

Witness Name: Dr Alison Lois Ventress

Statement No.: 1

Exhibits: ALV1

Dated: 24 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ALISON LOIS VENTRESS

I, Dr Alison Lois Ventress, will say as follows: -

Personal details

1. My full name is Dr Alison Lois Ventress.

Medical Career and employment at the Countess of Chester Hospital (COCH)

2. I graduated from Warwick Medical School in 2009 with an MBChB qualification from the University of Warwick. I completed my foundation training (between 2009 - 2011) in the West Midlands with George Eliot Hospital, University Hospital of Coventry and Warwickshire and Royal Stoke Hospital as well as four months in a GP Practice called Kidsgrove Medical Centre. I then progressed to a paediatric specialty training in Mersey deanery between 2011 – 2022. During this time, I worked at multiple hospitals across Cheshire, Merseyside and North Wales on 6–12-month rotations in paediatrics and neonates. I have listed the hospitals below.

- Macclesfield District Hospital
- Liverpool Women's Hospital
- Leighton Hospital
- Countess of Chester Hospital (COCH)
- Warrington Hospital
- Arrowe Park Hospital
- Glan Clwyd Hospital
- Alder Hey Hospital
- Royal Bolton Hospital

3. I also took time out of training between May 2016 – September 2017 when I went to work in New Zealand at a hospital called Christchurch Hospital, for 13 months, followed by some time travelling.
4. I worked at COCH as a paediatric registrar as part of my paediatric specialty training (ST) on three rotations. This was between 7 August 2013 – 4 February 2014 as ST3,

between 4 March 2015 – 1 September 2015 as ST4 and between 2 September 2015 – 1 March 2016 as ST5.

5. During my ST5 rotation, I was initially working in community paediatrics but covering on-call shifts in general paediatrics and neonates. However, I then had a period off work [redacted] I&S from October 2015 – January 2016. I had a phased return to work in January 2016. As a specialty trainee, I was not employed by COCH directly, but by the “Lead Employer” for doctors in training in the Mersey deanery based at St Helens and Knowsley NHS Trust (Lead Employer).
6. I was awarded membership of the Royal College of Paediatrics and Child Health (RCPCH) in 2013 after passing all the membership examinations. I completed my paediatric training in March 2022 and was awarded a Certificate of Completion of Training by the General Medical Council (GMC) and RCPCH and added to the GMC specialist register. I worked as a locum consultant in neonatology at Royal Bolton Hospital from April 2022 – 2023. Since May 2023, I have been working as a consultant neonatologist for University Hospital of North Midlands based at Royal Stoke University Hospital.

The culture and atmosphere of the neonatal unit (“NNU”) at the hospital in 2015-2016

7. As a paediatric registrar, I worked on the children’s ward and outpatient clinic as well as the NNU. Usually, one registrar was allocated to the NNU on weekdays between 08:30 – 16:30, although sometimes just for the morning if the registrar was needed for the outpatient clinic in the afternoon. Outside of these hours, there was one registrar covering the whole of paediatrics and neonates. The children’s ward was usually the busier department so we would usually be there unless we were called to see a baby on the NNU. I start with this to emphasise that although I worked on the NNU, it was not the main part of my work at COCH. Having also worked at 13 different hospitals, I cannot always recollect which events occurred at COCH and those that occurred at other hospitals.
8. I did not have a specific manager on the NNU. If I had any concerns, I would have approached one of the consultants or the NNU ward manager. I am confident that I would have been able to find someone to escalate my concerns further if I needed to.
9. From a registrar’s point of view, I had a good relationship with the other doctors, consultants, and nurses on the NNU. I think most doctors and nurses had good professional relationships and respected each other’s roles and worked together well. There was a feeling from the NNU nurses that the NNU was an afterthought for many doctors and that paediatrics took priority and the NNU was second place. However, I think that this mainly reflected the bigger workload on paediatrics compared to the NNU, which meant that doctors of all levels spent more time in the paediatric ward.
10. I did not have much interaction with managers. I knew who the NNU ward manager was, but no one beyond that. Clinicians under consultant level did not have much contact with managers, which is common across all hospitals that I have worked in. It

is only since I have become a consultant myself that I have more contact with management staff.

11. There were cliquey friendship groups among some of the neonatal nurses, but I didn't see this affecting the care given. I remember general dissatisfaction from some nursing staff with the management, but I can't remember any specific details.
12. I did not have any concerns that the relationships or culture of COCH was any different from other units I had worked in. I am not able to comment on whether relationships affected the management or governance of the hospital as I was not involved with management or governance at that time.
13. I was no longer working on the NNU after June 2016 so I cannot comment on any changes after that time.

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

Child E

14. In relation to Child E and Child F, from looking at the messages between Nurse T and Letby, I found out that Child E had died at the morning handover. All doctors for both the children's ward and the NNU would have a joint handover from the night team to the day team each morning. I do not remember what was said or any discussions about Child E's passing. I have not had access to Child E's medical notes and so I cannot remember his condition prior to his death, but I know from Child F's notes that they were born at 29+5 weeks gestation, and I would expect most babies born at this stage to survive.
15. Child E's death may have been a surprise, but I do not remember anyone raising concerns. I knew from previous experience that sometimes a baby's condition can change very quickly, and they can die, for example, from overwhelming sepsis and so I assumed something like that had happened.
16. I do not recall what I said to Nurse T about Child E's death. As we were friends outside of work and we both worked on the NNU at COCH at that time, it was not unusual for us to communicate about babies we both looked after.

Child F (Child E's twin)

17. In relation to Child F, I prescribed the TPN (Total Parenteral Nutrition) for him for the whole weekend and Monday prior to the weekend as that was the process at COCH at that time. I have no memory of the events as they did not stand out in my mind as anything out of the ordinary. From the medical notes, I can say that I became aware that Child F had low blood sugars on the night of 4th - 5th August 2015 at the Grand Round as I filled the Grand Round form in the morning of 5th August 2015. The Grand

Round at COCH's NNU was when all the babies on the NNU and their progress was discussed with the consultant of the week and the neonatal nurse in charge. The junior doctors allocated to the NNU would also be present. It was a round table discussion, and it did not take place by the cot side. The round table discussion took place after morning handover before going to review the babies.

18. From reading the notes, the initial general thoughts of the medical team for the cause of the low sugars combined with tachycardia was possible sepsis, for which Child F was appropriately treated. It seems that on the morning review, it was noted that the leg with the long line had become swollen and so there was a concern that the line had extravasated and was the reason assumed for the low sugars at that time. The morning review took place after the Grand Round, but I can't recall who was present during the review. The plan was to move the TPN to a peripheral line and insert a new long line. Lines extravasating is a known complication, and so there were no concerns that anything untoward had happened. I was not surprised by his presentation and did not have any concerns to raise.

19. I am not aware that there were any debriefs or discussions about Child F's low blood sugar readings on 4th - 5th August 2015. I would not expect that there would be any formal debrief as Child F responded to treatment. I was not aware of the raised insulin and low c-peptide levels until the police interviews for this case. These results usually take days to weeks to arrive, and Child F was transferred to another hospital by then, and so the results would go to the named consultant.

Child G

20. In relation to Child G and the events of 7th September 2015, I was asked to review her on several occasions on that night shift as documented in the medical notes and as documented in my police statement and court transcripts.

21. Child G's deterioration was not expected as she had been stable previously. However, unexpected deteriorations are not infrequent in any NICU (Neonatal Intensive Care Unit), especially in babies born extremely premature like Child G and it can happen for several reasons. The most common reason being infection, which was later shown to be the case for Child G.

22. In terms of Child G's "*large projectile vomit*", it is hard to comment on the issue with no recollection of the incident. Babies vomit frequently for many reasons, and the description of vomits is extremely subjective. I don't give much attention to how big or projectile the vomit is reported for a single vomit. Rather, I would assess the baby's condition and that would impact my management more than the description of the vomit. I cannot recall if I saw the vomit myself or if it was just reported to me by a nurse.

23. According to my police statement, I requested that the consultant on-call for that night (6th – 7th September 2015) who was Dr Brearey to be called in to assist at around 03:30 due to another baby also requiring medical input. If I hadn't needed his assistance at

that time, I would have called him after Child G required intubation to update him and discuss Child G's management. As it was, Dr Brearey came to the NNU and I would have discussed Child G's condition with him in person. I was concerned about her clinical deterioration and wanted to ensure that there was nothing else I should be doing.

24. From Nurse Booth's police statement, I note that there was a discussion about Child G during the night amongst the nurses. I cannot remember if I was part of that discussion or not. However, this sounds like the sort of discussion that occurs frequently among NNU staff, reflecting on what had happened and thinking aloud about what might have been the cause.
25. I cannot remember exactly what was discussed during the handover from the night to the day staff on the morning of 7th September 2015. I would have given a summary of the events from the night, what treatment had been given, response to treatment, any results that had arrived and what had or had not been told to parents. I would have also handed over any results to chase and the status of Child G's plan at that time.

Deaths on the NNU

26. I do not know the exact number of deaths on the NNU between 2015 - 2016. I am now aware of the deaths involved in the criminal court case (although I wasn't aware of all those deaths at the time), plus two others that I can remember. There were several deaths but then a period without any that I was aware of. I just thought it was bad luck that several deaths had occurred close together and I did not consider that it was anything out of the ordinary.
27. I did not have access to any data about the mortality rate and serious incidents on the NNU such as data prepared by MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other organisations. If I did have access, I was not aware of it and therefore did not access it.
28. In my current role, I am aware that all neonatal deaths are reviewed but I am not sure if I knew what the review process was when I worked at COCH. Having worked in multiple different NNUs, I cannot separate my recollection of how things worked at COCH from other hospitals in relation to morbidity and mortality meetings, incident reporting and sharing of learning points. Junior doctors (registrars / senior house officers) did not have any part in the review process.
29. I cannot remember if I was involved in any discussions or debriefs regarding the babies named on the indictment. Debriefs were held after unexpected deaths, but it was always difficult to find a time where all staff involved were able to attend at the same time. I do not feel a formal debrief was needed for any of the babies named in the indictment that I was involved with as none of the deteriorations lead to death at that time. Although one baby died at a later stage, at the time there was no concern that

anything out of the ordinary had happened. I cannot remember if I discussed my management of the babies with the consultant informally for my own learning.

30. With hindsight, it would have been helpful to know of the high insulin and low c-peptide level for Child F when that result came back, even though the baby had been transferred elsewhere by that stage. That is concrete evidence that Child F had inappropriately received insulin resulting in low sugars. I am surprised that an investigation was not conducted for this, or if it was, I was unaware of any investigation at that time. If the wider team were aware of this, then potentially any concerns may have been put together sooner.
31. I was not aware of any suspicions about Letby while I was working at COCH. I only became aware that she had been removed from clinical practice during a conversation with Nurse T after I had left. I did not report any concerns or suspicions as I didn't have any.

Safeguarding of babies in hospitals

32. All staff working in paediatrics must undertake compulsory safeguarding training. I was required to complete the registrar level 3 child safeguarding training. There was nothing specific in respect to abuse by a member of staff. I am not aware of any guidance or advice from the BMA (British Medical Association) or RCPCH regarding suspicion of abuse by a member of staff. However, if I had any concerns in that regard, I would initially have spoken to one of the consultants for advice. If I wasn't happy with their advice, I would consider speaking to one of the nursing managers or escalated my concerns to the clinical or divisional medical leads. I did not have any concerns myself while working at COCH, so I did not need to do this.

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

33. I cannot remember what the processes and procedures were for raising concerns within the hospital in 2015 - 2016 as I have worked in so many different hospitals before and since then. I can't recall if I was aware of whistleblowing and freedom to speak up guardians at that time, or when they were first introduced. However, if I had any concerns I would have spoken to the consultant or nursing manager in the first instance. I would have gone up the chain if my concerns were not addressed appropriately.
34. I did not have any training at that time on the processes and organisations involved in reviewing child deaths such as such Child Death Review, Sudden Death in Infancy/Childhood (SUDI/C) and the Coroner's Office. This was not part of my role at that time. From a medical point of view, these processes are entirely consultant led. I had no knowledge of any external scrutiny bodies with whom concerns could be raised at that time. I did not know that external reviews were taking place by COCH as I had left the hospital by that point. Therefore, I would not have provided any information about Letby, or expressed concerns or suspicions about the deaths or injuries to the babies named on the indictment to any external bodies.

35. I did not provide any information to the Coroner about the death of the babies named on the indictment. Firstly, I was not involved in any of the deaths, and secondly, it would have been the consultants' role to speak to the Coroner, and lastly, I had no concerns that needed raising at the time.

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

36. I did not raise any concerns about Letby with those with management responsibilities at COCH as I did not have any concerns.

Reflections

37. In my view, CCTV monitoring would not have prevented Letby's actions, but it might have made it easier to prove she was at the cot side at the time of each collapse. CCTV would not have been able to show exactly what she was doing, unless each individual baby had its own camera, which would go against privacy and safeguarding rules. Also, most incubators are covered to protect preterm babies' eyes from the light, which would block the CCTV's view.

38. I do not think that security systems monitoring access to drugs or babies would have helped in this case as Letby would have had full access as an experienced neonatal nurse. Even looking back in hindsight, it would be impossible to say if Letby accessed the drugs for appropriate nursing purposes or for criminal activity on each occasion. It would be difficult to determine the purpose for which drugs were accessed just by CCTV monitoring, or other security systems.

39. I do not think that any recommendations will keep babies safe from someone who is determined to cause harm. They will always find a way around it, if they are determined and such people are thankfully very rare. Any recommendations should not make the job more difficult for the overwhelming majority of staff, who only want the best for the babies in their care, and already work in difficult and stressful conditions.

40. I think treating insulin as a Controlled Drug in hospitals so two members of staff are required to check it out and checking of stock daily would help prevent the insulin cases. Insulin has been the method in other cases of healthcare workers murdering patients.

41. Understaffing is a big problem in most NNUs, and this would be the biggest recommendation to improve as it would be more difficult to perform any criminal actions with more people around.

Any other matters

42. I have no other evidence which is relevant to the Inquiry.
43. I confirm that my previous witness statement (included at **Exhibit ALV1 [INQ0000349]**) is accurate.

44. I have not given any interviews or made public comments about the actions of Letby or the matters of investigation by the inquiry.

Request for documents

45. I do not have any documents or any other information 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: Personal Data

Dated: 26.04.2024 | 14:31:58 BST