Witness Name Joanne Davies
Statement No: 1
Exhibits: JD01-JD15
Dated: 25 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JOANNE DAVIES

I, Joanne Davies will say as follows: -

1. My full name is Joanne Elizabeth Davies (FRCOG / MBChB).

2. I provide this statement in response to a request dated 26 April 2024 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request"). This statement is based on my personal recollection of events and a review of various documents, as referenced in this statement.

3. To assist the Inquiry to the best of my ability, I have addressed each question set out in the Rule 9 Request insofar as I am able to do so at this stage of the process.

Medical Career and employment at the Countess of Chester Hospital (the "hospital")

4. I qualified with a Bachelor of Medicine and Surgery (MBChB) from University of Liverpool in 1994. I received my Membership of Royal College of Obstetrics & Gynaecology (MRCOG) in 2001. I was awarded a Post Graduate Certificate in Medical Education in 2012. I became a Fellow of the Royal College of Obstetrics & Gynaecology (FRCOG) in 2013. I am also a Member of the British Maternal and Fetal Medicine Society (BMFMS).

5. I have been working in Obstetrics & Gynaecology (O&G) since 1995, undertaking my specialist training on the Mersey Region Registrar rotation from 1999 to 2004. I was employed as a Locum Consultant in O&G at the hospital from October 2004 to April 2005. I have been a substantive O&G Consultant at the hospital since April 2005 to current date (July 2024)

6. From 2015 - 2016, I was a Consultant in O&G at the hospital, with special interest in high-risk pregnancy and maternal medicine.

7. During this period, I was the Clinical Lead for O&G. This was a wide scoping role that included leadership of the medical team in O&G. This included representation of this team at internal Trust meetings and externally, such as at the CCG / regional O&G networks. I had responsibility for outcomes and performance, whilst motivating the team to achieve and develop.

8. I undertook the additional role of Lead for Obstetric Risk during the period of Dr Sara Brigham's sick leave from June 2015 to October 2015. This involved leading urgent reviews into patient safety incidents in Obstetrics (Obstetric Secondary reviews), developing action plans, supporting staff involved in incidents and providing clinical expertise in the writing of the serious incident reports.

The culture and atmosphere of the neonatal unit ("NNU") at the hospital in 2015 - 2016

9. I have been asked to describe the relationships between: (i) clinicians and managers; (ii) nurses, midwives, and managers; and (iii) medical professionals (doctors, nurses, midwives and others) at the hospital. I found that generally, relationships were good between the different professional groups within the hospital.

10. I cannot comment on relationships on the NNU as I have never worked on the unit. My experience of NNU nursing staff was limited to clinical scenarios such as their attendance at a delivery, phoning them to give them information about possible cases on the labour ward (that may require neonatal support) and visits to NNU after a delivery to check on the progress of a baby. I observed them working closely as a team with the doctors, having good communication skills, and empathy and support for the women who were our patients.

11. I worked more closely with the Paediatric Consultants. Clinically this was in the emergency setting on the labour ward if they attended to manage a baby requiring support or discussing / planning care if a woman requiring delivery may require neonatal care. In these instances, I observed relationships between obstetric and neonatal staff to be good. I felt they worked well as a team, to give the best care to both mother and baby.

12. Educationally we had three joint meetings with the paediatric team per year. This included doctors (consultants and training) from both specialities, neonatal nurses, midwives and clinical nurse and midwifery managers. These were excellent multidisciplinary meetings and demonstrated good working relationships between the different professional groups.

13. From my observations, I do not think the quality of relationships on the NNU affected the quality of the care being given to the babies on the NNU.

14. I am unable to comment on the culture on the NNU between June 2015 and June 2016 as I did not work on the unit. However, from my observations of the team working together well clinically and educationally, I would expect the culture to be good.

15. I do not think professional relationships affected the management and governance of the

hospital in 2015 and 2016.

16. As I did not work on the NNU, I am unable to comment on whether the quality of relationships, or the culture on the NNU, changed in any way after June 2016.

Whether suspicions should have been raised earlier and whether Lucy Letby ("Letby") should have been suspended earlier

Child D

17. Child D died on 22 June 2015. Child D was the third baby to die within a two-week period on the NNU. Child A died on 8 June 2015 and Child C died on 14 June 2015. Letby was found guilty of the murders of Child A, Child C and Child D.

18. Within 24 hours of the death of Child D, there was an Obstetric Secondary Review (OSR). I was part of the review team **(See Exhibit JD01).**

    a. This involved a multidisciplinary team (obstetrics, midwifery, and risk department) completing a detailed review of the clinical notes of the mother. It is essentially a review of clinical care against current guidance. It would initially review the antenatal history and care, assessing that all antenatal risk factors had been identified and managed, followed by a review of intrapartum care (labour) of the mother. Finally, a review of any postnatal care of the baby provided by the midwife would be undertaken. The review included the mother's handheld maternity notes, hospital records and results, cardiotocograph recording (CTG) (fetal heart rate monitoring) and observation charts.

    b. The aim was to complete the review as quickly as possible to ascertain if there were any care problems, and then to escalate findings for consideration at a serious incident panel. This could lead to changes in early assessment, facilitates, staff supervision, training, or guidelines to ensure the incident was not repeated.

    c. To the best of my recollection, in 2015 there was not an agreed list of obstetric/neonatal incidents that immediately indicated that a serious incident had occurred. Therefore, a neonatal death would not necessarily immediately result in an OSR. For instance, a neonatal death can result from extreme prematurity or a lethal congenital abnormality, which may not warrant review.

    d. This case was reviewed by the OSR team immediately as this was a term baby that had died unexpectedly, with no known fetal concerns in labour. This is a rare event which is understandably distressing for the parents and for the staff involved. We felt it needed

immediate review of the obstetric care to understand if there were any factors during the mother's care that related to the death which needed early action to prevent further harm, and to provide information and support to the parents / staff involved.

e. The OSR on Child D was completed on 23 June 2015. This review was undertaken by myself, Debbie Peacock and Lorraine Millward (Practice Development Midwife). To my knowledge Julie Fogarty was not at this original review.

   i. At this initial review we found that care had been as per the guidelines relating to intrapartum care **(Exhibit JD02)**, management of term rupture of membranes **(Exhibit JD03)** and induction of labour **(Exhibit JD04).** Ruptured membranes prior to labour were routine and a protracted time from commencing induction of labour to delivery was also commonly seen, as in this case.

   ii. It was noted that mother was 36+6 days gestation (1 day off 37 weeks which is full term). Strictly speaking this is still premature and the admitting midwife should have discussed the case with medical staff. However, it was felt that medical staff would have advised the same plan, which was to induce labour the following day.

   iii. The induction of labour and the management of term rupture of membranes was correctly performed. The labour ward midwifery management and documentation were excellent, with no evidence of either maternal or fetal infection. There was no evidence that earlier delivery should have been performed. It was an appropriate time and decision to perform the caesarean section.

   iv. Midwifery postnatal care of the baby and escalation to the paediatric team was appropriate.

   v. There were a few minor documentation and care elements gaps that were not relevant to the outcome. These were still identified as part of the action plan.

f. Ideally such review should be carried out 24-48 hours after an incident. In practice this was often longer as it required the availability of the appropriate staff to review the case. In this instance, I was able to make myself available as I felt this review was high priority due to the severity of the incident.

g. I considered the death of Child D to be unexpected. The death followed a very common scenario of a prolonged period of 48-72 hours, post rupture of the membranes, between starting induction of labour and delivery. There is careful monitoring during this period to look for signs of infection of the mother (seen with mother's temperature increasing, heart

rate increasing or symptoms of infection) or of the fetus (seen as abnormalities on the cardiotocograph). Any of these signs would have initiated the use of antibiotics or possible earlier delivery. There was no sign during the 72 hours of care suggestive of any infection. Additionally, we sometimes see evidence of the infection after delivery. For example, offensive liquor or maternal temperature increases. Again, this was not present in this case.

h. I had concerns about the circumstances of Child D's death because I could not understand how this baby had died of sepsis with no clinical signs from the mother and no identified bacteria. However, I recognised that sepsis can be overwhelming and very quickly fatal to all, particularly newborn babies, and that sometimes it can occur in the absence of positive bacterial growth. I am also not a specialist in neonatology, and I respected their clinical expertise that this was the most likely cause of death.

i. My Rule 9 request refers me to one of the report's conclusions **[INQ0003299 p.3]** which states "*Needs Neonatal Review – S. Brearey*". This appears to be an inaccurate reference to a different document **[INQ0008799, p.3],** an OSR report relevant to Child A. I was not involved in this review, so I am not able to comment on this conclusion.

19. On 22 June 2015, I was copied into an email from Stephen Brearey **[INQ0014197]**. It appears from this that I discussed obstetric aspects of the care of the mother of Child D. Stephen Brearey also refers in his email to the fact he is looking at the deaths of Child A and Child C. He refers in the email to the fact that there was one nurse who it appears was on shift for the deaths of all three babies, but is noted they were not the designated nurse for Child D.

a. I do not recall discussing the care of the mother of Child D with Stephen Brearey. However, this communication would have been normal. We had both completed a review of our own speciality and it would be useful to clarify these findings. Ideally the review should have been undertaken as one with both obstetric/neonatal consultants, nurses and midwifes present, but practically this can be difficult to achieve in a quick time frame.

b. As Stephen Brearey states, he felt from the clinical picture and blood results of the baby that neonatal sepsis was the most likely cause of death. I expect we would have been discussing if there was any additional evidence to support this and requesting me to chase up maternal results of swabs and post-natal recovery.

c. I specifically remember having similar conversations regarding Child A. His mother I&S I&S I had cared for her throughout the pregnancy. I&S I&S I&S I&S we had to

consider additional care or investigations for his sibling.

d. I do not recall having any similar conversations regarding Child C, possibly because I was not involved in the mother's antenatal care. However, I did lead the OSR on this case **(see Exhibit JD05).** I note that one of my actions was to discuss with Dr Brearey how we could improve the antenatal counselling, which I assume I would have done.

e. I don't recall being concerned about the reference in Stephen Brearey's email to the same nurse being on shift for all three deaths. Any concern would have related to whether the member of staff needed additional training or support, which I would expect the Neonatal Nurse Manager to follow up and act on. The wording of Stephen Brearey's email reassured me that they had reviewed all possible factors, including environment and staffing, and that they had found nothing that related to the three deaths.

20. The "Case Review" in respect of Child D dated 28 August 2015 (with an addendum added following the receipt of the postmortem report and a meeting on 12 October 2015) is at **Exhibit JD06**. The case review is described as: "*a report made following review of the clinical notes by each speciality in relation to care provided to the mother and baby*."

21. In relation to this "Case Review":

a. As detailed in the review, the original OSR and Neonatal Review were presented to the Executive Serious Incident Panel on the 2 July 2015. It was decided by the Medical Director (Ian Harvey) and the Director of Nursing and Quality (Alison Kelly) that the two reports should be consolidated into one report on a Level 2 template [**Exhibit JD06, p.2]**. I was not present at this meeting and cannot comment further on the decision making to conduct a Case Review in relation to the death of Child D.

b. I have been asked to explain the purpose of a Case Review. My understanding was that this was intended to formalise the initial reviews (which are very clinical, informal documents) to produce a standardised report using layman's terms, that can then be shared with external agencies. It allowed updates on additional clinical information that became available after the initial review on day one. In addition, a formal action plan would be generated and monitored.

c. From my recollection, I believe most of this report was produced by Debbie Peacock, using the Neonatal and Obstetric reviews, and putting them in to the Level 2 template. Stephen Brearey and I then would have added additional clinical context.

d. From my recollection, there was no additional meeting to write this report.

e. Once the postmortem results were complete, we had a further meeting on 12 October 2015 to discuss the obstetric and neonatal care and agreed on the addendum, which was added to the report. The purpose of this was to revisit the care provided with knowledge of the postmortem findings. Many of the original actions from the initial reviews had been completed, which we documented in the report. The meeting allowed further discussion of the care provided and the generation of additional actions required.

f. I am unable to comment on why it was decided that there should be a Case Review in respect of Child D. Please see my response at paragraph 21a.

g. To my knowledge, there was no similar Case Review for Child A or Child C. The OSR was completed by me for Child C **(Exhibit JD05)** and by Mr Jim McCormack for Child A **[INQ0008799]**. These reports were then presented by the Risk Manager (Debbie Peacock) to the Serious Incident Panel. This panel, which I did not sit on, reviewed each case and decided if it could be closed, or whether it needed referral to the Strategic Executive Incident System (StEIS) for further investigation.

h. To my knowledge, the Serious Incident Panel made the decision to close the cases of Child A and Child C. I would expect this was because detailed Obstetric and Neonatal Reviews had found no issues with either neonatal or obstetric care and that further review would not have yielded additional learning / actions. However, as I was not on this panel and not informed of their reasons for their decisions, this would need to be confirmed by those who were present.

22. The Case Review regarding Child D records that:

"*An Obstetric Secondary Review led by the Obstetric speciality was undertaken within 24 hours of the incident occurring [death of Child D] and a Neonatal Review, led by the Neonatal Team was also undertaken. All aspects of care provided to the woman was scrutinised to assess whether there were lessons to be learnt. The incident was escalated to the Medical Director and Director of Nursing and Quality and was subsequently discussed at an extraordinary Executive Serious Incident Panel on 2nd July 2015; there had been three neonatal deaths in a short period of time and the circumstances were discussed to identify if there was any commonality which linked the deaths..... It was agreed that no further investigation was warranted at this stage as there were no concerns highlighted in the obstetric or neonatal reviews, however the SI Panel were of the opinion that the Obstetric Secondary Review findings and the neonatal Review findings should be consolidated into one report on a Level 2 template. Once the Postmortem report is available the report is to be re- assessed to identify if any gaps have been identified or if further assurances are required.*"

23. The conclusion of the Case Review was that no factor in either the obstetric or neonatal care could be identified that accounted for the child's death.

    a. It was noted that the mother had been one day off term (37 weeks), which had not been fully appreciated at the time, but it was felt that care would not have been different if this had been identified. Induction of labour would have been offered the following day as occurred.

    b. There was no hospital guideline in place on the day of the death for the management of pre-term ruptured membranes (this action had been completed by the time of this report).

    c. There had been no missed opportunity to start intravenous antibiotics in the mother.

    d. The neonatal junior doctor had not appreciated that the baby had risk factors for infection and there had been an initial delay in transfer to the NNU. However once transferred, intravenous antibiotics had been administered within the recommended time limit.

    e. There had been minor care and documentation gaps in the care identified and actioned, but these were thought not relevant to the outcome.

24. The addendum to the Case Review notes that a further meeting was held on 12 October 2015, following the postmortem results in relation to Child D. I was listed as being present at this meeting. It is noted that "*the review team revisited the care received by the woman and her baby following receipt of the postmortem report*."

    a. At this time there was a quarterly perinatal mortality review meeting. This was a joint educational meeting between O&G and paediatrics. This included medical staff (consultants and trainees), neonatal nurses and managers, midwives and midwife managers and representation from the risk team. A Consultant Histopathologist from Alder Hey Childrens Hospital was also present. The aim was to review all stillbirths and neonatal mortality and morbidity. A case was only discussed once all results were back to allow meaningful discussion and learning.

    b. This meeting was scheduled and occurred on 10 September 2015, chaired by Mr Jim McCormack. Please see notes of this meeting at **Exhibit JD07.** Child D was the third case documented. The pathologist went through the postmortem findings, and we discussed the unusual features of lack of maternal evidence of infection and minimal signs of infection on

the postmortem. During the discussion I explained my OSR findings that care had followed guidelines relating to intrapartum care, management of term rupture of membranes and induction of labour. This was questioned and there was much discussion regarding the fact that the mother was 36+6 weeks, 1 day short of term. Some in the room felt strongly that she was pre-term and should have been following the preterm rupture of membranes guideline. Additional care the mother would have had if this policy were followed included admission the night prior to commencing induction of labour and oral antibiotics during that admission and labour. There was a consensus in the room however that this additional care was unlikely to have made any difference to the subsequent outcome.

c. Following this educational meeting, the further meeting on 12 October 2015 was arranged. Its aims were to reassess the original Case Review, add in the postmortem findings, to try and verbalise the clinical complexity of the case of her being one day off the guideline that was followed and to include that there was minimal national guidance regarding intravenous antibiotic use in labour.

d. The postmortem results stated that the cause of death was from pneumonia with acute lung injury likely already present prior to birth.

e. The postmortem results were noted in the 12 October 2015 meeting but were not further questioned.

f. The opportunity to question and discuss the postmortem findings was at the perinatal mortality review meeting of the 10 September 2015. I and other members of the obstetric team still found it difficult to understand how a fetus could develop acute pneumonia, why there had been no clinical signs of infection during labour or the postnatal period of the mother and why there were not more features in the baby and placenta of overwhelming infection. These issues were discussed in length at the meeting. We all added our own specialist knowledge to that discussion, which enhances the educational quality of the meeting. I respected the expertise of the pathologist and paediatricians reaching the conclusion of sepsis being the cause of death.

g. I met with Child D's parents on 16 September 2015 to explain the postmortem findings and the complexities.

h. By the time of this review in October 2015, another baby, Child E, had died on the NNU on 4 August 2015. I do not recall the death of Child E and I do not recall the increased mortality rate on the unit being discussed at the meeting on 12 October 2015.

25. The Case Review for Child D (which refers to the fact it was the third neonatal death in a short

period of time) **(Exhibit JD06, p. 11)** has a heading "*Reported to External Agencies*" and lists the CCG (Clinical Commissioning Group) and CQC (Care Quality Commission).

a. My understanding is that the final report would have been sent and reviewed by these external agencies. I was not involved and had no knowledge of reporting beyond the Womens and Childrens department.

b. My recollection is that the cases, whilst being reviewed, were itemised on the Womens and Childrens Governance Board (WCGB) agenda monthly. Once finalised these were submitted to the CCG, and once all the actions had been completed this would then be closed on the WCGB agenda.

c. To my knowledge, at this time in 2015, a neonatal death did not specifically require external reporting. A serious incident such as a neonatal death required a datix report and an initial departmental review. The review findings were then discussed at the Executive Serious Incident Panel and a decision made by this panel on the level of review required and if external agencies needed to be notified. Clinicians were rarely invited to this panel and had very little input into decision making. The Inquiry would need to ask the Executives present at the Serious Incident Panel of 2 July 2015 why Child D was reported.

d. I am not aware whether the deaths of Child A and Child C were also reported to the CCG and the CQC.

e. I am not aware whether the death of Child D (or the deaths of Child A or Child C) were reported to the Child Death Overview panel and/or reported as a Sudden Death in childhood or Infancy (SUDIC). I am not aware who had responsibility to do this.

f. The only responsibility that I was aware of as part of the obstetrics department was to report all perinatal mortality to MBRRACE-UK (Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK). This was performed by one of the Midwifery Managers so I would make her aware if I knew of a relevant case.

g. I do not know who had responsibility to report as a Trust to the CCG, CQC, Child Death Overview panel and/or SUDIC. As clinicians we were guided by the Risk Management and Executive teams.

26. The death of Child D was escalated to the Medical Director and Director of Nursing and discussed at a Serious Incident Panel on 2 July 2015 because there had been three neonatal deaths in a short period of time. These were to be looked at to identify any commonality **[Exhibit JD06, p. 2].** From the handwritten notes of the meeting, it does not suggest that I

was present **[INQ0003530]** and I do not recall being present at the Serious Incident Panel on 2 July 2015. It was recorded that at the 2 July 2015 meeting "*it was agreed that no further investigation was warranted at this stage as there were no concerns highlighted in the obstetric or neonatal reviews*" **[Exhibit JD06, p. 2].**

a. I do not recall being aware that the meeting was taking place at this time. It was not routine for clinicians to be invited to attend.

b. I do not recall discussing the conclusion reached (that no further investigation was needed), with Stephen Brearey or any other attendee of the meeting. However, I am certain we would have had it as we were concerned that we had had three neonatal deaths in quick succession.

c. In essence I agreed with the conclusion as we had performed a detailed review of the three cases and felt they were unrelated. Child A and Child C both had significant other issues that could lead to a higher neonatal mortality rate. In relation to Child D, we had found no evidence of gaps in maternal or neonatal care that would have made a difference to the outcome. I agreed that it would be appropriate to complete a more detailed report and to re-review the findings once we had the result of the postmortem as the cause of death remained unconfirmed.

d. As I was not present at the Serious Incident Panel, I cannot comment on what was said. However as far as any conversations I had with Stephen Brearey at the time, I do not recall there was any mention of members of staff having access to the babies before they all died.

27. I cannot recall any details of when I was first made aware that Child E had died. Unfortunately, I cannot recall any details of the case and any obstetric investigation into the mother's care.

28. Similarly, I cannot recall when I first became aware that Child I had died. Retrospectively on case review, I note that she was several months old after premature delivery in a different Trust, hence I was not involved into any obstetric investigation at the time of her death.

29. I was subsequently required to provide a statement for the coroner in the case of Child D **[INQ0008663]**. I had no interactions with the coroner regarding Child D apart from the attendance at coroner's court in May 2017. Requests for statements and advice regarding this was communicated through the Countess of Chester Legal Department. I did not contact the coroner's office regarding any other babies during this time.

30. In retrospect I am surprised that the hospital did not report the high neonatal mortality rate

and the current investigation to the coroner at the time this evidence was being collected (which was late 2016, early 2017). However, all communication and reports provided to the coroner's office were supplied by the Legal Department. Attending as a witness in a coroner's case was something I had not experienced before, and my priority was my statement. I had no knowledge of what else had been reported to the coroner regarding the case and which other members of staff were also witnesses.

Review of Neonatal Deaths and Stillbirths at Countess of Chester Hospital – January 2015 to November 2015

31. In my interview with the police **[INQ0007512, p. 23]** I say that I was one of the first people to notice that the hospital had more stillbirths and more neonatal deaths than usual.

32. Annually MBRRACE-UK (previously CEMACH, The Confidential Enquiry into Maternal & Child Health) produces a perinatal mortality report, detailing national and local data of stillbirths and neonatal deaths. Prior to 2015 the annual report was received by the Trust and disseminated for learning. I have always been alert to mortality figures as my interest lies in high risk pregnancy and the clinical care of women following a stillbirth.

    a. In 2015 I was first asked by the audit department to produce an executive summary of the perinatal mortality data which I produced in collaboration with Stephen Brearey, looking at still births and neonatal death between January 2013 to December 2013 and at comparative figures with other trusts, dated 7 September 2015 **[INQ0003576]**. The publication from MBRRACE-UK usually comes out 18 months after the years end, so in September 2015 I was reviewing the total mortality figures for 2013. The data is therefore not contemporaneous and does not provide an immediate alert or trend in mortality cases. My recollection is that the production of the report on this retrospective data was not the reason I was particularly alert to mortality rates.

    b. The executive summaries were provided by to the Trust's audit team and then presented to the Trust's CAG (Clinical Audit Group). I recall that the summary reports may also have been submitted to the WCGB at some point, but not in 2015 / 2016. The purpose of the summaries was to demonstrate that the Trust had received and read the MBRRACE-UK reports and, if necessary (e.g. if the reports indicated that the Trust was an outlier), had acted on them.

    c. I believe 2015 was the first time the Trust had asked me to prepare an executive summary, as I recall having to ask how to draft the report as there was no template available. No reports in respect of data from 2009, 2010, 2011, or 2012 can be located. I recall that prior to 2015 the annual MBRRACE-UK report was received into the Trust and Dr Jim

McCormack would share the information at an annual perinatal statistics joint meeting with the paediatricians (Jim McCormack led on perinatal reporting and education prior to me). **Exhibit JD08** is an example of a PowerPoint from 2011 that Jim McCormack gave on the 2008 data (published 2010) as an example of what I believe was the practice prior to 2015.

d. An executive summary report in respect of the 2018 data cannot be located. It is thought that, as a report on this data would have been produced in or around 2020, a report may not in fact have been produced at this time in view of the Covid period. The Trust cannot locate Clinical Audit Group agendas for 2020 and therefore believes meetings of this group may not have taken place during this time.

33. At the time as Clinical Lead for O&G I was receiving monthly labour ward statistics which included numbers of stillbirths and unanticipated neonatal admissions. Unusually I was also covering Obstetric Risk in Dr Sara Brigham's absence so had been involved in more OSR's than usual. I believe it is these two factors that alerted me to possible higher than usual mortality rates.

34. I sent an email to Cath Sales (Senior Midwife who completed all the MBRRACE-UK data on stillbirths and neonatal deaths), explaining my concerns on 21 September 2015 **(See Exhibit JD09).** We had a further stillbirth and neonatal death in September which I suspect alerted me. It is difficult earlier in the year to consider the rates are high as commonly you may get a spike of a few cases in one month and then nothing for several months. I cannot remember how I noticed. I had been involved in many of the cases as a reviewer of care. I also had been involved in some cases as a lead clinician, but I was not aware of all cases, hence why I asked for confirmation of all that had been registered to MBRRACE-UK.

35. I did not have access to data prepared by MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other organisations about the mortality rate and number of serious adverse incidents on the NNU.

36. I spoke initially to Jim McCormack (Lead for O&G Risk), Julie Fogarty (Head of Midwifery) and Stephen Brearey (Clinical Lead for Neonatology) and informed them of the increased still birth and neonatal deaths that I had identified. At the time, we were the senior clinical managers for Womens and Children with the decision-making capability. Julie Fogarty had regular meetings with the Executive team and was the department's main communication link to them, but I cannot confirm if she escalated these findings at this time.

37. I personally did not escalate the concerns at this time to the Executive Team. I felt we had identified a trend and needed to do a detailed review of all the cases prior to further action. I had observed over the years that perinatal mortality has peaks and troughs. Of the cases I

was aware of, there had been no common themes, and I would have felt I needed data and evidence to support my concerns prior to formally presenting these to the Executives. At this point, I was more concerned about the large number of stillbirths that we had, rather than neonatal deaths. The neonatal deaths, apart from Child D, had all been premature with risk factors for increased mortality.

38. I explained in my police statement that it was my view that we needed to review these deaths as a group.

    a. It was joint decision by myself, Jim McCormack and Julie Fogarty that a review should take place.

    b. I discussed the need for a review with Stephen Brearey. I did not personally speak to senior managers outside of the department, as I felt we needed to do a detailed review of all the cases prior to taking any further action.

39. In November 2015 due to "*a perceived increase in number of stillbirths and neonatal deaths at the Countess of Chester hospital in 2015*", I was involved as one of a panel to review the cases and identify any common themes or trends and lessons to be learnt from an obstetric perspective. **(See Exhibit JD010).**

40. As part of the methodology, all still births, and neonatal deaths were identified. In the event 15 cases were reviewed. This review, which was signed by Dr Sara Brigham, concluded that "*no new issues were identified from the review*".

41. On recognising that we had increased numbers by September 2015 of both stillbirths and neonatal deaths it was appropriate to form a panel review of cases. The panel had expertise in reviewing cases and needed to be multidisciplinary. It was important for transparency to include an external member (this was Lesley Tomes -External, supervisor of Midwives).

42. Today (July 2024), a standardised review by a multidisciplinary team with external representation is performed for all perinatal mortality cases as gold standard. In 2015 this did not exist. Most of the cases had undergone a review at the time (an OSR). Some of them had been reviewed at the joint perinatal mortality meeting which was a good educational meeting but did not review the cases to the same detail. We also wanted to remove any bias that results from different people performing the original review might bring and to maintain transparency for any clinical cases that myself, Jim McCormack and Sara Brigham, as the high-risk obstetricians, had been involved in clinically.

43. The main benefit of reviewing multiple cases together is that trends and themes can be

identified more easily. It also allowed us to review the quality of the previously undertaken reviews.

44. We were reviewing the obstetric and midwifery care only. At the time because a large proportion of the cases were stillbirths, we did not feel that a neonatal representative needed to be on the panel. I was aware that Stephen Brearey had reviewed the three neonatal deaths that had occurred in June 2015 looking for recurring neonatal themes in those three cases.

45. We went through each case and the review that had been done already. If there were any questions that arose from the team on the original review findings we re-examined that area of evidence within the case notes. We did not repeat a detailed case note review of each mother. Some of the cases were waiting for review at the next perinatal mortality meeting and so a detailed review was done of those at this meeting.

46. We were looking at clinical areas of practice and how that care compared to either local or national guidance.

47. Care reviewed included antenatal history and labour, relevant observation charts, fetal heart recordings and in the case of neonatal deaths, midwifery care to the baby prior to being transferred to the NNU.

48. The main aims were:

    a. Identify areas of practice where care may have given a different outcome;

    b. Revisit the quality of the original review and our process;

    c. To look for recurrent themes such as:

        i. Specific guidelines that were regularly not followed, which may be that the guidelines were not well written;
        ii. Areas of clinical practice where staff may require targeted learning;
        iii. Documentation that was regularly not fully completed;
        iv. Members of staff involved in recurrent cases;
        v. Communication/ Team problems; and
        vi. Equipment or staffing issues.

49. The report, "*Review of neonatal deaths and stillbirths at Countess of Chester Hospital — January 2015 to November 2015",* is at **Exhibit JD010.** This report is not accurately described. It should have been titled 'review of the obstetric care of neonatal deaths and stillbirths at

Countess of Chester Hospital – January 2015 to November 2015'.

50. At the time the decision to undertake the review and the list of cases that were to be included in the review was produced (beginning of October), all neonatal cases had been reviewed. We had that information available at the time of the review. We were also aware that the neonatal team had reviewed the three cases in June 2015 and that all three deaths were thought to be unrelated. I do not think there was an intention at this time for the neonatal team to do a further review.

51. From my recollection, over the next few months there had been a further death on the NNU (Child I) and there was a general feeling that the neonatal team should do a similar review, with the two reports combined. I do not recall if we had been formally asked by the Executive team to do this **[INQ0003220]**.

52. This neonatal review occurred in February 2016 but to my knowledge the two reports were never combined.

53. There is nothing in the report or appendices which relates to the NNU care or any commonality in staffing at the time of death. The deaths all had multiple risk factors that increased their mortality rate and I do not recall that they were being treated as unexplained. Child D remained a discussion point as it didn't quite fit, but the postmortem had informed us that she had died of congenital pneumonia, the result of which led to the actions regarding changing of guidelines.

54. We were not aware of a common neonatal staffing factor. The only comment regarding this had been the email from Stephen Brearey on 22 June 2015 which stated '*There does not seem to be any staff (medical or nursing) members present at all three episodes other than one nurse, who was not the nurse responsible for Child D on that shift*' **[INQ0014197]**.

55. We did look for a common midwifery or obstetrician factor, but none were identified.

56. This report was widely circulated on 9 February 2016, by Lorraine Millward (Practice Development Midwife) to myself and others **[INQ0015135]**.

    a. The wide distribution list is to all Midwives and all O&G Consultants in the unit. The purpose of the email is educational, so that the important points that were identified could be shared and learned from.

    b. I cannot comment on why this was distributed so long after the review date. I would expect it had to be agreed and finalised at Executive level before it could be shared. Julie Fogarty

may be able to confirm this.

c. I am uncertain when Dr Sara Brigham finalised the report. I note that in the minutes from the WCGB on 19 November 2015 **(see Exhibit JD11)** there is a comment in any other business, "*Formalised CTG meeting to be set up following review of all SB/NND for 2015 – JF and KG to be included".* This relates to one of the actions on the action plan. This suggests to me that the report was not quite ready for submission to the WCGB in November but that we were mindful of starting to work on the actions.

57. Stephen Brearey produced a "*Thematic Review of Neonatal Mortality 2015-Jan 2016*" dated 8 February 2016 **[INQ0003217]**.

a. I do not recall if this report was shared with me prior to the email on 2 March 2016 **[INQ0005693].** The contents did not cause me any concern. If anything, I was reassured. I could see a thorough review had been performed by specialists within neonatology (of which I am not), including external representation from our tertiary centre at Liverpool Womens Hospital.

Discussion of Neonatal Deaths and Stillbirths at Committees and Boards

58. The mortality review process was discussed at the Quality, Safety & Patient Experience Committee on 14 December 2015 **[INQ0003204]**. Item 11 of the minutes is headed "Neonatal and Still birth review." The minutes note: "*Ms Fogarty presented a review of neonatal deaths and still births at the Trust during January to November 2015."* I was not a member of this Committee.

59. Four days later, on 18 December 2015, the review was presented to the WCGB. Item 9 on agenda minute reads **[INQ0003224]**:

"*Stillbirth and Early neonatal death review and action plan - panel set up to review each case individually total of 18 cases – no themes identified and each case to continue to be reviewed at multidisciplinary meeting. Some additional actions identified and added to current plan already in process. Overall the process showed we have good record keeping, good escalation, compliance with Trust policies and the outcomes would not have been any different."*

a. As per the minutes, I did not attend this meeting.

b. I was never Deputy Chair for the WCGB and on this particular date, 18 December 2015, the Deputy Chair was Julie Fogarty (as recorded in the minutes).

c. I am unable to comment as to what was recorded in the minutes at Item 9 as I was not present at the meeting.

d. I would presume it refers to the document titled *'Review of neonatal deaths and stillbirths at Countess of Chester Hospital – January 2015 to November 2015'* **(Exhibit JD010).**

e. To note, I had initiated the review and had been present on the review panel, but the review had been chaired and the report written by Sara Brigham (who was Lead for Obstetric Risk, having returned form sick leave in the October).

f. The review and subsequent report found that there were no concerns or recurrent themes with the obstetric care provided. In retrospect I feel that the report does not clearly demonstrate that the review and conclusions relate purely to Obstetric and midwifery care.

g. I cannot comment on whether it was made clear at the meeting that the report did not address the care babies received in the NNU or consider any concerns or themes that arose from the neonatal care, as I was not present at the meeting.

60. On 2 March 2016, Stephen Brearey circulated his NNU thematic report by email **[INQ0005693] [INQ0003251]**. I was copied into that email. This refers to joining up the report with the obstetric review.

a. I cannot recall if I sent a response to this email at the time.

b. The contents did not cause me any concern. If anything, I was reassured. I could see a thorough review had been performed by specialists within neonatology (of which I am not) including external representation from our tertiary centre at Liverpool Womens Hospital.

c. My only concern was the sudden nature of the collapses, but I trusted the expertise of the paediatricians on reviewing these cases that they could find no reason for this commonality.

d. I did not conclude from this report that there was a common staff factor noted.

e. To my knowledge, I don't believe the Obstetric and Neonatal Reports were joined up and submitted as a formal report.

61. It appears that it was not until 16 June 2016 at a meeting of the WCGB **[INQ0003212]**, that

the "*NNU thematic Review*" dated 8 February 2016 was discussed. It seems likely the review circulated would have been the updated March version of the Thematic Review report dated 2 March 2016 **[INQ0003251]**.

a. I do not recall the meeting, but the minutes state I was present.

b. I was never Deputy Chair of the WCGB, it was always Julie Fogarty.

c. I have no recollection of the discussion of the NNU thematic review at this meeting and unfortunately the minutes do not reflect any discussion we had. All reports to be discussed at the meeting were available to review prior to the meeting. I do not recall if I re-read the review prior to the meeting in June 2016. I had read the review when it was first sent to me in March 2016.

d. I do not know the reason for the delay in the finalised report not being formerly received at the WCGB until June. I note that the Debbie Peacock (Risk and Governance Lead) left post in February 2016 with no replacement in post. It may have been the interim measures put in by the Trust caused this delay. I also note that the March 2016 WCGB was cancelled, which was when I would have expected the report to be submitted. However, I can see no reason why this report was not brought in April 2016. I note Dr Ravi Jayaram (Clinical Lead for Paediatrics) was at the April and the May meeting. He would be best placed to explain why he did not discuss the findings of the report and highlight any delays there were submitting it.

e. I had been reassured by the thematic review findings in March 2016 therefore I do not recall being aware that it hadn't been submitted or therefore concerned with any delay.

f. Unfortunately, the minutes do not reflect any discussion and are only a copy of the introduction of the report. Upon looking back through this report, the minutes of the WCGB and my own recollections of the time, I agree that there was no reference to the actual numbers of deaths that had occurred and what increase this represented.

g. Between February 2016 and June 2016 there was no discussion at the WCGB of there being a common staffing theme in all the deaths and the name of Lucy Letby was never known to me until much later in the police investigation.

h. I cannot remember what was raised and discussed at this meeting. I had concerns about the numbers of neonatal deaths, as did other colleagues, but we could find no common obstetric themes and I was assured that the paediatricians felt the same way. I believed that all the information had been appropriately escalated to the Executive team.

62. With regard to the WCGB:

    a. On reading the minutes from the WCGB for April, May and June 2016 and based on my recollection, I do not believe we were aware of the concerns of the NNU.

    b. No one had informed the Board of the ongoing concerns after the thematic review.

    c. My memory after I was aware of concerns that a specific nurse was on duty for all the deaths was that such accusations cannot be loosely made. It is possible the paediatricians felt that the formal procedure of the WCGB was not the appropriate place to raise theories and that they were reviewing their concerns via more informal avenues.

    d. I was not aware of the email on 16 May 2016 from Stephen Brearey to all the paediatric consultants **[INQ0005721]**, alerting them of the need to be alert of any babies who deteriorate suddenly or unexpectedly or requires resuscitation.

63. The minutes of the WCGB dated 26 January 2017 **[INQ0004388]** and 20 April 2017 **[INQ0004416]** both refer to the deaths of Child O and Child P as unexpected neonatal deaths and are listed as Serious Incidents. The minutes would, as a matter of course, list Serious Incidents. Following the deaths of Child O and Child P there was no change in how the minutes were recorded. On reviewing other minutes from 2016, Serious Incidents and their progress are listed. This has often been shortened to 'SI's' and may be related to the person who wrote the minutes.

Triplets

64. In my police statement I state that it was when the triplets Child O and Child P died that "*we became concerned that things weren't right.*"

    a. Prior to the death of the triplets, there was a general feeling that something was not right with the NNU as we had previously had such low mortality rates. There were rumours amongst the obstetric and midwifery staff and there was an occasional unfounded comment that we had another "Beverley Allitt". We were always quick to stop this gossip as it felt completely unthinkable. I felt that we needed to maintain a quiet support for our paediatric colleagues.

    b. To my recollection, there were never any rumours about specific members of staff.

65. An email from Stephen Brearey dated 28 June 2016 **[INQ0003116]** sets out his concerns at

the increased mortality on the NNU, the unexplained sudden deterioration of babies and "*the presence of one member of nursing staff at these episodes.*" He goes on to say that following the deaths of Child O and Child P, there was a consensus at the senior paediatricians meeting that based on patient safety, Letby should not have any further patient contact on the NNU. He also refers to reducing the number of cots on the NNU. Stephen Brearey says he has discussed this with me and "*she is entirely in agreement with our proposed actions.*"

a. Stephen Brearey came to see me and informed me that the Consultant Paediatricians had noted a specific member of the nursing staff being present at all the neonatal deaths and that they suspected that this may not be a competency/training issue but may be intentional. The priority was ensuring patient safety whilst investigating this concern appropriately. His opinion was that the member of staff (Lucy Letby was not named to me at this time) should not have patient contact until these concerns had been properly investigated. He told me that Alison Kelly and Ian Harvey were aware and that the Consultant Paediatricians felt that we needed to go to the police with their suspicions. He asked for the Consultant Obstetricians support when meeting the Executives and recommending this action. I agreed as we felt that we had investigated all causes of mortality within our remit, but it was out of our area of expertise to perform a forensic enquiry.

b. He explained his idea of reducing the numbers of cots on the NNU, which would improve the nursing to patient ratio. This could also result in the downgrading of the NNU (and the level of intensity of care that could be provided). Essentially, he needed me to work alongside him with this as any decrease in neonatal beds would impact on obstetric workload. This included not only patients in labour but those we were managing that were high risk through difficult pregnancies. I understood this would require some change in pathways of management, that we would need to plan for, and which would create a significant workload for obstetrics.

c. I was in complete agreement with him that we had to do everything possible to ensure patient safety. I agreed to discuss this meeting urgently with my O&G Consultant colleagues.

Reporting and Investigation of Neonatal Deaths

66. I am not certain how many deaths occurred on the NNU between 2015 and 2016.

67. From my recollection at this time there was no generic lessons learnt about adverse incidents for the whole Trust. We had several joint educational sessions throughout the year with paediatrics, general surgery, and anaesthetists to share specific cases and learning. We had

quarterly meetings with the paediatricians to discuss perinatal mortality and morbidity cases, with an annual meeting to discuss the previous years statistics. We had a robust programme for the learning of adverse incidents in obstetrics and midwifery as detailed in the *"Policy for management of incidents, complaints and claims (obstetrics, gynaecology and neonates)"* **(See Exhibit JD12).**

68. Prior to this period there were annual regional perinatal mortality meetings reviewing the MBBRACE-UK data and specific cases. This unfortunately stopped by 2015. During this period there was a new regional programme that aimed at reducing variation. I went to regular meetings as this was set up. Initially the meetings were focused on how it would work and what we could gain from it as a region. In 2015 work began on creating a regional dashboard and this work continued into 2016, i.e. a prospective monthly dashboard of all relevant statistics such as stillbirths and neonatal deaths for each hospital in the region. This was in its infancy at this time as analysts and clinicians worked together to formulate how it could technically work. During this time there was no specific data being shared with the regional network and no discussions as far as I was aware (although this was generally led by Julie Fogarty as Head of Midwifery).

69. Near the end of 2016 we set up special interest groups. Initially the meetings were to describe what we hoped to get from them but later they included case presentations and discussions about adverse events. This may have been in 2017.

70. At the same time, Jule Fogarty and I attended the West Cheshire Maternity Network monthly that was led by the CCG. All our data was shared and discussed with them.

71. In 2015-2016, a datix would be registered for a neonatal death. The case would be discussed by the Risk and Patient Safety Team with relevant lead clinicians. The investigation would very much depend on the case. In most cases there was a separate neonatal team and obstetric team review of care as soon as possible. In some cases, such as Child I who died several months old after being born prematurely, there was no obstetric review of care.

72. Following the initial review if it was felt that there had been some gaps in care that may have contributed to the outcome the case was referred to STEIS (Strategic Executive Incident System) and was managed as a serious incident.

73. All reviews performed for neonatal deaths (both neonatal and obstetric) included a doctor. This was commonly a consultant with experience to do these reviews. During the relevant years, this was mainly Stephen Brearey for neonates and either myself, Jim McCormack or Sara Brigham for obstetrics. We had an agreement with our consultant body that if all 3 of us were unavailable the consultant on call for the week would be part of this review.

74. I cannot comment on postmortem request for neonatal deaths. For stillbirths we had a policy of asking all parents for postmortem in the days after delivery. Neonatal deaths by definition were babies that had been born alive and were cared for and died on the NNU and were not our patients. The neonatal team would be responsible for speaking to the parents in this situation.

75. From 2014 the MBRRACE-UK annual perinatal mortality report also detailed local rate of postmortem requested. The internal executive summaries, which I produced, included this data:

    a. 2014 - 100% of stillbirths were offered post-mortem and 75% of neonatal deaths **(Exhibit JD13)**

    b. 2015 - 100% of stillbirths were offered post-mortem and 88% of neonatal deaths **(Exhibit JD14).**

    c. 2016 - 100% of stillbirths were offered post-mortem and 80% of neonatal deaths, compared with 96% and 91% UK-wide **(Exhibit JD15).**

76. It is difficult for me to comment on the Trust's risk management strategy or its implementation between 2015 - 2016. As a clinician, I was not fully aware of what should be in place at Trust level and how that should be achieved. I was focused on the O&G department and followed the processes that we were asked to perform.

77. Over the following years I have been involved in challenging the Executive team on a number of occasions on its staffing of Risk Management and Strategy, but at the relevant time we were only just starting to appreciate there were gaps.

78. As an obstetrics department we felt we had a robust risk management strategy and that we had investigated the rise in neonatal mortality appropriately. I trusted the review process that the paediatric team had completed confirming good quality of care. We were reporting and investigating serious incidents as required and this was being monitored at the WCGB. I had no reason not to expect that this review would be submitted appropriately to WCGB and for it to be joined up with the Obstetrics Review. I did not question the information that was going from this Board to the Executives and what their actions were in response. We had confirmation from the Risk Management Team monthly at the WCGB that the CCG were informed of the current serious investigations and progress. I attended a meeting with the CCG monthly and no concerns were flagged to me personally that they were not happy with our reporting or management of serious incidents.

79. Certainly, during this time there was a gap in the Risk Management Team after Debbie Peacock left. There appeared to be no urgency by the Executive team to replace her and the people covering her role appeared to have no knowledge of maternity and neonatology. There was no support from the lead for risk management and administrative support for the monthly WCGB was lacking.

80. At the same time, I was also involved in trying to improve triangulation between incidents, complaints, and claims in O&G. This proved very difficult, and I was unable to achieve this fully. This was due to difficulties in communication between the three teams who were all over stretched.

81. Years later we realised that other Trusts had many more members of staff dedicated to maternity risk management, which the hospital had never invested in. I believe finance is the key reason that led to the position the hospital was in.

82. I am noted as the author of a document titled "*Policy for management of incidents, complaints and claims (obstetrics, gynaecology and neonates)*". See **Exhibit JD12.**

    a. To the best of my recollection, Jim McCormack had been the original author. I was asked to update the policy in 2015.

    b. The policy was due for updating but I cannot comment on why I was asked rather than Jim McCormack. At the time I was Clinical Lead for O&G. I cannot remember who asked me to update this, but I felt that I did not have the relevant expertise. I felt things had moved on since Jim McCormack had originally written it and it needed to be written as a combined project between risk management, claims, and complaints.

    c. The resulting document is therefore clinically written and mainly concentrates on the management of incidents, with less information on claims and complaints, and particular emphasis on the arrangement for sharing lessons learned.

    d. I agreed to do it as I knew it needed to be done. I was supposed to receive support from Ruth Millward (I cannot remember her job title – possibly Lead of Risk and Patient Safety) to complete the task but this was lacking.

    e. It was being drafted in late 2015, and drafts were sent to Ruth Millward with much delay between drafts. It was submitted for ratification to WCGB in April 2016. I am unable to recall when it came into operation as a policy. It is no longer in operation as a policy.

f. To my knowledge, at the time, I considered this policy was being followed. The main areas that we may have fallen short of related to the communication with patients by a Lead Patient Support.

g. I have been asked to comment on which aspects of this policy I consider were not complied with in relation to the events of 2015 to 2016 and/or which had they been followed may have led concerns about Letby being identified earlier and earlier action taken to remove her from the unit.

i. I considered that we were following the policy at the time at the departmental level. However, it may be that the escalation and reporting requirements below were not being followed (which I was not aware of): –

"An initial assessment is made of the level of harm and if necessary will be escalated via SBAR to the Head of Risk & Patient Safety for review and if necessary escalation to the Executive Serious Incident Panel where the decision concerning the level of review required is made and appointment of a Lead Investigating Officer.

All patient safety incident investigations are reported externally to the Strategic Executive Incident System [StEIS] and are monitored externally via the NHS West Cheshire Clinical Commissioning Group Serious Incident Meeting and internally via the Quality, Safety and Patient Experience Committee".

ii. As a clinician, my main role would have been the initial assessment and opinion as to the level of harm, which I performed. The Risk and Patient Safety team were responsible for the onward actions. At no time did I attend or was asked to provide evidence with regards to external reporting or assurance.

iii. However, I am not certain that following these policies fully would have led to concerns about Lucy Letby being identified earlier.

Safeguarding of babies in hospitals

83. I attend level 3 safeguarding training annually, provided by the Trust safeguarding team. I do not recall that this training includes specific training on what to do where a member of staff is suspected of harming babies or children in hospital.

84. I do not know whether my professional body assists with safeguarding guidance or advice about what to do in a situation where a member of staff is suspected of harming babies or children. If I needed to seek advice in this situation, I would ask the hospital's safeguarding

team, who I have always found to be very knowledgeable and helpful.

85. I did not consider turning to anyone for safeguarding advice during this period. I was only made aware from 28 June 2016 of the paediatrician's concerns. This was not based on my own evidence, and I trusted their opinion and how they were taking it forward.

86. I did not receive training on the process used and organisations involved in reviewing a child death such as Child Death Review, Sudden Death in Infancy/Childhood (SUDI/C) and the Coroner's Office.

87. I appreciated there were external scrutiny bodies with whom concerns could be raised. For example, NHS England (and its regional bodies), local commissioners, Monitor, NHS Improvement, the Care Quality Commission, Child Death Overview Panels, the police or the General Medical Council or Nursing and Midwifery Council.

88. I did not provide any information about Letby, or express concerns or suspicions about the deaths or injuries to the babies named on the indictment to external scrutiny bodies as I did not have all the details of the concerns raised. I trusted my paediatric colleagues who had all the information and expertise and expected they would raise their concerns as appropriate.

Consideration of referral to the Local Authority Designated Officer

89. Appendix 6 of the Trust's Disciplinary Policy was titled: "*Consideration of Referral to the Local Authority Designated Officer (LADO) (Disclosure and Barring Service (DBS))*". It states:

"*If there is a concern raised or an allegation made about a person who works with children, whether a professional, staff member, foster carer or volunteer that they may have:*

- *behaved in a way that has harmed a child, or may have harmed a child*
- *possibly committed a criminal offence against or related to a child or*
- *behaved towards a child or children in a way that indicates s/he is unsuitable to work with children, then the process outlined below should be followed: -*

The member of staff raising the concern should first discuss this matter with the Professional Head / Lead Clinician or Head of Service for their Division (named senior officer). These managers will have responsibility for allegations management and will liaise with the LADO within the children's safeguarding unit, Local Authority…" **[INQ0002879, p. 120]**.

90. I was not aware of the above policy in Appendix 6. I have had no reason to read this guideline.

91. I did not contact the Local Authority Designated Officer or advise anyone else to do so. I am not aware if anyone else did so.

92. I did not make this contact as I was not aware of this policy. The paediatricians had raised their concerns to the Executive team whom I would have expected to be more knowledgeable of this policy and to take this forward.

Reflections

93. I do not think there any steps that could have been taken to identify earlier that Letby was harming babies on the NNU. I think the paediatricians spoke up when they felt they had enough evidence. Given the "no blame culture" of the NHS, when initially looking for common trends of staff I believed they were doing it from the perspective of possible competency issues that would require additional training and support, rather than actual intent to harm.

94. I am not certain that CCTV would have prevented the crimes of Letby, as I am sure that criminals will find their way round this.

95. It appears that CCTV was considered in the July 2016 Action Plan **[INQ0002850, p. 2].** The ongoing action plan from July 2016 was not shared with me, and I have no knowledge of any discussions regarding CCTV at this time.

96. I have been asked what recommendations I think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff:

    a. Staffing requirements met.
    b. DBS checks are all up to date.
    c. Mandatory training completed.
    d. Equipment requirements met.

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

Request for documents

98. Other than those exhibited to this statement, I do not have any further documents or other information which are potentially relevant to the Inquiry's Terms of Reference.

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: 31.07.2024 | 16:58:14 BST