Witness Name: William Vineall
Statement No.: 4
Exhibits: None
Dated: 05.02.2025

THIRLWALL INQUIRY

FOURTH WITNESS STATEMENT OF WILLIAM VINEALL

I, William Vineall, Director of NHS Quality, Safety and Investigations at the Department of Health and Social Care, 39 Victoria Street, London SW1H OEH will say as follows:-

1. I make this statement on behalf of the Department of Health and Social Care ("the Department"). I am authorised to make this statement on behalf of the Department.

2. I am Director, NHS Quality, Safety and Investigations at the Department. I have held that post since 2020. Further details of my role and employment history are set out in my first witness statement to the Inquiry dated 5 April 2024 **[INQ0015468]**.

3. I gave evidence to the Inquiry on 15 January 2025. Towards the end of my evidence the Chair asked about the recently published (on 17 December 2024) document entitled 'Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm' ("the 2024 MOU") **[INQ0108740]**. By reference to the transcript of my evidence, at page 211, line 25 to page 212, line 18 the Chair asked:

> **LADY JUSTICE THIRLWALL:** The December 24 document.
> But just really to make the observation there is no reference anywhere to the question of safeguarding, you know, what you do in a situation where the harm is being done or you suspect, on whatever basis, you suspect that harm is being done to a child and there is no reference to that. Was that, as far as you know, a deliberate omission?
> **A.** I don't know, but we can take it away and look at it.
> **LADY JUSTICE THIRLWALL:** Yes. It seems to me because the guidance there is very clear as to what has to be done in whatever the situation, including to healthcare professionals, to everyone. So it may be it may have been an oversight, but if you wouldn't mind, would you be able to just do a short couple of paragraphs on whether or not it was omitted deliberately?
> **A.** Yes, we'll send that to you.

4. I am grateful for the additional time to look into the matter and to provide this response, which I hope will be of assistance to the Chair.

5. By way of initial observation, the 2024 MOU does, in places, contain references to safeguarding. Safeguarding is mentioned at pages 17, 31 and 39. Most relevantly, at page 31 as part of Annex D – which contains a list of matters to be discussed at incident co-ordination group meetings – attention is drawn to the organisations' other statutory responsibilities:

> "- Do the organisations have other statutory responsibilities they should consider - for example, are there any safeguarding considerations in respect of a child or a vulnerable adult?
> - Should social services be informed?"

6. More broadly, the 2024 MOU does remind the reader of the need to seek assurance in respect of patient safety and makes clear that the safety reporting and assurance mechanisms which normally apply continue to apply and should be progressed alongside any processes being done in connection to the MOU. However, I do agree that the 2024 MOU does not seek to introduce safeguarding as a specific subject nor does it seek to repeat what is contained elsewhere in respect of safeguarding.

7. Having consulted with colleagues within the Department who were involved in the development of the 2024 MOU, I am not aware of any decision to exclude the subject of safeguarding from the 2024 MOU (indeed, as I note above, I do not believe it has been entirely excluded). My understanding, based on those discussions with colleagues, is that the 2024 MOU was not intended to replace or duplicate guidance on wider issues that may arise in the circumstances where the MOU may be relevant, i.e. where healthcare organisations, regulatory bodies, investigatory bodies and prosecutorial bodies in England will work together in cases where there is suspected criminal activity on the part of an individual in relation to the provision of clinical care or care decision making (see paragraph 3.1 of the 2024 MOU **[INQ0108740_0007]**).

8. To the extent that it may be relevant to the facts of a particular issue, I would also expect all organisations to have clearly in mind their own duties which are comprehensively addressed in 'Working Together to Safeguard Children 2023' **[INQ0012897]**. I would respectfully agree with Professor Sir Stephen Powis' evidence on this point: safeguarding features in many different documents and training provided to NHS staff (transcript of 17 January 2025, page 89, line 5 – page 90, line 4).

9. However, as I explained when I attended to give evidence, the Department will consider how the 2024 MOU is operating after a year. I also agree that the question of whether safeguarding should feature more prominently will be considered as part of that work.

10. I have been asked by the Inquiry whether consideration was given to including the NHS Safeguarding app as a resource to improve safeguarding in the 2024 MOU. I am not aware of any such consideration having been given by the Department when preparing the 2024 MOU. I am not aware of whether NHSE, as one of the principal contributors to the 2024 MOU did so. As explained above, the 2024 MOU is not intended to replace or duplicate guidance which exists elsewhere.

11. Finally, I have been informed by the Inquiry that Dr Joanna Garstang has told the Inquiry that no funds have been allocated by NHS England or the Department for the purposes of updating the national SUDIC guidelines of 2016 ("the 2016 guidelines"). I am asked to explain when and why the Department decided not to update these.

12. The 2016 guidelines were produced by a working group convened by the Royal College of Pathologists and endorsed by the Royal College of Paediatrics and Child Health ("the RCPCH"). In her oral evidence on 26 September 2024, Dr Garstang indicated that the RCPCH had agreed to lead in the creation of the update with the assistance of a team from the National Child Mortality Database. Her evidence was that NHS England was the body responsible for funding this update and a request had been made to NHS England for funding, but no agreement had yet been reached (page 173, line 19 to 176, line 11).

13. I understand that Dr Camilla Kingdon addressed the 2016 guidelines in her oral evidence on 12 December 2024. On behalf of the RCPCH she indicated that there was a need to update the guidelines and the concerns identified by Dr Garstang could be considered as part of this, but "there isn't a plan or funding to do the update as things currently stand" (page 180, line 4 to page 182, line 12).

14. Having discussed the question with others within the Department, I am not aware that any request for funding for a revised set of guidelines has been made to the Department, nor am I aware of the Department having made any decision on whether or not the 2016 guidelines need to be updated. A roundtable discussion took place on 26 July 2023, co-chaired by the Department and NHS England. It was convened to discuss a range of issues relating to sudden unexplained deaths in childhood, including research into its

causes, collecting and sharing data, and improving bereavement support for families. I understand that during these discussions it was suggested that the 2016 guidelines needed to be updated in relation to including the deaths of older children, and it was suggested that this would cost in the region of £ I&S To my knowledge, no decision or commitment to funding was made at that meeting for either this or any other update.

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 of its truth.

Signed: Personal Data

Dated: 05.02.2025