Witness Name: Katherine Jane Davis
Statement No.: 1
Exhibits: KJD1, KJD2, KJD3
Dated: 23 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR KATHERINE JANE DAVIS

I, Dr Katherine Jane Davis, will say as follows: -

Personal details

1. My name is Dr Katherine Jane Davis, my maiden name was previously Brown and I worked under this name until 2015.

Medical Career and employment at the Countess of Chester Hospital

2. My relevant qualifications are MBChB (University of Birmingham 2009), Postgraduate Diploma in Paediatric Palliative Medicine (University of Cardiff, 2011) and MRCPCH (Royal College of Paediatrics and Child Health, 2013). I completed 2 years of foundation training in Countess of Chester Hospital (COCH) from 2009 – 2011. This included six 4-month rotations in general surgery, general medicine, paediatrics, primary care and emergency medicine. Following this, I started paediatric training in Mersey Deanery in August 2011, which consisted of 6–12-month rotations throughout the region. I worked in paediatrics in COCH in March 2015 – September 2015. On completion of my paediatric training, I was appointed as a substantive (permanent) paediatric consultant in COCH in September 2019 and remain in this post at present.

The culture and atmosphere of the neonatal unit ('NNU') at the hospital in 2016

3. Between March and September 2015, I worked in COCH as an ST4 (speciality trainee, year 4). I was working on the middle grade rota with Dr Elizabeth Newby as my educational supervisor for this rotation. During a clinical shift, my direct clinical supervisor was the consultant 'on-call' for that shift. Any concerns, clinical or otherwise, were escalated to the consultant providing clinical supervision for that shift. The consultants were accessible 24 hours a day, and out of hours they were on-call from home.

4. During the time in question (March – September 2015), I worked on the paediatric ward, children's assessment unit and neonatal unit as well as attending deliveries on the labour ward. I reviewed babies on the postnatal ward and managed acutely unwell paediatric

patients in the Emergency Department. I had previously worked on the neonatal unit in COCH as a Foundation Year 2 doctor for 4 months and so already knew some of the nursing staff and felt that I had positive working relationships with nursing, midwifery, and the medical staff. My interaction with nursing staff was different in 2015 as I was significantly more senior and so I was involved in making a lot more decisions than I did previously. At no point was I significantly concerned with any of the care delivered. As a trainee, I had some contact with the neonatal ward manager during my day-to-day work, but limited contact with or knowledge of the non-clinical managers. The culture on the neonatal unit did not feel any different to any other unit I had worked on.

5. It is very difficult to recall specific feelings from such a long time ago, especially as I now work in the same neonatal unit as a consultant. I never had any concerns regarding the quality of care provided to babies on the neonatal unit I&S I&S. The relationships between staff on the unit did not feel any different to other units I had worked in, and the consultants were some of the most supportive I had ever worked with. I always felt able to escalate concerns to my supervising consultant and felt confident in the clinical and non-clinical advice and support offered to me. At the time, I was not aware of any conflict in professional relationships between any groups of staff. The paediatric department in COCH always had a good reputation with paediatric trainees.

Child C

6. I have been asked to comment further about my involvement in the collapse and subsequent death of Child C in June 2015. Due to the length of time that has passed since the event, I now only have limited recollection of specific details of the events surrounding the death of Child C. I believe there were no significant concerns regarding Child C prior to his collapse and subsequent death on 13 June 2015. He was much smaller than would be expected for his gestation but had done well prior to his collapse.

7. I think I was on the paediatric ward when I received a 'crash call' at around 2300 on 13 June 2015. This is an audible message relayed through my bleep requesting my urgent attendance on the neonatal unit. The distance between the paediatric ward and the neonatal unit was relatively small and as a result, I arrived within a couple of minutes. The crash call is activated by someone making an urgent call to the switchboard. It is then the switchboard operators voice that is sent through the bleep system. There is no way for me to know who requested the crash call to be put out or who made the phone call.

8. I can remember where in Nursery 1 Child C was located, as per my police statement, but I cannot remember with any certainty which nursing staff were present. When I arrived, there were several nursing staff around the incubator and resuscitation was underway. I would have been given a brief update by a member of the nursing staff on my arrival about what had happened and what resuscitation measures they had delivered. I can't recall exactly what I was told about Child C's condition when I arrived. I would have then taken over management of Child C's airway and leading of the resuscitation attempts. I followed the neonatal resuscitation guidelines, which is a standard approach to these situations. I immediately asked for the on-call consultant to be alerted and asked them to attend. I took over the management of Child C's airway and asked for emergency drugs such as adrenaline and bicarbonate to be administered. When Dr Gibbs, the on-call consultant arrived, he would have taken over the role of leading the resuscitation attempts from me.

9. We always think about the 'why' something may have happened as this can sometimes direct additional treatment we give and assist us with management of a patient during resuscitation attempts. For example, blood gases are often taken, if this showed hypoglycaemia then this would be treated. In this case, there was no obvious explanation as to what may have caused Child C's unexpected collapse. A nurse who had been caring for Child C had recently put a small amount of expressed breast milk down his Nasogastric Tube (NG) and was concerned that this may have been the cause. I recall reassuring her that this did not fit with what we were seeing. Even if the NG tube was in the incorrect place (which there was no evidence of) then such a small amount of breast milk put down an incorrectly located tube would have unlikely led to a cardiac arrest in the manner we witnessed. The lack of explanation for the collapse would have been known to Dr Gibbs. I did not feel the need to escalate this any further as Child C was referred for a post-mortem to determine the cause of their death.

10. As mentioned in my original police statement, my attempt to intubate Child C was initially unsuccessful. I was able to get a good view of his vocal cords, but they were swollen and so I was unable to pass a tube through them. This is something that I had seen before, especially when babies had previous unsuccessful attempts at intubation. During the acute event, I didn't really appreciate that this was unusual given I was the first person to attempt to intubate him. This is not something I thought about subsequently, until I was specifically asked about it in a police interview.

11. The lack of explanation for the collapse was unusual but more unusual was the lack of response to resuscitation and the complete lack of a heart rate at the time of my arrival. I had managed a number of neonates in need of resuscitation by that point in my career, and they usually have a slow heart rate, rather than an absent one. In my experience, most show some response to effective resuscitation, either with an increase in heart rate or gasping / starting to breathe. This may well not be sustained, but the total absence of a heart rate despite effective airway management, chest compressions and resuscitation medication were not something I had experienced before, or indeed since.

12. All the team present agreed that we had reached a point of futility and active resuscitation was stopped. Heart rate and saturations monitoring was turned off, but we continued with ventilation breaths via an endotracheal tube and chest compressions I&S I&S . At the time, this felt like a very short period but in hindsight it was relatively prolonged I&S I&S . Child C began gasping and the capnograph started changing colour. The capnograph indicates when carbon dioxide is being produced by changing colour. There is often no colour change during a cardiac arrest due to poor gas transfer in the lungs. I quietly alerted Dr Gibbs to this. He was present on the unit, although I am unsure if he was in the room at the time. I&S , we stopped chest compressions and ventilation breaths, we probably removed the endotracheal tube, although I am uncertain about this. Child C continued to show signs of life with some spontaneous breaths and a good heart rate. The fact that this happened following a prolonged period of chest compressions without the use of medication and without any response to earlier efforts when drugs were used was highly unusual. I was unable to think of any medical explanation why this had happened. I would have discussed this with Dr Gibbs but did not feel the need to escalate it any further. I did not have any suspicion at the time that Child C's collapse was caused by someone actively doing something to harm them. Child C was reported to the Coroner and a post-mortem was requested in view of the unknown cause of death.

13. The collapse and subsequent death of Child C was something I reflected on for a long time afterwards. With the benefit of hindsight, subsequent knowledge of Lucy Letby's arrest and the murder charges made against her, the possibility that someone may have deliberately caused harm to Child C (something I had not considered at the time) became a possible explanation. I have subsequently been involved with a case where a child suffered from an air embolism (a known but rare complication of a surgical procedure), which led to a cardiac arrest. The child's heart started beating again after a period of time, presumably when the air from within the circulation dissipated.

14. When listening to a recording of my interview to verify my transcript prior to the criminal trial, I became upset at the thought that Child C could have had a different outcome if we had reinstated intensive care. Leading up to the trial and on reflection of the events and knowledge of the allegations against Lucy Letby, I made a retrospective comment to the police about whether continued treatment, such as putting Child C on a ventilator would have provided a different outcome. However, this was not my professional medical opinion, but just a personal thought given the circumstances around Child C's death. At the time of treating Child C, I was not aware of the murder allegations against Letby and so at that time, this thought would not have occurred to me. My thinking process before the trial was, 'If' someone had done something, which had time to resolve during our longer than usual period of chest compressions, could Child C have survived? However, our resuscitation efforts at the time were appropriate and timely, with good airway management and saturations on the monitor.

15. I am unable to recall any details about the debrief I attended about Child C other than the fact that it was felt the medical care we delivered post collapse was appropriate and it was felt that there was nothing else we could have done. From the clinical notes, it appears there was acknowledgement of the unexplained nature of the collapse and Dr Gibbs was planning on discussing with his consultant colleagues. A postmortem was requested but the outcome was not available during the debrief session. As far as I can recall, this was the only debrief meeting I attended about Child C. I don't recall anyone raising any concerns during the debrief.

16. The role of debriefs has become a lot more embedded in practice in the intervening years since the death of Child C. During my early training, including during the time covered by the Inquiry, debrief sessions were often fairly informal. They were *'are you ok?'* type discussions. Over time, debriefs have become more formal in terms that it is held at a pre-arranged time with invites sent to all staff involved. The role of both hot (which is held in the immediate aftermath of an event) and cold (held a few days/weeks after the event) debriefs are much more embedded in practice in the present day than I remember it being back in 2015 - 2016.

17. During my 6-month rotation in COCH in 2015, it became clear that we were experiencing an above average rate of death and collapses. As a group of trainees, we discussed if we felt we were missing something. Due to the small number of middle grades and close working of the team it was, and still is, common practice to debrief informally with

colleagues following a stressful event. As a result, we all knew that other babies had collapsed unexpectedly and in atypical ways. When we attended regional teaching or local paediatric courses, colleagues would ask if we were doing okay, as they had heard that we were having a particularly bad run in COCH. This is not unusual and still happens today. Paediatrics is a small speciality, and many trainees know each other and look out for each other. Sick neonates will often be transferred from a DGH (District General Hospital) to a tertiary centre and sick children to regional PICU (Paediatric Intensive Care Unit). Trainees often become aware if a person / location is going through a difficult run of cases. Any 'concerns' raised were around the wellbeing of colleagues, who are often friends. I was not privy to any concerns being expressed as to the collapses being unnatural in cause or because of substandard care.

Response to Neonatal Deaths

18. It is easy to look back in hindsight and recognise that the neonatal unit in COCH was experiencing an increasing number of deaths and collapses. The frequency with which I was asked to review babies due to nursing concerns did not register as being out of the ordinary. Everyone is often extra cautious in the aftermath of a death and fluctuations in the level of concerns expressed is normal. Multiple factors influence the level of concern including recent events, nursing, and medical staff's level of experience as well as the level of parental concern. Several of the paediatric trainees, including me, had just come from a tertiary neonatal unit, which may have led us to underestimate the extent of the increase from normal baseline in the number of deaths and collapses for a level 2 neonatal unit. The handover process did not really serve as the mechanism by which events were communicated, rather the way in which outstanding jobs, recent events and current concerns about patients were shared. The frequency of this was reflective of the workload we were experiencing.

19. Several of the trainees I was working with at the time, including me, had just come from a rotation in Liverpool Women's Hospital (LWH). As a tertiary neonatal unit LWH cares for some of the smallest and sickest babies in the region, this is likely to have led to us to underestimate the relative frequency of deaths / unexpected collapses in COCH, as these events are not uncommon in a tertiary unit. The consultants in COCH were aware of the deaths as they were involved in each case. I did not feel sufficiently concerned to feel the need to escalate concerns above the paediatric consultants. I had no concerns about the medical care given and my involvement with resuscitation of Child C. Whilst sadly it was unsuccessful, the collapse of Child C was appropriately managed. Towards the end of my 6-month rotation, I was aware that an internal review had begun, looking into the deaths

and any possible links. I would have had access to any publicly available data produced by MBRRACE-UK and NHS England, but this was not something I would have routinely looked at as a trainee.

20. I recall attending a debrief following the death of Child C as outlined above. I believe this took place in the parent sitting room on the neonatal unit and involved all staff present for the resuscitation plus the ward manager. This was led by Dr John Gibbs and focused on the care delivered. Other than the debrief for Child C, I am unable to recall attending any other discussions or debriefs about any other specific deaths / collapses on the neonatal unit. I was heavily involved in caring for another baby, who subsequently died during this rotation. The baby in question died following a transfer out of COCH to a tertiary unit. I have been interviewed about this baby by the police. Her death, in my opinion, was not suspicious and followed a typical recognised course of her underlying condition. I believe she is not part of the ongoing investigation. I do not recall there being a debrief for this patient, this would not be out of keeping with standard practice at the time.

Reviews of Deaths and Adverse Events

21. From memory, deaths were reviewed in local morbidity and mortality meetings. In these meetings, care was reviewed with a view to identifying any learning. I do not recall any specific details of cases discussed at these meetings and, often, the acute demands of the neonatal unit and paediatric ward means that trainees are not always able to attend. It is now practice for all neonatal deaths to be reviewed with input from independent panel members, e.g. consultants from other Trusts, via the PMRT (Perinatal Mortality Review Tool) process. I am not sure when this was implemented. I do not recall being involved in any such meetings as a trainee, although this does not mean they did not take place.

Awareness of suspicions

22. I only became aware of the suspicions against Lucy Letby when several family members sent me the BBC article following her arrest. I was not aware of the concerns against Lucy Letby during my first police interview. I did not have any concerns to report, although it did appear that a lot of babies were dying, some in an unexplained manner. I never for one minute thought that anyone was doing anything to deliberately harm babies.

Safeguarding of babies in hospitals

23. As a paediatric trainee, I was required to undertake safeguarding training. This typically includes how to recognise abuse as well as the process by which concerns should be escalated. I believe I was always up-to-date with the training required for my level of

training, which would have been reviewed at my annual review of progress by the Deanery. I do not have the exact dates of when I completed the training, and I am not able to recall the specific content of any training I attended. Training was offered as a mixture of face-to-face sessions, as well as via online learning platforms such as e-learning for health.

24. If I had concerns about a member of staff, I would have escalated the issue internally, initially via consultant supervisors. If I was not happy with the response, I would have approached my defence union for advice on how to take my concerns further. This is not a process I used as I had no specific concerns that needed escalating.

25. I do not know what the processes and procedures for raising concerns within the hospital were in 2015 - 2016 as I did not have to utilise them. I would have looked on the intranet if I needed to access these and spoken to the deanery, who were responsible for my paediatric training (if I remained unclear what process to follow).

26. As a trainee, I had limited involvement in the child death review process. I had been involved in SUDI/C (Sudden Unexpected Death in Infancy/Children) cases in the Emergency Department, but my involvement was usually limited to the initial acute management of the patient. Generally, the completion of the paperwork required after death and attendance at subsequent meetings was the role of the consultant, not a trainee. Through my medical training, I was aware of what cases legally required escalation to the Coroner.

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

27. I have never attempted to raise concerns to external scrutiny bodies, the Coroner or Trust management about the events in 2015 as I did not have any concerns at the time. I was not involved in the discussion of any neonatal deaths with the Coroner. Again, this would usually be the role of the consultant, not a trainee. As a foundation doctor, I had been involved in discussing adult deaths with the Coroner. In contrast, in the paediatric setting, such conversations are almost universally undertaken by the consultant.

Reflections

28. It is impossible to say if the use of CCTV would have prevented the crimes of Lucy Letby, I think it is unlikely. By their very nature, premature babies are very small meaning it would be easy to obscure the camera view of a baby. I do not think it would be practical to install

and maintain CCTV in a way that provided a constant, detailed, and unobstructed view of a baby at all times. Similarly, I think it is vital to consider the impact of CCTV on parents, who may feel they are being watched, especially mothers who are trying to initiate breast feeding.

29. In my view, any system monitoring access to a neonatal unit or medication is fallible. On a day-to-day basis, I walk through doors in the hospital with colleagues where only one of us would use a swipe card. In an emergency, it is not feasible to require everyone to swipe in individually. Of note, Lucy Letby has been convicted of harming a baby with an air embolus, this did not require the use of any 'drug', only a syringe filled with air. Requiring swipe access to be necessary to access syringes is completely impractical.

30. Whilst it is imperative to do all we can to protect the vulnerable babies on neonatal units, this needs to be balanced against the families' right to privacy and ensuring that the care of babies is not inadvertently hindered by delaying access to important equipment and personnel. Lucy Letby has been convicted of murdering the babies in her care and I think care needs to be taken to ensure the unthinkable criminal actions of one evil individual doesn't have negative impact on the experience of care of future families facing the exceptionally difficult, often unexpected admission of their baby to a neonatal unit.

Any other matters

31. I have no other evidence to give that I think would be of relevance to the enquiry. I have reviewed my statement (included at **Exhibits KJD1 [INQ0000138], KJD2 [INQ0000139], KJD3 [INQ0001564]**) and transcript and agree that they are an accurate representation of the interview given.

32. I have not given any interviews or made any public comments about the actions of Lucy Letby.

Request for documents

33. I have no other documents, or information, which may be 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: 25/04/24