Witness Name: Sarah Jane Rylance
Statement No.: 1
Exhibits: SJR/01 and SJR/02
Dated: 08/04/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SARAH JANE RYLANCE

I, Sarah Jane Rylance, will say as follows: -

Medical Career and employment at the Countess of Chester Hospital

1. I am currently working in Geneva, Switzerland as a Medical Officer at the World Health Organization. I moved to this position in January 2021.

2. I qualified as a medical doctor (BM BS, Nottingham University) in July 2000.

3. My training in Paediatrics began in 2001, and I gained my CCT (Certificate of Completion of Training) in Paediatrics in October 2015. I am a member of the Royal College of Paediatrics and Child Health. During my 14-years of training I worked at Barnsley Hospital, Sheffield Children's Hospital, Jessop Wing (Sheffield), Queen's Medical Centre (Nottingham), Warrington Hospital, Liverpool Women's Hospital, Alder Hey Children's Hospital and Countess of Chester Hospital, in the UK. I have also spent 7-years working overseas as a doctor (in Tanzania 2005-7, and Malawi 2010-11 and 2017-2020). I gained a Masters in Research from the University of Liverpool in 2017 and a PhD in Global Health from Liverpool School of Tropical Medicine in 2020.

4. I was employed at the Countess of Chester Hospital (COCH) from 5th February 2014 to 7th July 2015, as a specialty trainee in Paediatrics (grade ST7-8). This involved working in the paediatric ward, neonatal unit, postnatal wards, labour suite and outpatient clinic. As a senior trainee, my work involved supervising junior colleagues, liaising with nursing staff and discussing cases with consultant colleagues, as required. I provided medical care

for children attending the paediatric department (referrals from general practice and the Accident and Emergency department), paediatric inpatients, and children attending outpatient clinic. I reviewed new born babies on the postnatal ward, attended high-risk deliveries on labour suite, and cared for babies on the neonatal unit.

5. I worked part-time (0.6 whole time equivalent) on a 1 in 7, full shift rota, which consisted of short days (0830-1630), long days (0830-2100) and night shifts (2030-0900).

The culture and atmosphere of the neonatal unit at the hospital in 2015

6. During my time at COCH I reported to the various medical consultants (Drs Gibbs, Brearey, Jayaram, Newby, Saladi and Doctor V), depending on which consultant was on-call, in clinic, or responsible for a particular patient. My educational supervisor was Dr John Gibbs. To my memory, I did not have any direct interaction with hospital managers and am not able to comment on the relationships between hospital managers and clinicians, nurses and midwives. There was a positive and supportive relationship between doctors, nurses and midwives at the hospital. There was a pleasant working environment and I enjoyed the time I spent at COCH.

7. I believe that the working relationships between doctors and nurses on the NNU were of a high professional standard which impacted positively on the quality of care provided to the babies.

8. The atmosphere on the NNU was caring and friendly, with respectful relationships between medical and nursing staff.

9. I don't feel able to comment on whether professional relationships affected management and governance of the hospital in 2015, since I had minimal interaction with those in the most senior positions.

10. Compared to Liverpool Women's Hospital and Alder Hey Children's Hospital, I found the working environment at COCH to be more collegiate and supportive, and I experienced

positive relationships with senior colleagues. Senior colleagues were readily accessible out-of-hours, were keen to teach and provided opportunities for professional development, relevant to my level of clinical experience.

11. I did not hear comments or reports on: (i) the quality of care; (ii) the quality of the management, supervision and/or support of doctors; or (iii) the nature of the relationships between medical and managerial staff at COCH's NNU in 2015/2016.

Child C

12. Regarding my involvement with Child C, I am unable to provide any additional information to that provided in my previous statement dated 25 August 2020 **[INQ0000143]**. I attach this statement as my **Exhibit SJR/01**. I don't recall how I became aware of Child C's death or whether there was any debrief around the circumstances of Child C's death. In my opinion, I think there should be a debrief after every death in a neonatal or paediatric setting. If there was a debrief or discussion relating to Child C, I believe that I should have been involved, even if it occurred after I had left the Trust.

Child D

13. Regarding my involvement with Child D, I am unable to provide any additional information to that provided in my previous statement dated 26 July 2018 **[INQ0000811]**. I attach this statement as my **Exhibit SJR/02**. Specifically, I have no further information on the circumstances in which I attended Child D on 20 June 2015, Child D's condition and the actions I took, or my clinical assessments on 21 June 2015.

14. I was surprised when I learned of Child D's death, since when I left the hospital at the end of my shift on 21 June 2015, I believed Child D was improving clinically and would have a positive outcome. I don't recall how I became aware of Child D's death and can't remember whether I discussed my surprise with anyone. After the 21 June 2015, I had several days off duty and only returned for shifts on 1, 2 and 3 July 2015 before leaving this position. To the best of my memory, I don't believe I was involved in any debrief. I believe that there should have been a debrief relating to the death of Child D and that I should have been involved, even if it occurred after I had left the Trust.

Concerns and response to Neonatal Deaths

15. During the period I worked at COCH in 2015, I was not aware of others' concerns or suspicions regarding the circumstances of the deaths of Child C and Child D.

16. I cannot recall what information I received regarding the death of Child A and collapse of Child B – on reviewing my diary, I was not on duty on the 8 or 9 June 2015, and would have arrived for a night shift on 10 June at 8:30 pm.

17. My last shift at COCH was on 3 July 2015 and I was not subsequently involved with any discussions regarding Child A, B, C or D.

18. I did not consider that there might be some connection between Child A's death, Child B's collapse, Child C's death, and Child D's death.

19. During my time at COCH I do not recall being concerned about the number of deaths on the NNU. I don't remember having access to national databases on neonatal mortality rates or serious adverse incidents.

Reviews of Deaths and Adverse Events

20. To the best of my memory, adverse events were recorded contemporaneously on an electronic form and were then reviewed by the clinical team, with involvement of additional senior management depending on the nature of the event. I was not involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

21. Following a neonatal death, the lead consultant would discuss the need for a post mortem with the family. A senior doctor would discuss the case with the coroner, before completing the death certificate.

22. I don't recall being involved in any debriefs or discussions (formal or informal) relating to Child A, C or D. However, these discussions may have occurred in my absence, due to my shift pattern, part-time employment, and leaving the hospital relatively soon after the deaths occurred.

23. I do not have the necessary information to comment on whether there should have been discussions relating to specific events that have since been attributed to Letby.

Awareness of suspicions

24. During my time at COCH, I was not aware of any suspicions relating to Lucy Letby and I did not personally have any concerns about her conduct. I did not use any formal or informal process to report any suspicions or concerns about Letby, or any concerns for the safety of babies on the NNU.

Safeguarding of babies in hospitals

25. During the course of my training in Paediatrics I attended educational sessions on safeguarding but cannot recall specific details (the content or location).

26. I have not worked clinically in the UK since August 2016 and so am not up to date with what advice or support the General Medical Council or Royal College of Paediatrics and Child Health could offer. I did not turn to any professional body for advice in respect of events at COCH.

Speaking up and notification of external bodies

27. I cannot recall the procedures for raising concerns within COCH in 2015. I did not have any suspicions about Letby or the neonatal unit deaths in 2015 and therefore did not consider contacting any external bodies.

28. I cannot recall specific details (the content or location) of training on the process used and organisations involved in reviewing a child death such as Child Death Review, Sudden

Death in Infancy/Childhood (SUDI/C) and the Coroner's Office. However, I believe I did receive some educational sessions on this during my Paediatric training.

29. I am unable to comment on which external scrutiny bodies I would have considered raising concerns to in 2015.

30. I was not involved in providing information to the Coroner regarding any of the deaths of the babies names on the indictment.

Responses to concerns raised about Letby from those with management responsibilities within the Trust

31. I did not raise any concerns about Letby to those with management responsibilities at the Trust.

Reflections

32. I don't know whether CCTV would have helped to prevent the crimes of Letby.

33. As I recall, there are procedures for monitoring and accounting for specific drugs on the neonatal unit – I am not sure that additional security measures would have prevented the events that occurred.

34. I do not have the full information on what actions were taken and when by the clinical staff and managers working at COCH between June 2015 and June 2016 – I left COCH in July 2015. I therefore feel it is inappropriate for me to speculate on what the Inquiry should recommend.

Any other matters

35. I have no additional evidence of relevance to the Inquiry.

36. I believe that my previous statements (**Exhibit SJR/01**) **[INQ0000143]** and (**Exhibit SJR/02) [INQ0000811]** are accurate and complete.

37. I have not given any interviews or made public comments about the actions of Letby or the Inquiry investigation.

Request for documents

38. I do not have any documents or additional information of relevance to the Inquiry.

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.

Personal Data

Signed:

Dated: 08/04/2024