so unless further information was received. To my recollection there was never any cause to revisit a case at a subsequent CDRP meeting whilst I was Chair.

The CDRP's Consideration of a third baby named on the indictment

37. I understand that searches have been carried in the Health Board for patient case files relating to this baby. I am informed that no patient case files are held for this baby and they have never been registered on the Health Board's system as they were never a Health Board patient.

38. However, the Health Board have been able to source some hard copy documentation which has been retained in relation to this baby [**LAD6**]. This consists of a notification of birth and the Document for the Internal (BCUHB) Notification of a Child Death Form. This indicates that the death was notified by telephone by Irrelevant & Sensitive, Health Visitor, on Irrelevant & Sensitive.

39. Page 2 of the Document for the Internal (BCUHB) Notification of a Child Death Form indicates the parties notified of the death of this baby and the date of this notification.

40. The Document for the Internal (BCUHB) Notification of a Child Death Form would have been used to inform the CDRP discussions, along with any additional input provided by other professionals who make up the CDRP. This information would have been sufficient for the purpose of the CDRP discussions.

41. I have been provided with a copy of the minutes of the Flintshire and Wrexham Child Death Review Panel of Irrelevant & Sensitive [***INQ00012020***] by the Inquiry. The entry marked by the Inquiry as this baby states as follows: "*The child was born at* I&S *gestation at the*

Countess of Chester Hospital. Irrelevant & Sensitive *The case was not previously known to Flintshire Social Services or Police*". The document notes that professionals in attendance included representatives from Health, Police and Social Services.

42. Based on my review of the minutes of the Flintshire and Wrexham Child Death Review Panel of Irrelevant & Sensitive [***INQ00012020***] provided by the Inquiry, it does not appear as though any further actions were taken or any external reviews initiated by the CDRP.

43. The minutes indicate that the physical meeting planned for Irrelevant & Sensitive had to be cancelled due to lack of professionals able to attend. It was therefore agreed that the review would be held via email. This is not a verbatim record of the discussion but is an accurate summary.

44. The only hard copy documents identified by the Health Board relating to this baby are the Notification of Birth and the Document for the Internal (BCUHB) Notification of a Child Death Form.

45. The Health Board have also conducted a search of my emails, as per my request. Searches produced the email chain with Cheshire Police which is described above at paragraph 24. The list of names provided by the police included this baby. The email I sent in response enclosed copies of the meeting minutes where the children (which included this baby) were discussed [**LAD3** above].

46. In addition, the email of I&S from Jayne Belton referred to above at paragraph 35 also makes reference to this baby, advising that there was no PRUDIC (Procedural Response to Unexpected Deaths in Childhood) and that the case was not previously known to the Flintshire Social Services [**LAD5** above].

47. The CDRP would not revisit a case at another CDRP meeting. There would be no need to do so unless further information was received. To my recollection there was never any cause to revisit a case at a subsequent CDRP meeting whilst I was Chair.

Increased mortality rate on the neo-natal unit at the Countess of Chester Hospital; suspicions and concerns

48. I do not recall being contacted by any representative from the Countess of Chester in 2015 or 2016 regarding concerns about the mortality rate on the neo-natal unit, and/or concerns about the possible causes.

49. I do not recall attending, or being invited to attend, any meetings at the Countess of Chester Hospital in relation to an increased mortality rate at the neo-natal unit, and/or concerns about the possible causes during 2016 or 2017.

50. Searches have been conducted of my emails for correspondence received from Ms Alison Kelly, Countess of Chester Hospital. The searches do not indicate that I received any email from Ms Kelly directly. However, I have been provided with copies of two emails sent by Ms Kelly to Dr Lindsay Groves, which were subsequently forwarded on to me.

51. On 6 April 2017, Ms Kelly emailed Dr Groves attaching two documents, the RCPCH Invited Review of November 2016, along with a Draft Action Plan. On 23 May 2017 Dr Groves forwarded the email on to me and asked if I knew anything about this or how many cases were North Wales babies. I responded the same day to advise that I did not [**LAD7**].

52. On 25 May 2017 an email was sent by Dr Groves to Ms Kelly thanking her for forwarding the Neonatal Service Review and Action Plan and querying whether any of the 15 babies who died were from North Wales. It appears that a list was sent which was forwarded to me by Dr Groves on 2 June 2017. I sent an email to Dr Groves on 5 June 2017 advising of the dates that the five children had been discussed at the Wrexham and Flintshire CDRP (referred to as CDOP in the email) [**LAD8**].

53. I had no direct discussions with anyone in relation to suspicions and concerns of deliberate harm being caused to babies on the neo-natal unit at the Countess of Chester Hospital in 2015 / 2016.

54. I do not recall having any discussions with other members of the CDRP regarding suspicions or concerns regarding the neo-natal unit at the Countess of Chester Hospital in 2015 / 2016.

55. Flintshire and Wrexham CDRP Annual Reports were provided to Dr Lindsay Groves, Named Doctor for Safeguarding Children. As noted above, as Assistant Named Doctor, I would submit a form to the Programme (which at the time was hosted by Public Health Wales NHS Trust) when notification was received of a child death. No mention was made of the neo-natal mortality rate at the Countess of Chester in the CDRP Annual Report or notification to the Programme as this information was not known to me until May 2017 when I received a copy of the RCPCH review via Dr Groves.

56. I do not recall receiving any email from Sue Eardley regarding the number of deaths at the Countess of Chester Hospital between June 2015 and July 2016. I understand that searches of my emails have been conducted which do not indicate that any such email was received. As noted above, a copy of the RCPCH review, of which Sue Eardley was an author, was received by Dr Groves from Ms Kelly in April 2017.

57. I do not consider it would have been possible for the Flintshire and Wrexham CDRP to have spotted a rise in the neo-natal mortality rate at the Countess of Chester Hospital.

The Flintshire and Wrexham CDRP only considers child deaths where parents were resident in the Flintshire or Wrexham areas. Therefore, the CDRP would only be aware of a small percentage of the total deaths at the Countess of Chester neo-natal unit. As indicated above, the purpose of the CDRP is to identify regional patterns and trends and not to detect or investigate deliberate harm in specific cases.

58. In my view the Flintshire and Wrexham CDRP should have been informed of a rise in neo-natal mortality rate at the Countess of Chester Hospital given that patients falling within the CDRP's remit were treated there. As indicated above, a copy of the RCPCH review into neo-natal services was provided to Dr Groves in April 2017 by Ms Kelly and passed to me in May 2017.

Reflections

59. I am not in a position to comment on treatment provided by an organisation that I was not employed by, particularly given that I have not had access to sufficient information to form an opinion. In terms of the actions of the CDRP, in my view, a panel with the remit that the CDRP had would unfortunately not have been in a position to identify issues of the nature that occurred.

60. As noted above, when notified of a child death, the CDRP obtains Health Board notes and information from relevant professionals. The CDRP would not have asked the Countess of Chester Hospital for information unless there were concerns around the cause of death.

61. The information obtained and considered was sufficient for the purposes for which the CDRP was established.

62. In addition, given that the CDRP only considered deaths from the Countess of Chester where the children's parents were resident in Wales, it would not have had sufficient evidence to demonstrate a pattern or trend which might indicate a concern in relation to the Countess of Chester Neonatal Unit. This is particularly the case given that the deaths were spread over a fairly significant period of time.

63. I retired in 2021 and have had no involvement in the CDRP since that point. As such, I am not in a position to comment on any changes or improvements which have been made or which should be made in the future.

Any other matters

64. I have no further evidence from my knowledge and experience which I believe to be of relevance to the work of the Thirlwall Inquiry.

65. I have not given any interviews or otherwise made any public comments about the actions of Letby or the matters under investigation by the Inquiry.

66. I am unable to comment or provide any recommendations to keep babies in NNUs safe from any criminal actions of staff as I am no longer in practice and have never been a neo-natal specialist.

Request for documents

67. I have no further documents or other information which I believe to be of relevance to the work of the Thirlwall Inquiry.

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: 30 July 2024