Witness Name: Sarah Harper-Lea
Statement No.: 2
Exhibits: SHL24 – SHL30
Dated: 4 November 2024

THIRLWALL INQUIRY

SUPPLEMENTARY WITNESS STATEMENT OF SARAH HARPER-LEA

I, Sarah Harper-Lea, will say as follows: -

1. I make this supplementary witness statement following a supplementary rule 9 request from the Inquiry. My first witness statement provided to the Inquiry is dated 24 June 2024 **[INQ0102365]**.

Guidance on Writing Statements

Please consider INQ0008638. Who drafted this guidance? In what circumstances was it provided to potential witnesses? Was any other material provided to potential witnesses? If so, please identify this.

Who drafted this guidance?

2. The Guidance on Writing Statements **[INQ0008638]** was in place prior to my appointment in the Legal Services Department. The examples provided on page 2 of this document relate to 2009 so it is likely that the guidance may have been drafted around this time. I do not know who drafted the guidance.

[INQ0108391]

3. I exhibit (**Exhibit SHL24**) a copy of NHS Resolution's current Guidance for health providers in supporting staff to prepare for an inquest which details similar information to the above guidance.

4. The Trust were accredited by Lexcel, the Law Society of England and Wales' accreditation from 2007 to 2019, whose assessors would establish whether the Legal Department's practice complied with the requirements set out in Lexcel's practice management standards. This was established by examining the Trusts, procedures, policies and plans, sample files and by interviewing employees. The assessment included review of the Trust's Claims Handling Policy in which the Guidance for Writing Statements, detailed above, was set out at Appendix 3.

In what circumstances was it provided to potential witnesses? Was any other material provided to potential witnesses?

5. When a witness statement for the Coroner was requested it was, and still is, standard practice to provide all potential witnesses with a copy of the Guidance for Writing Statements. The purpose of the guidance is to assist the witness with how to write a statement in an appropriate format.

[INQ0108392]

6. The Staff Support Letter (**Exhibit SHL25**) was also provided to signpost witnesses to support if this was required, for example from the Occupational Health Service or their line manager, and a copy of the Trust Letterhead Template (**Exhibit SHL26**) to draft the statement on. The Guidance was available of the Trust's Intranet Pages, which are accessible by staff.

[INQ0108393]

Roles and responsibilities

At paragraph 12 of your Inquiry witness statement, you state: "The job description for Head of Legal Services describes the role as being responsible for the management and co-ordination of coroners' inquest investigations, claims investigations and access to medical records." Noting also what you say at paragraphs 22 to 25 of your Inquiry witness statement:

a. Please set out your duties and role in respect of the management and co-ordination of coroners' inquest investigations.

7. Prior to 4th July 2016 I had the following roles and responsibilities in respect of the management and coordination of Coroner's inquest investigations:
    - I was responsible for the line management of the Legal Services Inquest Assistant.
    - I held regular meetings with the Inquest Assistant to discuss any matters that would require escalation or to address any difficulties with the investigations, for example delays in obtaining a statement from a witness when multiple requests had been made.
    - I considered, with the Inquest Assistant, more complex cases where escalation to the Serious Incident Panel was required and where Legal Representation may be required.
    - I was responsible for ensuring that Datix had been searched for prior knowledge when an inquest investigation was opened, and that the inquest was linked to any investigation on Datix.
    - I was responsible for ensuring that liaison with the Risk Management Leads, notifying the inquest investigation and following up on any outstanding reports.
    - I was responsible for escalating to the Trust Solicitor, Stephen Cross any inquests that may require legal representation for a decision to be made on whether representation should be instructed.

- I was responsible for ensuring that Pre-Inquest Support Meetings were arranged in good time ahead of the inquest hearing.

8. From the date of my first period of absence from work, 4 July 2016, and up until December 2016, my responsibilities in respect of the management of the coroner's inquest process at the Trust was significantly reduced. The Band 3 Inquest Assistant, Joshua Swash was directly supported by Stephen Cross, Trust Solicitor in this respect.

b. Did that role include the preparation of witnesses for giving evidence and/or meeting with them prior to inquests? If so, what was expected of you in this regard?

9. As set out above prior to 4th July 2016 my role, and that of the Band 3 Inquest Assistant Joshua Swash, involved the administrative preparation and coordination of witnesses giving evidence at Inquests, which included:
    - Circulation of Witness Summons' to all witnesses called to attend the inquest hearing and coordination of responses to the Coroner.
    - The coordination and setting down of the Pre-Inquest Meeting for witnesses, and senior staff who would be supporting the witnesses, with the Trust Solicitor Stephen Cross, and if instructed, the legal representative.
    - Ensuring the Coroner's bundles were circulated to all witnesses, staff support and, if instructed, the legal representative ahead of the Pre-Inquest Support Meeting.
    - Reminding witnesses of the importance of reading the bundle ahead of the Pre-Inquest Support Meeting and taking the bundle along to the Pre-Inquest Support Meeting.
    - Attending the Pre-Inquest Support Meeting to note take any actions required to be undertaken following the meeting i.e. additional information to be obtained and the ordering of taxis for transport to the hearing.
    - Communicating to the Coroner any special requirements that witnesses may have, i.e. the order of evidence to enable them to return to the Trust promptly to attend clinics etc.
    - Communicating travel arrangements to the inquest hearing and sharing of contact details for any difficulties on the day.

10. From 4th July 2016 the above administrative preparation responsibilities were undertaken by the Band 3 Inquest Assistant, Joshua Swash, with support and guidance from Stephen Cross, Trust Solicitor.

c. In the event external solicitors and/or counsel were involved in relation to a coroner's investigation, what was their role, if any, in relation to the preparation of witnesses for giving evidence?

11. If external solicitors and/or Counsel were involved in relation to a Coroner's investigation their role in relation to the preparation of witnesses for giving evidence included:

- To receive copies of the inquest bundle which would include witness statements, relevant reports and procedural documents for consideration, and to consider if any further information was required to be obtained.
- To lead the Pre- Inquest Support Meeting, including informing witnesses of the purpose of the inquest investigation and advising on what to expect on the day i.e. the structure of the hearing, who may be in attendance, the layout of the courtroom, the roles and responsibilities of the Coroner and other interested parties and how long the inquest was expected to last (for example, a full day or half day).
- Explaining the process of giving evidence to witnesses i.e. to swear in either by a religious oath or affirmation and that they should have a copy of their witness statement with them to refer to.
- Explaining that questions will be led by the coroner, and that the family or their legal representative can also ask questions and that follow up questions can be asked by the Trust's legal representative at the end of the evidence to pull in any key facts that may be relevant or missed.
- Explaining there may be a short adjournment on the day for the Coroner to consider the evidence before returning with the conclusion. The most common conclusions would be explained to the witnesses.

Child A's Inquest

The Inquiry notes that you were away from work in the period before and at the time of Child A's inquest hearing as set out at paragraph 44 of your Inquiry witness statement. Nevertheless, to the extent that you have any knowledge of the matters identified, please answer the following questions:

a. Who, if anyone, from within the Trust took over your responsibilities in relation to Child A's coronial investigation?

12. Following my absence from work from 4 July 2016, and up to and including the inquest hearing for Child A, it is my understanding that the inquest investigation was handled by Stephen Cross with administrative support from the Band 3 Inquest Assistant Joshua Swash. Legal representation was provided by Louis Browne (Counsel), then QC at Exchange Chambers in Liverpool.

b. To what extent was Stephen Cross involved in Child A's inquest?

13. Stephen Cross instructed Counsel, Louis Browne, to represent the Trust at the inquest hearing and supported the Band 3 Inquest Assistant, Joshua Swash, with their administrative responsibilities from the start of my absence on 4th July 2016 and up until the inquest hearing into the Death of Child A on 10th October 2016.

Was his level of involvement consistent or inconsistent with the level of his involvement ordinarily? If inconsistent, please explain your understanding of why this was.

14. I was not involved with the inquest investigation into the death of Child A from the start of my absence on 4th July 2016 so am unable to comment as to whether Stephen Cross' level of involvement was consistent or inconsistent with his usual level of involvement in an inquest.

15. The variation that I can confirm is that from 4th July 2016 Stephen Cross was required to Line Manage the Band 3 Inquest Assistant, Joshua Swash, and guide and support him in his role. Joshua was a new member of staff having only been employed in this role since 6 June 2016.

c. Was the guidance identified at paragraph 1 above provided to any of the witnesses in Child A's inquest? If so, please set out the circumstances of this provision.

16. It was and still is standard practice when approaching a potential witness for a statement to provide them with a copy of the Statement Writing Guidance and Staff Support Letter, detailed above. The guidance was intended to assist witnesses in writing a professional and well-structured statement in what may be a potentially stressful situation.

d. Noting what you say at paragraph 25 of your Inquiry witness statement, who undertook the role of Inquest Assistant in relation to Child A's inquest?

17. Heidi Douglas was employed as the Band 3 Inquest Assistant from 22 February 2015 to 27 April 2016. Keya King was seconded from Hill Dickinson to cover the Inquest Assistant vacancy from 26 April 2016 to 10 June 2016.

18. Joshua Swash was employed as the Band 3 Inquest Assistant from 6 June 2016 to 15th January 2021.

19. Joshua left Legal Services to take up a position within the Medical Examiner's Office at the Trust where he was employed until 29th April 2022.

e. The Inquiry understands that external solicitors and counsel were retained in the case of Child A's inquest. Please identify the organisations and individuals who were instructed/involved.

20. As set out above, Louis Browne of Exchange Chambers was instructed by the Trust Solicitor, Stephen Cross to represent the Trust at the inquest. Upon my return from my absence, Counsel had already been instructed and the inquest process had been continued to be supported by the Trust Solicitor, Stephen Cross and the Band 3 Inquest Assistant, Joshua Swash.

f. Was any information given to any of those retained about the fact that Child A's death was part of an increase in the death rate on the Neonatal Unit and that that there existed concern that an individual member of staff may have been responsible?

21. I was not involved in the inquest investigation into the Death of Child A from the date of my first period of absence, 4th July 2016 and am therefore unable to comment upon the information provided to Counsel.

Please provide full details and any documentary material relevant to this issue. If no information was provided, please explain why this was.

22. I was not involved in the inquest investigation from the period of my first absence, 4th July 2016. To assist the Inquiry, I have attempted to obtain copies of correspondence between the Trust and Exchange Chambers. The Chambers Director at Exchange Chambers has confirmed that paper copies of the documents relating to the Inquest were received by post, from the Trust, on 7 September 2016 and were returned to the Trust by post on 12th October 2016, after the inquest hearing had concluded. Exchange Chambers did not retain a copy of the papers and to the best of my knowledge, noting my absence, the Trust no

longer has a copy of the papers. The Chambers Director at Exchange Chambers has confirmed that searches of email correspondence have been undertaken but that only one email has been discovered. This is likely because in 2016 it was still common practice for correspondence to be sent via the Postal Service. I exhibit (**Exhibit SHL27**) this email chain, including attachments, from the Chambers Director. [INQ0108394]

23. I have also undertaken a search of all filing cabinets within the Legal Services Department at the Trust. I have located the notebooks that belonged to the Band 3 Inquest Assistant, Joshua Swash. I exhibit (**Exhibit SHL28**) [INQ0108404 - INQ0108407] copies of the relevant pages relating to babies listed on the indictment and Operation Hummingbird. I can provide full copies of the notebooks if this would assist the Inquiry. Upon review of Joshua Swash's notebooks, I have identified the following, notes taken at the Pre-Inquest meeting, notes of a subsequent telephone conference with Counsel and notes taken at the inquest hearing held on 10 October 2016.

g. To your knowledge, was there any discussion or decision that the Coroner should not be told about either of the matters identified in question 3(f) above? If so, please provide full details.

24. I was not involved in the inquest investigation following my absence from work from 4 July 2016 and therefore I did not have any knowledge whatsoever of any discussions or decision making in relation to what should be disclosed to the Coroner.

25. I was not included in any discussions about the member of staff that may have been responsible for the increase in the neonatal death rate.

h. Did you participate in or were you aware of any discussions with the doctors about the evidence they would give? If so, please identify when and in what circumstances such discussions took place. What was said and by whom?

26. I was absent from work from 4th July 2016 and did not return until December 2016. I did not at any time participate in or have any awareness of any discussions with the doctors about the evidence that they would give.

i. Upon your return to work, were you surprised that neither Dr Jayaram nor Dr Saladi told the Coroner about the concern which existed that a member of staff may be responsible for the increase in the neonatal death rate? If so, did you discuss this with anyone? If so, who, when and in what circumstances? If you were not surprised, please explain why.

27. I was not aware of what Dr Jayaram or Dr Saladi told the Coroner at the inquest. I was not involved in the inquest hearing due to my absence from work from 4th July 2016. On my return to work following this absence my responsibilities in relation to Coroner's inquest investigations were significantly reduced.

Pre-Inquest Support Meeting in respect of Child D on 13 March 2017

The Inquiry has been told by Stephen Cross that a pre-inquest meeting was held in respect of Child D on 13 March 2017. Mr Cross has suggested that you attended.

a. Please identify by INQ reference and/or provide the record(s) of this meeting.

28. A pre-inquest support meeting was held in respect of Child D on 13 March 2017. I exhibit [INQ0108401] (**Exhibit SHL29**) the summary of action notes from this meeting which was received by email from Victoria McManus, Solicitor at Hill Dickinson, by email on 13 March 2017 at 15:25.

b. Who else attended?

29. I do not have any recollection of the meeting due to the passage of time. From review of the inquest file, this meeting was attended by Julie Fogarty (Head of Midwifery), Dr Joanne Davies (Consultant Obstetrician who was to present the Case Review at the Inquest), Dr Elizabeth Newby (Consultant Paediatrician), Joshua Swash (Band 3 Inquest Assistant at the Trust), myself Sarah Harper-Lea and Victoria McManus (Solicitor at Hill Dickinson, who was legal representing the Trust and led the pre-inquest support meeting).

c. What advice was given to the witnesses – and by whom – as to what they should say at the inquest?

30. I do not have any specific recollection of the Pre-Inquest Support Meeting, this could be due to the passage of time or the reasons set out above in relation to my reduced responsibilities in respect of Inquest Investigations.

31. From review of the Action Notes emailed by Victoria McManus and the list of Pre-Meet Actions drafted by the Band 3 Inquest Assistant, Joshua Swash, [INQ0108402] (**Exhibit SHL30**), the meeting was held to consider the provision of a Lesson Learning Report, to be drafted by the Head of Midwifery, to agree who would be best placed to complete a Neonatal Lesson Learning Report and who would be the most appropriate witness to present the Lesson learning evidence at the inquest hearing. A second pre-inquest support meeting was

planned for 18 May 2017 but did not take place as the inquest was adjourned prior to that date.

d. Was there any discussion within the meeting of the concerns that had been raised by the Consultants about the series of unexpected and unexplained collapses and deaths that had occurred on the Neonatal Unit between June 2015 and June 2016? Was Letby discussed, whether directly or inferentially? If not, why not?

32. From review of the notes and action required email that are available to me there is no reference to the concerns raised by the Consultants or to Letby directly or inferentially.

33. I do not recall any discussion whatsoever regarding the concerns that had been raised by the Consultants being discussed at this meeting. From review of the notes of the meeting sent by Victoria McManus, the meeting was focussed on the preparation of Lesson Learning Statements.

34. I do not have any recollection as to why not. This may be due to my period of absence from July 2016 to December 2016 and the fact that my involvement in the management of Coroner's inquest investigations was significantly limited as set out above.

Statement of Truth

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

Signed: Personal Data

Dated: 4th November 2024