Witness Name: Duncan Burton
Statement No.: 2
Exhibits: DB2/1-DB2/6
Dated: 6 February 2025

THIRLWALL INQUIRY

SECOND WITNESS STATEMENT OF DUNCAN BURTON

I, Duncan Burton, will say as follows: -

1. I am the Chief Nursing Officer of England, having been appointed to this position on 25 July 2024. This is my second statement in connection with the Thirlwall Inquiry ("the Inquiry") and is made on behalf of NHS England in response to the supplementary questions asked by the Inquiry in its Rule 9 letter dated 22 January 2025.

2. This statement has been drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. As some of the questions in the Rule 9 letter go beyond matters which are within my own personal knowledge, this statement is the product of drafting after communications between those external solicitors and senior individuals within NHS England in writing, by telephone and video conference.

Communications between the Trust and families

3. The Inquiry has asked NHS England to provide any further information on when its North regional team had sight of what was being communicated to the families about updates in the Countess of Chester's investigation.

4. Given the passage of time, the best evidence of what NHS England knew about the Trust's communications with the families are the records exhibited to the witness statements of Margaret Kitching [**INQ0107036**] and Michael Gregory [**INQ0107034**]. In summary, NHS England relied on the express and specific assurances provided by Ian Harvey, in his capacity as Medical Director of the Trust, that the Trust was being open and transparent with the families.

5. On 23rd February 2017, Michael Gregory, Andrew Bibby and Lesley Patel met with Ian Harvey [**INQ0014656**]. The meeting arose as Lesley Patel was raising concerns about the

Hospital's response to the RCPCH review and their failure to share the recommendations of the external report. As recorded in the meeting notes, and confirmed by Michael Gregory in his witness statement to the Inquiry (**INQ0107034**, at paragraph 101), Ian Harvey gave a commitment at the end of that meeting that once the Trust had completed its planned review of the individual deaths this would be shared with the affected families and NHS England.

6. Further, on 27 April 2017, Margaret Kitching and Vince Connolly had a teleconference with Ian Harvey and Stephen Cross [**INQ0003193**]. As Margaret Kitching explains in her statement (at paragraphs 116-121), the purpose of the meeting was arranged in light of Ms Kitching's concern that the Hospital had not shared all the relevant facts with NHS England and NHS Improvement regarding the increased mortality rate in the neonatal unit, and for her to understand how the Trust's actions would impact on the service and patient care moving forwards. During this meeting, Ian Harvey expressly stated that "*the Trust has shared everything with the Coroner throughout this process and kept the families involved*" [**INQ0003193**, top of page 2; and **INQ0107036**, at paragraph 118(g) and (h)].

7. It would not have been normal practice for NHS England to ask to see copies of any information the Trust had chosen to share with the families but it does appear that the Trust was asked on a number of occasions to provide assurance around what information it had shared and/or was planning to share. NHS England also understands from Ian Harvey's oral evidence before the Inquiry that he now accepts the families were not in fact kept properly informed about the events and that "*the standard and the nature of our communications was way below the standard that was -- was expected of us and that we should have maintained*".[1] NHS England's overall reflections on the adequacy of the Trust's openness and candour with the families are contained within its written Opening Statement (paragraphs 60-79).

The NHS Safeguarding App

8. The NHS Safeguarding App ("the App") was commissioned by NHS England's National Safeguarding Steering Group in 2018. (The role of the National Safeguarding Steering Group is described in NHSE/1, **INQ0017495**, paragraphs 747-748). The National Safeguarding Steering Group is currently chaired by Acosia Nyanin, Deputy Chief Nursing Officer for England (since August 2023) – Professional and System Leadership, who leads the assurance of the NHS safeguarding system and offers strategic leadership for safeguarding across NHS England and the health economy.

9. The App was developed by a core team of clinical safeguarding subject matter experts. This team currently includes NHS England's 3 National safeguarding clinical safeguarding leads and 7 Regional safeguarding leads, as well as the 4 elected chairs of our national safeguarding networks ("Core team"). The four national safeguarding networks cover primary care, adult care, paediatric care and maternity. The elected chairs are professionals, or experienced safeguarding practitioners who are independent from NHS England.

10. It was developed as a comprehensive resource for healthcare professionals, carers and citizens to increase their awareness and understanding of safeguarding. It was drafted for "Level 1 awareness", which can be summarised as spotting the signs of neglect, harm, abuse, exploitation and violence to and by patients, visitors and colleagues. It signposts to other more detailed materials on the 19 common types of harm that fall under the statutory definition of safeguarding.

11. The App is also available in secure estates, such as prisons. In these secure estates, the web version may not be available due to secure firewalls, so the App enables staff to access key safeguarding information.

12. It also has sections on how to raise concerns, safeguarding assurance in the NHS, the context of NHS safeguarding and multiagency safeguarding arrangements. The section on "Raising Concerns" seeks to provide guidance on how to raise a safeguarding concern, allegations against staff, the legal responsibilities for safeguarding and information sharing. It makes it clear where it is considered that a member of health staff poses a risk to children or might have committed a criminal offence against one or more children, any relevant information <u>must</u> be shared with the Local Authority Designated Officer.

13. By the end of 2023, there had been 332k downloads of the App from the Apple store and 142k downloads of the App from the Google Play store. The app analytics from May 2022 – January 2023 are exhibited at DB2/1 [**INQ0108858**], and those from January 2023 – February 2024 are exhibited at DB2/2 [**INQ0108859**]. A further breakdown of this data is exhibited at DB2/3 [**INQ0108861**]

14. The Core Team reviews the App every 6 months, under the supervision of the Deputy Director for NHS Safeguarding. An annual survey of users is also conducted for the core team to receive any feedback on the content and operation of the App. This survey asks users to describe, amongst others things, their overall experience with the App, what they like and dislike about the App, whether the App solves a particular problem and how it can

be improved. The results of the 2024 survey are exhibited to this statement [DB2/4, **INQ0108860**].

15. In 2024 the DHSC Digital Procurement Group recommended migrating the content of the App to the NHS.Uk website (see https://safeguarding-guide.nhs.uk/) and this website went live in November 2024 (known as the "NHS Safeguarding Guide"). However, the App can currently still be downloaded on the Google Play and Apple Stores. It will remain available both online and as an App for at least the next 12 months, after which NHS England will decide, following an evaluation of its use, whether it will remain available for download on the Apple and Google Play stores.

16. On 6th July 2024 the National Safeguarding Steering Group ratified 7 protocols to be used by all ICBs in connection with their safeguarding duties. These protocols were published on FutureNHS on 21 January 2025. FutureNHS is owned and managed by an expert team within NHS England and is a safe and secure place for people working in health and social care to save, access and share resources and content.

17. The safeguarding protocols are:

    a. NHS Safeguarding Child Protection Information System (CP-IS) with integrated care boards (ICBs);

    b. NHS Safeguarding female genital mutilation protocol with integrated care boards – January 2025;

    c. NHS Safeguarding modern slavery and human trafficking protocol with integrated care boards - January 2025;

    d. NHS Safeguarding domestic abuse, sexual violence, and serious violence duties protocol with integrated care boards – January 2025;

    e. NHS Safeguarding domestic homicide reviews (DHRs) with integrated care boards Protocol - January 2025;

    f. NHS Safeguarding child death reviews protocol with integrated care boards - January 2025 (as the NHS England safeguarding team were aware that the Child Death Review process is an issue being carefully considered by the Inquiry, it was noted on page 2 of this protocol that further updates may be required in light of any findings or recommendations made by the Inquiry in due course);

    g. NHS Safeguarding prevent duty protocol with integrated care boards – January 2025.

18. These protocols will be signposted in the next iteration of the App/NHS Safeguarding Guide, which will be completed by June 2025. NHS England has exhibited the protocol that it considers most relevant to the Inquiry's work, the NHS Safeguarding child death reviews protocol with integrated care boards (January 2025), to this statement at DB2/5 – DB2/6 [**INQ0108862- INQ0108863**].

The SUDIC Guidelines

19. Dr Joanna Garstang was correct in her evidence that the national SUDIC Guidelines (otherwise known as the ("Kennedy Guidelines"), have not been updated since 2016. NHS England was not involved in the development of the first iteration of the Kennedy Guidelines in 2004 as this predated its establishment in 2013. We have been unable to locate any record of NHS England being involved in the 2016 update and note that NHS England is not named as a member of the Working Group for the 2016 updates (see Appendix 9, page 104).

20. NHS England was approached by the Royal College of Paediatrics and Child Health in relation to the potential funding for an update to the 2016 SUDIC guidelines. However, NHS England is not the appropriate body to determine, by itself, the timing or scope of any update or to make a decision as to funding such an update, given the multi-agency nature of the guidelines, which apply across health and social care settings. The RCPCH were informed of this at the time their request was declined.

21. As the Inquiry is aware, overall responsibility for the Child Death Review process lies with the Department of Health and Social Care and any decision to update the 2016 SUDIC guidelines (and a consequential decision as to funding) would need to be taken by the Department. NHS England's view is that a holistic review and update (as appropriate) of the Child Death review statutory guidance, alongside considering how best to update the 2016 SUDIC guidelines, would be most effective and would enable changes to the overall system, such as the introduction of the statutory Medical Examiner system, to be consistently and clearly reflected. NHS England will of course assist the Department of Health and Social Care in connection with any such review if requested to do so and it has informed the Department of its views and willingness to support this, as set out in this section of the statement.

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:6 February 2025