Witness Name: Dr Claire Thomas
Statement No.: 1
Exhibits 9 **[CT/1 - CT/9]**
Dated: 6th September 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR CLAIRE THOMAS

I, Dr Claire Thomas, of Public Health Wales (2 Capital Quarter, Tyndall Street, Cardiff, CF10 4BZ) will say as follows: -

1) I qualified as a medical doctor in 1993 from the University of Birmingham and went on to specialise in Paediatrics becoming a Consultant Paediatrician in 2004 with a subspeciality of Community Child Health. My qualifications are MBChB, MRCP, FRCPCH and Dip CPH.

2) I am currently employed in the following four roles.

   a) Clinical Lead for the National Strategic Clinical Network for Child Health – NHS Executive (Wales), a post I commenced in May 2024.
   b) Paediatric Lead Child Death Review Programme (Public Health Wales), a post I commenced in 2020.
   c) Consultant Community Paediatrician, Cardiff, and Vale University Health Board, a post I commenced in 2023.
   d) Consultant Paediatrician, South Wales Regional SARC, a post I commenced in 2021.

3) Previously, I was employed in the following roles.
   a) Designated Doctor for Safeguarding - National Safeguarding Service (Public Health Wales) between 2020 and 2024.
   b) Consultant Community Paediatrician CTMUHB between 2020 and 2023
   c) Consultant Community Paediatrician C&VUHB between 2017 and 2020
   d) Consultant Community Paediatrician Royal Wolverhampton NHS Trust between 2004 and 2017
   e) Designated Doctor Safeguarding Children and Child Deaths – Wolverhampton CCG between 2011 and 2017

f) Designated Doctor Safeguarding Children and Child Deaths – Walsall CCG between 2015 and 2017

4) Prior to 2004, I was a Specialist Trainee in Community Paediatrics in the West Midlands Deanery.

Experience

5) I have worked clinically as a Specialist in Safeguarding since I became a Consultant in 2004 seeing Children for suspected physical abuse, neglect, and sexual abuse throughout this time.

6) Until 2017 I worked as a Consultant SUDIC Paediatrician who responded to the unexpected deaths of children and undertook the investigations, examination and multi-agency working as part of the joint agency response in Wolverhampton.

7) As the Designated Doctor for Safeguarding Children and Child Deaths for both Wolverhampton CCG and Walsall CCG, I sat on the Wolverhampton/Walsall Child Death Overview Panel (CDOP) reviewing all child deaths which occurred during this time. I was also responsible for ensuring implementation of the joint agency response (JAR) and CDOP processes within health in these areas.

8) I was Chair of the Wolverhampton Regional Safeguarding Board Serious Case Review committee until 2017, recommending the commissioning of serious case review in cases where abuse or neglect were thought to have contributed to a child's death and overseeing the review process and the subsequent implementation of recommendations.

9) I was a member of the team who developed the highly rated SUDIC Simulation programme for senior registrars and new consultants which was commissioned for all Registrars in the West Midlands.

10) Since 2020 I have been the Paediatric Lead for the Child Death Review Programme in Public Health Wales. Along with the Public Health Lead of the programme we have responsibility for reviewing all deaths of children within Wales and Welsh children who die outside of Wales to identify patterns or trends and modifiable factors which may mean that we are able to prevent future deaths and have authored a number of reports, reviews and rapid reviews into areas of child death in Wales.

11) As Designated Doctor for Safeguarding within the National Safeguarding Service in Public Health Wales from 2020 to 2024. I led a number of large pieces of work including the rapid review of multiagency practice following a series of concerning child deaths which occurred in one area of Wales at the request of the Regional Safeguarding Board. This review generated an action plan and recommendations for implementation while the criminal investigations and **child practice reviews** were ongoing.

12) At the request of all regional safeguarding boards in Wales, I lead and authored the revision of the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) response to unexpected death in childhood guidance in Wales in 2022.

13) I have also undertaken the following roles:

a) Previous chair of the paediatric mortality meeting at the Noah's Ark Children's Hospital for Wales.

b) Current member of the Wales Medical Examiners Stakeholders Group and participated in the development of the National Medical Examiner's Good Practice Series No. 6 Medical Examiners and Child Deaths.

c) Currently elected Welsh representative on the Association of Child Death Professionals executive committee.

d) Currently Co-chair of the Wales Family Justice Council Expert committee.

Unexpected Baby Death – England and Wales Current Processes

14) I have been referred to the statements provided by Dr Joanna Garstang, Consultant Community Paediatrician and Chair of the Associations of Child Death Review Professionals, in which Dr Garstang has provided information in relation to current safeguarding procedures in England. These statements are dated 20th March 2024 [INQ0017975] and 12th July 2024 [INQ0106963].

15) In 2.20 of her statement [INQ0017975], Dr Garstang says; *"The current process for managing all child deaths whether these occur in hospital or not is detailed in the 2018*

Child Death Review Statutory and Operational Guidance (HM Government, 2018) and Working Together to Safeguard Children (HM Government, 2023). The determination and management of any safeguarding procedures is included in this process."

16) The current process in Wales for investigating all unexpected child deaths whether these occur in hospital or not is detailed in the multiagency Procedural Response to Unexpected Deaths in Childhood (PRUDiC) 2023 (EXHIBIT CT/1 INQ0107973) and The Wales Safeguarding Procedures for children and adults at risk of abuse and neglect (EXHIBIT CT/2) which helps practitioners apply the legislation Social Services and Wellbeing (Wales) Act 2014 (EXHIBIT CT/3 INQ0107974). and statutory safeguarding guidance Working Together to Safeguard People (EXHIBIT CT/4 INQ0107975). The determination and management of any safeguarding procedures is included in this process. The PRUDiC response is not statutory in Wales and child death procedure was not included in the legislation when the Social Services and Wellbeing (Wales) Act 2014 came into force.

17) In 2.1 of her statement [INQ0017975], Dr Garstang says; *"For most children who die in hospital, the death will not be unexpected, and doctors will be able to issue a Medical Certificate for Cause of Death (MCCD). However, if the cause or circumstances of death are not clear, it is from external causes, or there are concerns about care or service delivery further investigation is required."*

18) The processes in Wales are the same.

19) In 2.2 of her statement [INQ0017975], Dr Garstang says; *"Within 1-2 hours of the death, the senior paediatrician responsible for the child should have obtained enough information to decide (1) whether the death meets criteria for a Joint Agency Response (JAR) and if so, contact the relevant multiagency professionals to initiate it. (2) if a MCCD can be issued and if not to refer the death to the coroner. (3) whether an issue relating to healthcare or service delivery has occurred or is suspected and if so, refer the death to the coroner and for NHS incident investigation. (4) determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff."*

20) This process is the same in Wales apart from the differences in process and terminology detailed below.

a) The senior paediatrician is known as Consultant Paediatrician (or doctor with appropriate training and competence)
b) The Joint Agency Response (JAR) is referred to as a PRUDiC in Wales and is a different process to the JAR referred to in Dr Garstang's statement.
c) The NHS Incident investigation process in Wales includes reporting National Reportable Incident to Welsh Government in accordance with the 'Putting Things Right' Guidance (EXIBIT 5) INQ0107976

21) In 2.3 of her statement [INQ0017975], Dr Garstang says; "*If the senior paediatrician is uncertain as to whether the death meets criteria for JAR, they should initiate multi-agency discussion so that all agencies can agree whether to proceed with a JAR or not. In practice, this usually means starting the JAR although if sufficient information becomes available all agencies may agree that the JAR can be stopped.*"

22) This process is similar in Wales. If the Consultant Paediatrician (or doctor with appropriate training and competence) is uncertain whether to proceed with a PRUDiC then they should initiate multi-agency discussion so that all agencies can agree whether to proceed with a PRUDiC or not. In practice, this usually means starting the process although if sufficient information becomes available all agencies may agree that the PRUDiC can be stopped.

23) Chapter 11 of PRUDiC (2023) states if there is disagreement over whether the PRUDiC process should be initiated following the death of a child then there needs to be a discussion between the Head of Safeguarding, Police, Paediatrician (or doctor with appropriate training) and Social Care to discuss any issues surrounding the death. If there are any concerns around the cause of death, then PRUDiC processes should be commenced.

24) In 2.4 of her statement [INQ0017975], Dr Garstang says; "*If there are safeguarding concerns relating to a child death, these would be managed by starting the JAR, this would notify the police and Local Authority, and further multiagency safeguarding enquiries would follow as needed.*"

25) In Wales, if there are safeguarding concerns relating to a child death, these would be managed by starting the PRUDiC, this would notify the Police and Local Authority, and further multiagency safeguarding enquiries would follow as needed.

26) In 2.5 of her statement [INQ0017975], Dr Garstang says; *"If the safeguarding concerns related to a member of staff, the hospital should also follow their policy for 'People in positions of trust', which should require that the Local Authority Designated Officer (LADO) be informed within one working day (HM Government, 2023)."*

27) In Wales, this process is part of the Wales Safeguarding Procedures – section 5 (EXHIBIT CT/2).

28) In 2.6 of her statement [INQ0017975], Dr Garstang says; *"The following deaths should be referred to the coroner: deaths due to poisoning or exposure or contact with toxic substances, deaths due to medicinal products, controlled drugs or psychoactive substances, deaths due to violence trauma or injury, deaths due to self-harm, deaths due to neglect, deaths due to treatment or medical procedures, deaths due to injury or disease related to employment, deaths that are unnatural but not falling into previous categories, deaths where the cause is unknown, deaths that occur in custody, deaths where a doctor is unable to sign a death certificate, and deaths where the identity of the person is unknown. Full details are given in 'Guidance for registered medical practitioners on the Notification of Deaths Regulations' (Ministry of Justice, 2022)."*

29) This is the same process in Wales.

30) In 2.7 of her statement [INQ0017975], Dr Garstang says; *"An unexpected child death in hospital may therefore be referred to the coroner for a variety of different reasons."*

31) This is the same process in Wales.

32) In 2.8 of her statement [INQ0017975], Dr Garstang says; *"The National Medical Examiner system is being rolled out but is not yet being used for child deaths in all areas of England. It is intended that this should happen by April 2024. The Medical Examiner will scrutinise all deaths that are not referred to the coroner; this will involve a review of the case notes and a telephone conversation with the family to identify if they had any concerns with their relative's treatment and care. All MCCDs will be scrutinised Medical Examiners and if necessary, deaths referred to coroners (Department of Health and Social Care, 2023)."*

33) This is the same in Wales – with the legislation coming into force in both England and Wales for all non-coronial deaths on September 9th, 2024.

34) In 2.9 of her statement [INQ0017975], Dr Garstang says; *" A JAR should be initiated if a child's death: is or could be due to external causes, is sudden and there is no immediately apparent cause, occurs in custody or if the child is detained under the Mental Health Act, where the initial circumstances raise suspicions that the death may not be natural, or for an unattended stillbirth."*

35) In Wales, a PRUDiC should be initiated under the same circumstances.

36) In 2.10 of her statement [INQ0017975], Dr Garstang says; At *"A JAR should take places for all cases of Sudden Unexpected Death in Infancy or Childhood (SUDIC). SUDIC is defined as the death of an infant or child (or collapse leading to death), which would not have been reasonably expected to occur 24 hours previously, and in whom no pre-existing medical cause of death is apparent (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2016). SUDIC is a descriptive term used at the point of presentation, many SUDIC will subsequently have a cause for death determined."*

37) In Wales, a PRUDiC should take place for all cases of unexpected deaths in children.

38) PRUDiC states that, unexpected deaths are 'The death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death'. and as: 'The death of a child where there is no known antecedent condition that might be expected to cause the death at that time, and the child dies either immediately or subsequently from the consequences of the precipitating event or collapse.' (EXHIBIT CT/1 **INQ0107973**

39) The PRUDiC applies to all deaths in children from birth until their 18th birthday whether from natural, unnatural, known, or unknown causes, at home, in hospital or in the community. This includes road traffic collisions, apparent suicides, and murders. It does not include.

a) Stillbirths (This is a birth on or after a gestation of 24 weeks (168 days), where the baby does not breathe or show any other signs of life)

b) Neonates where the birth was in hospital and was attended by a professional, who have never been discharged into the community and where the death was expected.
c) Those with a life-limiting condition known to the Palliative Care Team and where death was expected.

40) In 2.11 of her statement [INQ0017975], Dr Garstang says; *"A SUDIC investigation is the same as a JAR. There are nationally recognised guidelines for SUDIC investigation (Royal College of Pathologists and Royal College of Paediatrics and Child Health, 2016). These state on page 14: 'When a newborn infant collapses and dies on a neonatal unit, consideration should be given as to whether a joint agency response is required. In most situations this would not be appropriate.' The national SUDIC guidelines are also referred to as the 'Kennedy Guidelines' or 'Kennedy Protocol' as the working group was chaired by Baroness Helena Kennedy."*

41) PRUDiC is the process which is followed following the unexpected death of a child in Wales. This takes the place of both the JAR and SUDIC investigation referred to in 2.11 of Dr Garstang's statement.

42) In Wales, PRUDiC 2023 (chapter 7) states, in those neonates where the death was not expected 24 hours before the death and the death was not from a recognised neonatal complication, then a discussion between the Consultant Neonatologist/ Paediatrician (or doctor with appropriate training) and the Head of Safeguarding/Named Midwife for Safeguarding (and Police/Social Services as necessary) should be held, to decide whether the PRUDiC process should be followed. Although it is important to not duplicate other mortality processes which run in parallel, it is important to be able to identify those unexplained unexpected deaths where harm may have occurred. Sometimes a death may be from a recognised neonatal complication, but this was not expected in this child. Conversely, a death may be expected 24 hours before the death, but the underlying cause/ event may have happened some days or even weeks earlier and may have been unexpected. In such cases consideration should be given to initiation of the PRUDiC process through discussion with the Consultant Neonatologist/Paediatrician (or doctor with appropriate training) and the Head of Safeguarding/Named Midwife for Safeguarding (and Police/ Social Services as necessary)

43) In 2.12 of her statement [INQ0017975], Dr Garstang says; "*In practice, if an infant or child dies unexpectedly and with no explanation while an inpatient in hospital, the SUDIC*

process would now normally be initiated, and there would be discussions between senior paediatricians and police as to how best to investigate the death. These are, however, rare events."

44) This is the same in Wales – following the processes in chapter 7 PRUDiC 2023.

45) In 2.13 of her statement [INQ0017975], Dr Garstang says; *"Our experience in Birmingham and Solihull is that when we are notified by consultant neonatologists or hospital paediatricians of sudden unexpected deaths on the neonatal unit or paediatric ward, we always have an immediate discussion with them and the on-call police about whether it is appropriate to start a JAR but often conclude it is not needed. However, we fully expect to have a discussion with the police about any case such as this."*

46) In Wales, the processes detailed in chapter 7 PRUDiC 2023 should be followed for unexpected deaths of a neonate in hospital.

47) In 2.14 of her statement [INQ0017975], Dr Garstang says; *"The JAR/SUDIC investigation would vary from the national guidance for a death occurring in hospital as the guidelines are written from the perspective of deaths occurring in the community. The following should take place for a JAR/SUDIC investigation where a baby has died on a neonatal unit."*

48) PRUDIC 2023 has been written from both a community and in hospital perspective for all unexpected deaths in children including neonates.

49) In 2.15 of her statement [INQ0017975], Dr Garstang says; *"A lead health professional should be appointed to co-ordinate the health response to the death. For deaths occurring in the community this would be a Specialist SUDIC paediatrician (or the Designated Doctor for Child Deaths) but for a sudden death on a neonatal unit it may be more appropriate for a consultant paediatrician or neonatologist from the hospital to take this role, with advice and support from the Specialist SUDIC paediatrician"*

50) In Wales, the Consultant Paediatrician (or doctor with appropriate training and competence) would lead the health response and if the death is on a neonatal unit, then this may be a neonatologist. Unlike England, Wales does not have Specialist SUDIC Paediatricians or Designated Doctor for Child Deaths, these are not included within the

legislation of the Social Services and Well-being (Wales) Act 2014, nor the Wales Safeguarding Procedures, as PRUDIC is not a statutory process within Wales.

51) In 2.16 of her statement [INQ0017975], Dr Garstang says; *"The consultant paediatrician or neonatologist should attend the neonatal unit; if there is a specialist SUDIC paediatrician on-call they may be asked to attend or give advice. Usually, for deaths occurring in neonatal units or other inpatient areas, the consultant paediatrician or neonatologist would lead the SUDIC investigation in the hospital with support from the specialist SUDIC paediatrician, as they would already know the baby and family."*

52) This is the same in Wales although without the Specialist SUDiC Paediatrician support.

53) In the absence of Specialist SUDIC Paediatricians, Specialist SUDIC Nurses and Designated Doctor for Child Deaths in Wales, there are a number of ways in which advice is sought. This may be from the Named Doctor for Safeguarding or the Head of Safeguarding who are both employed by each Health Board, Designated Doctor for Safeguarding (National Safeguarding Service, PHW) or Paediatric Lead for the Child Death Review Programme (PHW) but there is no specific pathway for seeking this advice within Wales.

54) In 2.17 of her statement [INQ0017975], Dr Garstang says; *"The on-call police officer for SUDIC/JAR should be contacted immediately and asked to attend the neonatal unit. This is usually a Detective Inspector with specialist training in child death and child protection, and they should not be in uniform. There is no requirement or expectation that hospital management would be asked to consent to police being contacted; this is a standard part of the SUDIC/JAR process."*

55) PRUDiC (2023) states; when a child dies unexpectedly a Police Senior Investigating Officer will be appointed and take responsibility for the management of Police resources and for ensuring appropriate and proportionate lines of enquiry are instigated. Senior Investigating Officer appointments will be in accordance with Force Policy and in consideration of the National Police Chiefs' Council (NPCC) Guidelines.

56) Where circumstances indicate that attendance at the scene will benefit the enquiry, an experienced Detective Officer will be tasked to immediately attend the scene. Where the possibility of child maltreatment is present, it is essential that the Detective Officer has

child protection experience or liaises with a colleague who has child protection experience.

57) This would also apply to children who die unexpectedly on the neonatal unit (and meet the criteria detailed in PRUDiC 2023, chapter 7).

58) In 2.18 of her statement [INQ0017975], Dr Garstang says; that as SUDIC/JAR is a statutory process, parents should not be asked for consent nor are they able to decline the process. They should however be kept fully informed and supported throughout.

59) Although not statutory within Wales – the safeguarding component of the process is statutory according to Wales Safeguarding Procedures and therefore this is similar in Wales.

60) In 2.2 of her statement [INQ0017975], Dr Garstang confirms "the police officer and consultant paediatrician, or neonatologist should examine the baby together and document any injuries or marks, including those from medical interventions on a body map. If needed police may take photographs."

61) This is the same in Wales.

62) In 2.20 of her statement [INQ0017975], Dr Garstang says; "*The baby should have post-mortem samples taken on the neonatal unit for infection, metabolic conditions, and toxicology as detailed in national guidelines, these include skin biopsy, blood samples, lumbar puncture, and swabs. This is because there are often delays of several days before formal post-mortem examination, and these samples are best taken soon after death.*"

63) There is a different process with regards to postmortem samples within Wales – which is detailed within Chapter 15 of PRUDiC 2023.The Consultant Paediatrician (or neonatologist, or doctor with appropriate training or competence) should:

a) fully document any samples taken from the child before death, providing available results to the Pathologist and recording those still outstanding on transfer to the mortuary.
b) Seek advice regarding sampling from the Pathologist if the history or examination suggests a metabolic disorder. (The Doctor does not need to take any other samples

from the body). Genetic/metabolic diseases may be more easily identified where an early skin biopsy is taken; this should be discussed with the Pathologist.

64) In 2.21 of her statement [INQ0017975], Dr Garstang says; *"The consultant paediatrician or neonatologist should take a detailed medical and family history from the parents; the police officer should be in attendance for this and ask any further questions as needed. The consultant paediatrician or neonatologist and police officer will also take a detailed account from the nursing staff caring for the baby in the hours before the death."*

65) This is the same process in Wales.

66) In 2.22 of her statement [INQ0017975], Dr Garstang says; "*Social care should be notified, as standard practice for all SUDIC cases; this is often as a standard child protection referral to the Multi-Agency Safeguarding Hub (MASH). Police will conduct lateral checks on the family and home address."*

67) This is the same process in Wales although not all areas in Wales have a Multi-Agency Safeguarding Hub (MASH), every area has a referral process which is clearly documented on the local authority website.

68) In 2.23 of her statement [INQ0017975], Dr Garstang says; *"There would be no reason to carry out a joint home visit by police and paediatrician or specialist nurse as the collapse did not occur at home. If the collapse occurred for example on the post-natal ward, or in parents' hospital accommodation (rooming-in prior to discharge from the neonatal unit) it would be very important the parents show the paediatrician/neonatologist and police officer the exact position the baby was in prior to the collapse, as well as the position they were found in. This is particularly relevant for sudden deaths when babies are in bed with parents."*

69) Joint home visits are not undertaken in Wales by police and a paediatrician or specialist nurse for any unexpected Child Deaths – however it would be important for the police to inspect the scene as detailed above in Dr Garstang's response in 2.23.

70) In 2.24 of her statement [INQ0017975], Dr Garstang says; *"The death should be reported to the coroner, who should arrange for a skeletal survey and a paediatric pathologist to conduct the post-mortem examination."*

71) This is the same in Wales.

72) PRUDiC 2023 states "The post-mortem examination will be authorised by HM Coroner and should be conducted by a pathologist with up-to-date expertise in paediatric pathology. Where neglect or abuse is suspected a Home Office Pathologist should be involved. The examination should take place as soon as possible after the Information Sharing and Planning Meeting and within five days, unless dictated by a possible public health issue."

73) In 2.25 of her statement [INQ0017975], Dr Garstang says; *"An initial case discussion should be arranged within a few days of the death; the consultant paediatrician or neonatologist should chair this. SUDIC paediatrician or SUDIC specialist nurse. It should be attended by neonatal unit staff, including the baby's named consultant, police officer, social worker, coroner's officer, midwife, and family GP; they are usually held online now. The meeting considers all the information currently available about the death, what further information is needed and how the family are going to be supported. Following the meeting, the consultant paediatrician or neonatologist, SUDIC paediatrician or specialist nurse should write a detailed clinical report for the coroner to share with the pathologist. "*

In Wales – the PRUDiC process includes :
Phase 1: The Information Sharing and Planning Meeting.
Phase 2: The Case Discussion Meeting
Phase 3 meeting: The Case Review Meeting

74) Phase 1: The Information Sharing and Planning Meeting.
This meeting will be convened within two working days of the unexpected death and prior to the post-mortem examination. A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will convene, chair and minute an initial Information Sharing and Planning Meeting. In specific circumstances (e.g. neonatal deaths) input or guidance may be needed from the Consultant Paediatrician (or doctor with appropriate training and competence), Head of Safeguarding or Neonatologist.

75) In 2.25 of her statement [INQ0017975], Dr Garstang says; *"The meeting considers all the information currently available about the death, what further information is needed and how the family are going to be supported."*

76) This is similar to the purpose of Phase 1: The Information Sharing and Planning Meeting referred to in PRUDiC 2023. The Minutes of the meeting with a copy (redacted if necessary) are send to the Child Death Review Programme (CDRP) in Public Health Wales (PHW).

77) The Consultant Paediatrician or doctor with appropriate training or competence will prepare a detailed report for the Coroner and Pathologist.

78) In 2.26 of her statement [INQ0017975], Dr Garstang says; *"Once the post-mortem report is available, the coroner should share it with the SUDIC paediatrician or specialist nurse. A final case discussion (also referred to as a Child Death Review Meeting — CDRM) is convened; this should have the same attendees as the initial case discussion. All the information from the case is reconsidered, including the post-mortem report and any other investigations such as patient safety or clinical governance. The full causes for death and any contributory or modifiable factors are reviewed and there should be an explicit discussion of whether child abuse or neglect was a feature in any part of the death. A report from this meeting is shared with the coroner to inform any inquest which should not be held until after this final case discussion. The family should be offered a follow-up meeting with a paediatrician to discuss the cause of death."*

79) In Wales, a copy of the final post-mortem report will be sent by the Pathologist to HM Coroner, who will share with appropriate professionals at their discretion.

80) In Wales, Phase 2: The Case Discussion Meeting must be convened within 5 to 28 days. A Detective Inspector or Senior Protecting Vulnerable Persons Unit Officer or Public Protection Unit Officer will convene, chair and minute the meeting. As a minimum the Senior Police Officer, Health Board Head of Safeguarding, and a Children's Social Care representative of appropriate seniority will attend. The meeting should also include the Consultant Paediatrician (or doctor with appropriate training and competence) and the Pathologist. With the agreement of HM Coroner, the preliminary results of the post-mortem examination may be made available.

81) The purpose of this meetings is to Receive any further information, discuss any further investigations which are ongoing and discuss the preliminary results of the post-mortem examination. Consider any safeguarding or child protection concerns. And to consider the need for referral to the Regional Safeguarding Children Board for a Child Practice Review. Consider support for family and professionals, media interest and actions.

82) In 2.27 of her statement [INQ0017975], Dr Garstang says; *"A standardised Child Death Review analysis form is completed at the final case discussion and passed to the local Child Death Overview Panel (CDOP), along with all documents and information relating to the JAR."*

83) In Wales following this meeting the Chair will provide available information to the RSB Business Manager and the Child Death Review Programme using the Child Death Notification Form along with copies of the minutes (redacted as necessary) for the CDRP.

84) In Wales, with the agreement of the Chair and depending on circumstances and on the course of any criminal investigation, the Consultant Paediatrician (or doctor with appropriate training and competence) will write a letter to the parents (if appropriate) offering to meet them to discuss the available information concerning the cause of their child's death, answer any questions, and offer future care and support.

85) In Wales there is a final Phase 3 meeting: The Case Review Meeting (Within 12 months). The purpose of the Case Review Meeting is to provide assurance to the Regional Safeguarding Children Board that every unexpected child death has been thoroughly investigated and all learning identified.

86) Wales does not have Child Death Overview Panels within the processes for management of child deaths.

87) The Child Death Review Programme (CDRP) is a programme within Public Health Wales (PHW) which receives and collects multisource information about all deaths of children in Wales or Welsh children who die elsewhere.

88) The Child Death Review Programme looks at national and regional patterns and trends to identify factors contributing to deaths that may help prevent future child deaths. It receives information and reviews every child death in Wales but does not have the remit

to investigate individual cases as the function is population based to identify issues which can reduce childhood mortality through national interventions. Information received includes information from the Welsh clinical portal, Health Boards and Trusts, Regional Safeguarding Boards, PRUDiC meetings, Wales Paediatric Surveillance Unit, DHCW (Digital Health Care Wales) and the Medical Examiner's Office of Wales.

89) The information about every child death received is reviewed by the team which includes a Consultant in Public Health and Consultant Paediatrician.

90) In 2.28 of her statement [INQ0017975], Dr Garstang says; *"Babies who received care on neonatal units and who die in the first 28 days of life will also be reviewed using the Perinatal Mortality Review Tool (PMRT)(National Perinatal Epidemiology Unit, 2022); this concerns the quality of obstetric and neonatal care received by the mother and baby. The findings from PMRT are fed into the Child Death Review process. PMRT is not designed to identify or manage safeguarding concerns."*

91) This is the same in Wales although currently this information Is not yet being fed into the CDRP as PHW are in the process of obtaining updated information sharing agreements with all the Health Boards following receipt of an amended NHS HRA Confidential Advisory Group (CAG) approval. Currently this feeds into the Maternity and Neonatal Network of the NHS Executive (NHS Wales) and is discussed at their mortality meeting.

92) In 2.29 of her statement [INQ0017975], Dr Garstang says; *"All child deaths, whether there is a JAR or not, are reviewed by a local CDOP, currently based on the home address of the child. CDOP is a multi-agency, multi professional group who provide independent scrutiny and oversight of child deaths, identifying themes and learning across a local area. There are representatives from health, social care, education, public health, and police. They use standard national templates. Individuals cannot be involved in the review of any child for whom they have had named responsibility for in life."*

93) This is not the process within Wales, as detailed above there is no national process within the management of expected or unexpected child deaths in Wales which include Child Death Overview Panels (CDOP).

94) It is my understanding that there is a process within North Wales where they run a multiagency review of child deaths which is titled CDOP locally, but this does not fulfil the remit of the CDOP's in England and has no statutory or national basis. I do not have any

further information or the terms of reference about this process and the CDOP does not share the outcomes of their reviews with the Child Death Review Programme, and I am unclear where this process reports to. My understanding is that this runs in parallel with the nationally adopted PRUDiC processes. However, it may be of benefit for the inquiry to consult with the chair of the North Wales CDOP for more detailed information about the process.

95) In 2.30 of her statement [INQ0017975], Dr Garstang says; *"Detailed information from individual case reviews at CDOP is passed to the National Child Mortality Database for further national analysis and reporting."*

96) In Wales, this happens for all deaths as part of the multisource information sharing process with the CDRP.

97) In 2.31 of her statement [INQ0017975], Dr Garstang says; *"I have not detailed the support that families should receive as part of this process; however, it is expected that they are kept informed and all information shared with them unless there are criminal investigations underway."*

98) This is the same for Wales and PRUDiC (2023) details what support is available.

99) In 2.32 of her statement [INQ0017975], Dr Garstang says; "*A summary of the JAR and CDOP process is shown below in figure 1 taken from the 2018 Child Death Review Statutory and Operational Guidance."*

100) This is not used in Wales. The charts which detail the process for management of inpatient and out of hospital unexpected child deaths in Wales are found on page 37 and 38 of the PRUDiC 2023. (EXHIBIT CT/1 INQ0107973

Process in 2015 / 2016 in Wales

101) In 2015 and 2016, I was not working in Wales and was not aware of the processes which were followed for investigation of child deaths in Wales at this time.

102) It is my understanding that the following are the processes which were in place in Wales at this time.

103) In 2015 and 2016, PRUDiC 2014(EXHIBIT CT/7) was in place and therefore this procedure should have been followed. The process at this time is detailed in point 105-110.

104) In 2015 and 2016 the Safeguarding Processes in Wales which were followed were the All-Wales Child Protection Procedures (EXHIBIT CT/6 INQ0107977

105) "The PRUDiC applies to all unexpected deaths in children from birth until their 18th birthday, whether from natural, unnatural, known, or unknown causes, at home, in hospital or in the community. This includes road traffic collisions, apparent suicides, and murders. This does not include stillbirths and the death of pre-viable babies born before 24 weeks.

106) If a baby dies within 24 hours of birth before discharge from hospital but with no immediate medical explanation apparent for the death, the Consultant Neonatologist and a Named Professional for Safeguarding Children will discuss the situation. They will make a decision, informed by the circumstances surrounding the death and information available to them within health, as to whether the case should be regarded as an unexpected death and so fall within the PRUDiC.

107) If a baby dies within 24 hours of birth after discharge from hospital, the death will be treated as an unexpected death and fall within the PRUDiC process.

108) If a baby dies within 24 hours of a home birth with no immediate medical explanation apparent for the death, the death will be treated as an unexpected death and fall within the PRUDiC process.

109) If a baby dies within 24 hours of birth whilst under medical supervision, (whether in a medical setting or not), and there is a clear medical explanation for the death, this will not be treated as an unexpected death.

110) When a child dies in England, but is normally resident in Wales, the PRUDiC or the English Child Death Overview Panel process may occur wherever and however the family and the principles of the PRUDiC process will be best served. There should be communication between the SIO and the relevant Heads of Public Protection, the Lead Managers for Safeguarding in Children's Services, and the Health Boards Heads of Safeguarding in both areas to decide how to proceed"

111) Therefore, if the deaths of the 7 babies were deemed unexpected at the time, then this should have triggered either a JAR from the English procedures or a PRUDiC from the Welsh Procedures. As PRUDiC (2014) states the process at this time may occur wherever and however the family and principles of the PRUDiC process will be best served – with appropriate multiagency communication to decide how to proceed.

112) With specific regard to safeguarding the process stated in the PRUDiC14 guidance at that time was: "Where child protection (CP) concerns are identified, the CP and PRUDiC processes will run in parallel. The CP process will not be a substitute for the PRUDiC process, but one will inform the other and vice versa. If CP concerns are identified a Strategy Meeting will be held chaired by Children's Social Care, according to timescales and processes defined within the All-Wales Child Protection Procedures. The Chair of the Local Safeguarding Children Board (LSCB) will be notified by the Chair of the Information and Planning Meeting for consideration of a Child Practice Review."

113) I have not been party to the information about the seven deaths or their investigation other than information reported in the media. However, with regard to reporting safeguarding concerns and raising In Wales, all staff working on a Neonatal Unit would have to complete Safeguarding Mandatory Training which would detail how to report safeguarding concerns and how to raise concerns about members of hospital staff. The level of training needed for different individuals would be in line with the Intercollegiate Guidance Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) (EXHIBIT CT/8 **INQ0107979**

114) Welsh Government published Speaking Up Safely: A Framework for the NHS in Wales in 2023 (EXHIBIT CT/9 **INQ0107980**) which details how to raise concerns and a framework of how to do this. Once circulated widely, used appropriately and comprehensively I believe it will strengthen the ability to raise concerns across Wales.

Updates Since 2015, 2016

115) PRUDiC was revised in both 2018 and 2023 superseding previous versions and the Wales Safeguarding Procedures launched in 2019 superseding the All-Wales Child Protection Procedures.

116) Since the revision of PRUDiC 2023, information sharing processes have been strengthened within Wales for both those not normally resident who die in Wales and children normally resident in Wales dying in other countries. These strengthened processes are detailed in points 117-121.

117) "When a child dies in Wales, but outside of their normal area of residence in Wales, wherever practicable the PRUDiC will occur in the Police Force area where the child normally resides."

118) "When a child dies in England, Scotland, or Northern Ireland, but is normally resident in Wales, the PRUDiC process should usually be followed in the area where the child normally resides, and relevant information shared by the Welsh Police Force with the equivalent for England, Scotland, and Northern Ireland. Notification should be made by the relevant Child Death Review Team in England, Scotland, or Northern Ireland to the Head of Safeguarding in the Welsh Health Board where the child resides who will connect with relevant colleagues in the police and local authority to determine whether the PRUDiC should occur. If a decision is made for PRUDiC not to occur, then this conversation should also include what support is needed for the family and wider community and referrals for support made. Minutes of the PRUDiC meeting (redacted, if necessary, at the discretion of the chair) should be shared with the relevant child death review programme where the child died and likewise the minutes from the English, Scottish and Northern Ireland Review Process shared with the Wales CDRP."

119) "If a child dies in Wales, the PRUDiC will be implemented even if the child is normally resident in a country other than Wales. Notification should be made to the relevant Child Death Review Team in England, Scotland, and Northern Ireland by the Head of Safeguarding in the Welsh Health Board where the child died. Minutes of the PRUDiC meeting (redacted, if necessary, at the discretion of the chair) should be shared with the relevant child death review programme where the child died and likewise the minutes from the English, Scottish and Northern Ireland Review Process shared with the Wales CDRP."

120) "Health Boards who routinely send children to English hospitals for secondary/tertiary care should ensure that those hospitals are aware of the PRUDiC process so that their Head of Safeguarding can be promptly informed when a Welsh child dies and the PRUDiC process initiated."

121) "When notified of a death abroad, professionals where the child is normally resident in Wales will consider implementing this procedure as far as is possible and fully record any decisions made. If a decision is made for PRUDiC not to occur, then this conversation should also include what support is needed for the family and wider community and referrals for support made."

122) There are also a number of meetings which have been developed in the last 4 years and occur regularly to support processes around cross border deaths of which the Wales CDRP are active participants. These include.

a) Four nations (and Channel Islands) child death meetings – where inter country processes and developments are considered.
b) Cross Border Child Death Meetings where Wales CDRP meet with those counties and CDOP's which have a land border with Wales and includes Designated Professionals from the ICB which covers the Countess of Chester Hospital.
c) Associated of Child Deaths Professionals

123) These meetings aim to improve and develop processes for cross border deaths and share best practice but are not for discussion of individual cases as this information sharing should be happening as detailed earlier in my statement.

Further Areas to be considered from Dr Jo Garstang's witness statement INQ0106963

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

124) I have not commented on these as I am not currently working in England and do not consider myself the appropriate person to comment on the processes.

CDR processes for children who live in Wales.

125) In 6.1 of her statement [INQ106963] Dr Garstang says; "*There are different CDR processes in Wales, and the 2018 CDR Statutory guidance only applies to England. This will have added further complexity to the situation at Countess of Chester.*"

126) I am in agreement with these comments.

127) In 6.2 of her statement [INQ106963] Dr Garstang says; "*In Wales, the equivalent process to the JAR or SUDIC investigation is the Procedural Response to Unexpected Deaths in Childhood (PRUDiC)(National Safeguarding Service, 2023). There is no statutory basis to PRUDiC, and the investigative process is less comprehensive than the*

English JAR. There is no equivalent to the Lead Health Professional or SUDIC paediatrician; there are no joint home visits by police and healthcare professionals following sudden infant or child deaths in the community."

128) This is correct and the process is detailed above.

129) In 6.1 of her statement [INQ106963] Dr Garstang says; EXHIBIT CT/ Personal Data 7 .*"The 2014 PRUDiC guidelines (Public Health Wales, 2014) included unexpected deaths of children who are inpatients at the time of collapse or death. In section 3.2 it states that: 'The PRUDiC applies to all unexpected deaths in children from birth until their 18th birthday, whether from natural, unnatural, known or unknown causes, at home, in hospital or in the community.' 6.4. In section 3.3 it states 'If a baby dies within 24 hours of birth before discharge from hospital but with no immediate medical explanation apparent for the death, situation will be discussed by the Consultant Neonatologist and a Named Professional for Safeguarding Children. They will make a decision, informed by the circumstances surrounding the death and information available to them within health, as to whether the case should be regarded as an unexpected death and so fall within the PRUDiC.' 6.5. In section 3.7 it clearly states that PRUDiC should be started if there is uncertainty: `Where professionals are uncertain about whether the death is unexpected, the death will be treated as unexpected, and this procedure will be followed.'*

130) This is correct for Wales.

131) In 6.6 of her statement [INQ106963] Dr Garstang says; "*The 2023 version of the PRUDiC guidelines includes sections on unexpected neonatal deaths and unexpected deaths on paediatric critical care units. I am not sure of the cross-border arrangements in place for Welsh children and babies at Countess of Chester for the management of sudden unexpected deaths in 2015- 17. However, it is clear a multi-agency investigation was expected either under the English SUDIC process or Welsh PRUDiC, and this would have enabled early discussion with police and social care as a matter of routine.*"

132) This is correct for Wales, and it is clear in the guidance that a multi-agency investigation was expected either under the English SUDIC or Welsh PRUDiC.

133) In 6.8 of her statement [INQ106963] Dr Garstang says; "*I understand that there are now regular meetings between English and Welsh paediatricians and CDR teams to enable effective cross-border investigation after child death*."

134) These meetings are listed in more detail in paragraph 122.

135) In 6.9 of her statement [INQ106963] Dr Garstang says; "*In Wales, there is no equivalent to CDOP. There is a public health led Child Death Review Programme (Public Health Wales, 2024), which looks at patterns and trends in deaths but does not conduct individual detailed case reviews as in the English CDR system. This is a public health programme rather than a statutory process. There are no Designated Doctors for Child Death.*"

136) This is partially correct. There is no equivalent to CDOP in Wales. However, the PHW led CDRP reviews all cases of deaths of children in Wales and children resident in Wales who die outside Wales but does not conduct investigations. The multiagency part of the process occurs during the PRUDiC process and then the CDRP is the Public Health function. Child Death processes in Wales are not included in legislation in Wales. There are no Designated Doctors for Child Death in Wales.

137) In 6.10 of her statement [INQ106963] Dr Garstang says; "*I understand that in North Wales, a team of doctors had set up a CDOP project based on the English system, but again this was not on a statutory basis. I have not been able to find out any further information on this CDOP project.*"

138) This is partially correct and is detailed in paragraph 94. My understanding is that this is a multiagency process (rather than a team of doctors), however it would be of benefit to explore this further with the Chair of North Wales CDOP.

139) In 6.11 of her statement [INQ106963] Dr Garstang says; "*The lack of CDOP equivalent in Wales is a weakness; there is no independent detailed oversight and scrutiny of child deaths. This limits identification of modifiable factors, potential safeguarding concerns, and learning from deaths. It would also make it much more difficult to spot a cluster of unexpected hospital deaths, regardless of the cause for these.*"

140) In my opinion, although there are some areas for potential improvement for the investigation of child deaths in Wales which would strengthen processes and are detailed in paragraphs 140-151, the lack of CDOP is not a weakness as this process is covered by the PRUDiC and CDRP functions. These processes are in place to identify modifiable factors, safeguarding concerns and learning from deaths and in the situation of a cluster of unexpected hospital deaths, it should be possible to identify and escalate as necessary if appropriate information has been shared.

Areas for Suggested Improved Process

141) In practice consideration of cross border deaths is a complex area but has improved over the last 5 years although there is certainly room for improvement with clear information sharing processes made explicit in all the areas of the UK where a child may die.

142) At the time of the deaths in 2015 and 2016 information sharing was poor , the CDRP did not receive any information from the CDOP's in England with regards the Welsh children who died in the Countess of Chester (of which we are aware) , brief information was received on some of the deaths from Paediatricians working in North Wales and in some cases CDRP would only have confirmation of the death via the Welsh Demographic Service and the ICD 10 cause of death code which may not be accurate as this depends on the cause written on the MCCD at the time of death.

143) Information sharing across the borders has been strengthened recently with the new guidance and multiagency cross border and national meetings to improve processes, however this is only effective if this information and guidance is shared with the local teams and CDOP's in those areas outside of Wales where Welsh children die. This is the responsibility of the Designated Doctor for Child Deaths (in that area of England) to ensure that this information is shared in their areas with multiagency partners and health professionals.

144) It would be of benefit to strengthen information sharing processes between the 4 nations as if good information sharing is present at the time of the death, then the Wales CDRP may be able to raise concerns of an unusual patterns of deaths occurring in the future.

145) Whilst multiagency agreement in PRUDiC 2023 that the PRUDiC minutes will now be shared with the Wales CDRP is an improvement, which means earlier information sharing may mean that the CDRP will pick up trends and escalate concerns as necessary, it is important to note that the CDRP is a Public Health function in the same way that the NCMD is in England.

146) Although I was not working in Wales in the period 2015-2016, it is my understanding that until the outcome of a PHW review of the function of the CDRP in 2017, not all deaths were reviewed in detail. Following this review all multisource notifications of child deaths were reviewed by the CDRP team, and this continues to be the process.

147) It is of concern that the Wales CDRP(PHW) are still unable to be confident that we have identified all of the babies who were murdered by Lucy Letby as the names are understandably not in the public domain and approaches to the North Wales CDOP, Cheshire ICB and Operation Hummingbird have not been successful.

148) There are no national CDOP's in Wales (although there is a process adopted by North Wales referenced in 94) and the management of Sudden Unexpected Deaths in Infancy is detailed in the Wales wide Procedural Response to Unexpected Deaths in Childhood (PRUDiC). This is a multiagency process which is owned by the Regional Safeguarding Boards who requested that PRUDiC was reviewed in 2022. PRUDIC 23 and the previous versions of PRUDiC do not refer to CDOP's.

149) In my opinion although compliance with PRUDiC appears good across Wales and is well supported by the local RSB's and multiagency partners, the lack of legislation to support the processes for Investigation of Unexpected Deaths in Childhood is a risk. The fact that PRUDiC is not statutory is a weakness of the process although the Safeguarding Components of the investigation are legislated in the Social Services and Wellbeing Act (Wales) 2014 and the Wales Safeguarding Procedures.

150) I am not aware of a national audit of PRUDiC processes having been undertaken since 2015 and it would be of benefit to understand more about the national picture of compliance and any variation from the process stated in PRUDiC 2023.

151) The lack of specific health professionals in Wales with expertise in the management of unexpected child deaths is also a risk which may mean further local variation and a

lack of implementation of a national coherent process. In England these are SUDIC Paediatricians or SUDIC Specialist Nurses and Designated Doctor for Child Deaths.

Statement of Truth

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** ___Dr Claire D Thomas

Dated: _____6/9/2024_____