Witness Name: Nicola Lyon
Statement No.: 1
Exhibits: n/a
Dated: 19 November 2024

**THIRLWALL INQUIRY**

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**WITNESS STATEMENT OF NICOLA LYON**

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I, Nicola Lyon, will say as follows: -

1 I&S I&S There was no avenue for an independent investigation into this very serious event. An internal review (RCA) by the hospital later found that there had been numerous serious failings in the care provided and that NICE guidelines had not been followed.

2. In 2013 I co-founded the Campaign for Safer Births to raise awareness of avoidable harm in maternity and neonatal services and to campaign for independent investigations.

3. I have since acted as a patient voice/service user representative on many committees, boards, programmes of work and research including

- RCOG Each Baby Counts and Avoiding Brain Injury in Childbirth (ABC)
- NHS England Maternity and Neonatal Programme (MNP)
- NHS Resolution Maternity Voices Advisory Group

4. From my knowledge and after 10 years of campaigning for maternity safety, I feel there is large and unacceptable variation in Coroner reporting within hospitals and in responses/action from Coroner Offices.

5. It has long been a concern of mine that Hospital Trusts are not correctly reporting baby deaths to the Coroner. I feel some may not report baby deaths deliberately to avoid scrutiny (particularly where they know there could have been substandard care or the death was potentially avoidable), where for others there is a lack of clarity on when to refer to the Coroner. Review by the Coroner, particularly in cases of potential negligence, allows for independent investigation, parents voices to be heard and raises public awareness. The Coroner is able to make Regulation 28 Recommendations and identify any repeated issues/concerns.

6. An example of non-reporting to the Coroner is the case of baby I&S documented by the I&S family in I&S'. East Kent Hospitals University NHS Foundation Trust Hospital did not initially report I&S's unexpected death following term labour to the Coroner. Eventually, an Inquest was held but only as a result of I&S's parents' persistence in reporting to the Coroner themselves. The Inquest resulted in a finding of 7 gross failings that amounted to neglect and 19 Recommendations in a Regulation 28 Prevention of Future Deaths Report. The Trust was eventually prosecuted by the CQC for unsafe care and treatment – for a death that they tried to document as 'expected' and was 'not needed' to be referred to the Coroner.

7. Some Coroners became so concerned about the non-reporting of baby deaths that they instructed their local hospital trusts to report all baby deaths to them as a matter of course.

8. As Campaigners we have tried to raise awareness of avoidable baby death with Coroners and have met with Chief Coroners.

9. HM Senior Coroner, Penelope Schofield has a specialist interest in baby death within the Coroner Service and has worked to raise knowledge and awareness amongst her fellow Coroners.

10. I hope that the statutory introduction of Medical Examiners will result in more consistency and increased accuracy and quality in reporting. Medical Examiners *should* also be speaking with bereaved parents to understand if they have any concerns about the care/treatment given or cause of death that would warrant a referral to the Coroner.

11. I hope the Inquiry is able to review all guidelines on reporting of neonatal deaths and contested stillbirth certification to the Coroner.
This would include reviewing:

- training and written guidance for clinicians
- information for bereaved parents & public documents (e.g. NBCP)
- training and written guidance for Medical Examiners
- training and written guidance for Coroners and Coroners Officers

12. I trust that if your inquiry finds these areas to be an issue that you will ensure changes/improvements are made to ensure future accuracy and consistency in reporting and investigation.

13. I do need to also raise the fact that a huge and dangerous void exists in the investigation of babies registered stillborn at birth. These deaths (which in some cases are a direct result of poor or negligent care) are not reviewed by Medical Examiners and Coroners have no legal jurisdiction for inquests in these cases. These are the only deaths that Coroners have no power to review. This change is subject to a Private Members Bill that received Royal Assent some years ago - but has not yet been enabled.

**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**: 19/11/24