Name of Witness: Dr Emily Elizabeth Thomas
Statement No.: 1
Exhibits: EET1, EET2 and EET3
Dated: 22 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR EMILY ELIZABETH THOMAS

I, Emily Elizabeth Thomas, will say as follows: -

Personal details

1. My name is Emily Elizabeth Thomas.

Medical Career and employment at the Countess of Chester Hospital

2. I qualified as a doctor with an MBChB awarded by the University of Sheffield in July 2011. I have had full registration with a licence to practice medicine from the General Medical Council (GMC) since August 2012. I passed my Specialist Paediatric examinations and was awarded membership of the Royal College of Paediatrics and Child Health (RCPCH) in January 2020 and obtained a Certificate of Completion of specialist training in September 2022. I am now on the GMC specialist register as a General Paediatric Consultant.

3. Following graduation from medical school, I completed my two years of foundation training in South Yorkshire from August 2011- August 2013. This was comprised of three, four-monthly rotations in my Foundation Year (FY) 1 based at the Northern General Hospital in Diabetes and Endocrine, Psychiatry and Vascular Surgery. My FY 2 was based at Chesterfield Royal Hospital (CRH), and I completed four-monthly rotations in Emergency Medicine, Paediatrics and Gastroenterology.

4. I had a year out of training following my foundation training. For the first half of this year (between August 2013 – September 2014), I worked as a Trust grade doctor in Paediatrics at CRH as well as undertaking some voluntary work in Tanzania. In the second half of the year, I travelled and undertook ad hoc locum work in Paediatric and Accident and Emergency Departments in South Yorkshire and Merseyside.

5. I commenced a specialist paediatric training job in September 2014 based in Merseyside. As a junior doctor in specialist training in the Merseyside Deanery, I was employed by the "Lead employer" based at St Helen and Knowsley NHS Trust. This training involved 6 – 12-month jobs in different paediatric departments and hospitals based in Merseyside, Cheshire, and North Wales over an 8-year period. Rotations would commence on either the first Wednesday of September or the first Wednesday of March. The aim of rotating was to gain the relevant experience required to complete the training and become a Paediatric Consultant. During the first two years of specialty training (also known as ST1 and ST2), I worked at a more junior level, supervised by a more senior paediatric trainee doctor, as well as a Consultant. From ST3 onwards, I was in a more senior role supporting more junior doctors and supervised by a Consultant.

6. I have set out below details of my employment history.

Dates	**Training grade**	**Hospital**	**Specialty**
September 2014-March 2015	ST1	Liverpool Women's Hospital	Level 3 neonates
March 2015 – September 2015	ST1	Countess of Chester Hospital	Paediatrics and level 2 neonates
September 2015 – March 2016	ST2	Alder Hey Hospital	Paediatric Cardiology
March 2016 – September 2016	ST2	Alder Hey Hospital	Paediatric Respiratory
September 2016 – March 2017	ST3	Arrowe Park Hospital	General Paediatrics
March 2017 – September 2017	ST3	Warrington Hospital	General Paediatrics and level 2 neonates

September 2017 – March 2018	ST4	Whiston Hospital	General Paediatrics and level 2 neonates
March 2018- September 2018	ST4	Liverpool women's hospital	Level 3 neonates
September 2018- March 2019	ST5	Arrowe Park Hospital	Community paediatrics with level 3 neonates on calls
March 2019 - September 2019	ST5	Arrowe Park Hospital	General Paediatrics
September 2019 – March 2020	ST6	Alder Hey Hospital	Paediatric Endocrinology
March 2020- September 2020	ST6	Alder Hey Hospital	Paediatric respiratory / covid rota
September 2020- March 2021	ST7	Whiston Hospital	General Paediatrics and level 2 neonates
March 2021- September 2021	ST7	Arrowe Park Hospital	General Paediatrics
September 2021- March 2022	ST8	Leighton Hospital	General Paediatrics and level 2 neonates
March 2022- September 2022	ST8	Whiston Hospital	General Paediatrics and level 2 neonates

7. Since October 2022, I have been employed by Leighton Hospital Mid Cheshire Hospitals Trust as a Consultant in General Paediatrics with a specialist interest in epilepsy.

8. When I worked at the Countess of Chester Hospital (COCH) in 2015, I was in the final 6 months of my first year of specialist paediatric training as a junior doctor. I did not have any management duties or additional responsibilities.

9. I left COCH on 1st September 2015 and have not worked there since.

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

10. As a rotating junior doctor employed by the Lead Employer, I did not have a direct manager on the neonatal unit. However, I was allocated a clinical and educational

supervisor who was responsible for my training and supervision during the rotation. This was Dr John Gibbs. I would have been able to escalate any concerns in meetings with him or discuss issues with any member of the paediatric team, who were more senior to me. I felt comfortable approaching any member of the Consultant team whilst working at COCH.

11. I feel unable to comment on the relationships between clinicians and managers at COCH as it has been a very long time since I worked there, and any working relationship that has not left a lasting impression on me. As a very junior trainee, I did not have a great deal of contact with the management team.

12. I do not know what the relationship was like between nurses, midwives, and managers.

13. I recall the midwives, nurses and doctors working well together. As a junior doctor, I found that the postnatal ward and the midwives were friendly and welcoming. I also found it easy to work with the nurses on the neonatal unit and found the unit to be friendly.

14. I do not have the impression that the quality of care of the babies on the neonatal unit was affected by relationships. I was not aware of any negative relationships whilst I was working at COCH.

15. As an ST1 trainee, I did not spend a lot of time on the neonatal unit as patient care on the neonatal unit was more senior led, and handovers regarding the neonatal patients would have been completed by ST3 trainees and above. I would have mainly worked on the postnatal ward and the paediatric ward.

16. With regard to my impression of the culture on the neonatal unit in 2015 other than as a junior trainee, I felt very supported, and I enjoyed working in Paediatrics at COCH. I felt that communication between doctors and nurses was good.

17. As a very junior trainee, I was not aware of any professional relationship issues, governance issues and would not have been involved in any management decisions.

18. In terms of a comparison with other hospitals that I worked at in 2015 and 2016, I found the culture at COCH to be supportive. In my position as a junior trainee, the work was less busy and less stressful in comparison to other hospitals in which I worked during

training. I felt that it was a close-knit Paediatric team in a small District General Hospital (DGH), and I therefore felt that I got to know the Consultants better than when I worked in other hospitals. As such I felt more comfortable asking for help and advice.

19. In comparison to other hospitals during my training from 2015 - 2016, I felt that the relationship between midwives and doctors was better. There was more of a feeling of being part of one team.

20. I am not aware of hearing any comments, positive or negative or reading any reports at the time about the quality of care or the nature of relationships between medical, nursing, midwifery, and management teams. Before rotating to COCH, I heard through other trainees that it had a good reputation as a paediatric department for supervising and supporting junior trainees. Staff tended to enjoy working there and would ask to rotate there because it was known to be a positive working environment and the Consultants were supportive. It seemed common knowledge among trainees that if you were a paediatric junior doctor working at COCH and you needed help from a Consultant, they would come in and help and they were easy to approach.

Whether suspicions should have been raised earlier and whether Lucy Letby should have been suspended earlier

Child A and Child B

21. I do not recall when I was first made aware of the death of Child A. I think I might have I&S and heard about it on my return from a colleague.

22. In my police statement I stated that I was *"really surprised"* on learning that Child A had died. I think this was probably because the gestation of the twins meant it was not likely that Child A would not survive. Before Child A and B were delivered, I was learning about how to counsel parents about what to expect, if they were to have a preterm baby. I went with a senior trainee to speak to Child A's mother about what to expect when he and his twin were born. Not surviving before going home was not something that we discussed because it was not something that we expected. We anticipated that the twins may have needed a bit more support than another baby of the same gestation as they were twins. Their mother was also known to have I&S, but we were not expecting either baby to be critically unwell.

23. I am struggling to recall any informal discussions about Child A's death. I recall that there was some discussion about an unusual rash and possible questions about whether there was a blood clotting issue I&S

24. I don't recall being present for a debrief regarding Child A.

25. I do not remember when I learnt that Child B had collapsed. I think I may have become aware by chatting to other trainees informally.

26. I was not present at a debrief about Child B, as far as I can recall.

Child D

27. I attended Child D at 0140. Dr Brunton called me from the Children's Ward because Child D had a very unusual rash. He (Dr Brunton) told me that had never seen a rash like it before and wondered if I ever had. I hadn't, and I have not seen such a rash since.

28. I did not discuss the rash with anyone else at the time as I was fully aware that Dr Brunton had discussed it with Dr Newby, the Consultant who he had called in overnight to look at Child D. I know that there were then further discussions at the Morbidity and Mortality meeting attended by the wider team.

29. I didn't have any concerns about the rash, which I had not seen before because as a very junior trainee in my first year of training, there were a number of things that I had never seen before. I suspected the rash was a sign of infection, and I was aware Dr Brunton and Dr Newby had changed the antibiotics Child D was on.

30. My recollection of being called for help to assist with Child D at 0430 on 22nd June 2015 is mainly taken from my police statement as a significant period of time has now passed. I was called into the room and noted that Child D was desaturating, and her heart rate was dropping, despite receiving breaths via a neopuff device as she was not breathing for herself. I immediately asked for a crash call to be put out to urgently summon the Registrar, Dr Brunton (who was on the Children's Ward) and I asked for the emergency trolley. We commenced full resuscitation with Dr Brunton managing Child D's airway whilst I performed cardiopulmonary resuscitation (CPR). We requested emergency doses of adrenaline, fluid boluses and sodium bicarbonate,

which were given. Dr Brunton also asked for the Consultant to be called in urgently. Whilst he (Dr Brunton) was performing intermittent ventilation via a neopuff and ET (endo-tracheal tube) I was performing CPR. A portable telephone was put to Dr Brunton's ear by one of the nurses (I can't recall the nurse's name) with who we both assumed was the Consultant (Dr Newby) on the other end of the phone. Dr Brunton began explaining the situation and asked the Consultant to come in urgently. However, it then became apparent that it was not Dr Newby on the phone but the mother of Child A and B who had been ringing to see how Child B was doing. I do not know how that mix up occurred. Dr Brunton was mortified. Fortunately, Dr Newby had received the emergency call on her bleep as she was staying on site and quickly arrived on the neonatal unit. We continued to follow the resuscitation algorithm and Child D's parents came down to the neonatal unit. Very sadly the resuscitation was not successful.

31. Following the resuscitation, I recall that Lucy Letby (Letby) commented that, *"this is the second baby that this has happened to. This has happened to me a couple of times."* This did not strike me as particularly unusual, however, I think what stood out to me was how upset Letby was. At the time, immediately after we stopped the resuscitation, we were all very much in shock and quietly upset. Letby was visibly upset and needed comforting. At the time I attributed this to the fact that she had recently been at the resuscitation and death of another baby, and therefore found the similar situation more difficult to cope with.

32. Immediately after the resuscitation, I discussed the case with Dr Brunton as he wanted to know what had happened prior to his arrival to formally document the information in the notes. I don't fully recall the conversation after the resuscitation with Dr Brunton. I know that he would have asked me what happened before he arrived and talked through what we did in the resuscitation. He would have also provided an on-the-spot debrief for me.

33. I remember Dr Brunton mentioning that he was relieved that he called Dr Newby earlier in the night to look at the rash as if Child D had collapsed and he hadn't asked her (Dr Newby) to review her, he would have worried that he had missed something. However, he was reassured that a Consultant had also seen Child D.

34. As far as I am concerned, Child D's deterioration and death were an unexpected event.

35. I do not recall having any undue concerns regarding Child D's death other than I had not been expecting it. I would have informally discussed the situation with Dr Brunton and/or Dr Newby at the time.

36. Child D's death would have been discussed at the morning handover, but I cannot remember who was present or what was said.

37. After the event, I was emailed by Dr Newby and asked to do a power point presentation containing a timeline of events and results from Child D's case to generate wider discussion at the joint paediatric and obstetric Morbidity and Mortality meeting. These meetings were part of the department's clinical governance and would have been formally chaired by one of the Paediatric Consultants.

38. I don't recall attending or being invited to a debrief regarding the death of Child D although I may have been. I think a debrief or discussion about any serious incident is important.

39. I cannot recall any specific conversations regarding Child C, who also died on the neonatal unit, but whose care I was not involved in. I recall my friend and colleague, Dr Gail Beech **Irrelevant & Sensitive** **Irrelevant & Sensitive** was upset when he died. She would have likely mentioned being upset to me informally.

40. I remember that there were conversations about the similarity between Child A and B's collapses. I think I assumed (at the time) that because they were twins and both collapsed, there was something they had both been born with or inherited genetically that made them unwell. I suspect that people were surprised that four babies had collapsed in a short space of time. However, all babies were different in terms of gestation, size, and reason for being on the neonatal unit and my impression was that the situation was very unlucky.

Child E

41. Based on the notes I made at the time, I believe Child E was in a good condition when examined by me at 1410 on 3rd August 2015 and appeared well.

42. At 1450, I was asked to review the blood sugar of Child E, which was high enough for him to start an IV insulin infusion. I prescribed this at a very low dose as I noted previously that he was sensitive to high doses and had dropped his blood sugars quickly.

43. At 1930, I was asked to look at the blood test results for Child E, which were good showing a CRP <1 (which means infection is unlikely) and improving neutrophil count. I noted that the blood cultures did not show any sign of bacteria growing from his blood stream and his blood sugars, which had been very high, had fallen and were being maintained on his insulin infusion.

44. I was not asked to examine Child E by a senior doctor or neonatal nurse, and there were no clinical concerns raised by the nursing team throughout that shift. There was no reason to examine Child E at 19:30 as he was well when I examined him as part of the ward round review that day and no new concerns had been raised from the nurse looking after him. We would not examine or handle a baby on the neonatal unit unless we had been made aware of a query or concern.

45. I was not aware of any discussions regarding suspicions or concerns regarding the death of Child E.

46. I did not attend a discussion or debrief regarding Child E. I remember informally meeting my colleague, Dr McCarrick, for a coffee at work to talk about the case. I cannot remember the details of the conversation, but I remember being worried that I had missed something so I think that a debrief would have been helpful

47. I do not know about the number of deaths that occurred in 2015. I was only present for 6 months of 2015 and so I am not aware of any deaths before or after my rotation.

48. I don't recall being provided with any organisational data about the mortality rate and serious incidents on the neonatal unit. I don't think this is something I would have been involved in or thought to look at as a ST1.

49. I was not involved in discussions with other hospitals about incidents or deaths at COCH. I imagine that lessons would have been learnt at clinical incident meetings based on DATIX reports submitted when there was a serious incident. I do not recall how this worked in 2015 at COCH or being involved in any such meetings.

50. The number of deaths at COCH did not stand out to me at the time. As a rotating trainee, I would not have known about the bigger picture. As a ST1 trainee, I did not have a lot of prior experience in paediatrics and neonates. However, I previously worked a weekend at CRH on paediatrics, where there were two deaths in very close succession (I think it was the same weekend) and then none for the rest of the year. I assumed the neonatal deaths in June 2015 were a similar unlucky cluster at COCH. I had also just rotated to COCH from Liverpool Women's Hospital (LWH) where there were sicker babies. My experience of what was "normal" was probably coloured by my experience at LWH. It is only since working as a more senior doctor on other level 2 neonatal units that I have gained the breadth of experience to note how unusual the number of deaths and unexpected collapses were. For example, I have only been on shift for the death of one baby in a level 2 neonatal unit in the last 9 years. By this point, I had already given statements to Chester Police.

51. I don't recall and I am not sure if I knew at the time how deaths on the neonatal unit were investigated or when post-mortems were requested. This is not something I would have been involved in as a ST1 trainee.

52. I have not been involved in any later discussions or debriefs about the deaths on the neonatal unit other than attendance at the Morbidity and Mortality meeting, where I think Child C and D were discussed. In hindsight, it might have been helpful to attend a debrief for Child E.

53. I do not recall attending any debriefs for any of the cases for which charges of attempted murder were brought. However, I don't think this was necessary as I do not think I had any direct involvement in their care.

54. I was only aware of suspicions regarding Letby when I found out through the media that she was arrested. At the time of my first statement to the police, I knew they were looking into excess deaths on the neonatal unit but did not know that it was a murder investigation.

55. I did not have any formal suspicions or concerns regarding Letby or for the safety of the babies on neonatal unit whilst I worked in the department.

Safeguarding of babies in hospitals

56. I have level 3 paediatric safeguarding training, which formally is renewed every 3 years. It is also a requirement of the hospital where I am currently employed that the training is renewed by a local face-to-face training session annually. I have completed several face-to- face sessions as well as online national level 3 safeguarding training on the e-learning for health website. The focus is on recognising child abuse and child exploitation. It does not cover what to do if there are suspicions of a member of staff harming a patient. I am not aware of any training that covers this.

57. The GMC has generic guidance about the principles around safeguarding children. RCPCH has a very useful online "Child Protection Companion" which provides advice and resources for different scenarios. There is a section entitled "abuse in special circumstances" which sets out how to escalate concerns if you suspect a child is being harmed in a healthcare setting. If I needed to seek help and advice in that situation, my first port of call would be to discuss my concerns with the hospital safeguarding team and the Lead Paediatrician for safeguarding locally.

58. I did not turn to any professional body for advice whilst I worked at COCH as I did not have any concerns, or suspicions at the time. If I had, I would have discussed my concerns with my clinical supervisor, Dr Gibbs.

Speaking up and whether the police and other external bodies should have been informed sooner about suspicions about Letby

59. I am not aware of what whistleblowing or other procedures were in place at COCH in 2015.

60. At the point of my training as a ST1, I had not received any training in the process used and organisations involved in reviewing a child death. I don't think it would have been expected at that stage in my training.

61. I did not have any suspicions regarding Letby and so I did not discuss concerns with any external scrutiny bodies.

62. I did not have any involvement in providing information to the Coroner.

The responses to concerns raised about Letby from those with management responsibilities within the trust

63. I did not raise any concerns about Letby.

64. I do not know if monitoring the babies by CCTV would have prevented Letby from committing her crimes.

65. Security systems relating to monitoring of access to drugs and babies in neonatal unit might mean that there is more information available if there were concerns about a staff member harming a baby. I do not know if it would prevent deliberate harm.

66. Since 2015, I understand that there are some newer systems in place (for example, freedom to speak up guardian) that should make it easier for any member of staff to escalate concerns. As these systems are usually based at the same hospital Trust, I wonder whether there should be easier access to an independent body to flag concerns

67. Closer scrutiny of neonatal deaths also now occurs, which is a good thing, as often lessons can be learnt to improve clinical practice and provide higher quality care. Currently (regionally) all neonatal deaths are being discussed with the Coroner. This practice should continue. It would also be helpful for junior members of staff in all health professional teams, who might not have a good understanding of NHS management systems to know how to escalate concerns easily. There should be regular reminders about how to access this process. This would also be useful for rotating junior doctors, who may not be familiar with the Trust they are working in.

Any other matters

68. I do not have any other evidence, which I am able to give to the Inquiry.

69. I confirm that my statement (included at **Exhibits EET1 [NQ0000723]**, **EET2 [INQ0000507]** and **EET3 [INQ0000225])** are accurate.

70. I have not given any interviews or made any public comments about Letby or the matters under investigation.

Request for documents

71. I no longer have the PowerPoint presentation in respect of Child D. I was asked by Chester Police (by an individual called CI Kevin Lee) for it via email in May 2021. I could not find a copy of it at that time on my old laptop, electronic portfolio, or secure NHS mail. I emailed Dr Breary at the time of request from the police, and he stated that the hospital had a record of it as it was at a formal mortality meeting. I believe he passed it on to the police, but I am not certain.

72. I do not have any other documentation or information that is relevant to the Inquiry's terms of reference.

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: 22.04.2024 | 14:39:35 BST