Witness Name: Dr Andrew Niall John Brunton
Statement No: 1
Exhibits: ANJB1, ANJB2 and ANJB3
Dated: 16 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ANDREW NIALL JOHN BRUNTON

I, Dr Andrew Niall John Brunton, will say as follows: -

Personal Details, Medical Career and Employment at the Countess of Chester Hospital.

1. My Name is Dr Andrew Niall John Brunton. I have a Certificate of Completion of Training in Paediatrics with Subspecialty Training in Neonatal Medicine from the General Medical Council (GMC). I was awarded this on 24th December 2019. My GMC Number is I&S. I am a member of the Royal College of Paediatrics and Child Health, and my membership number is I&S.

2. I qualified as a Doctor in August 2009 from the University of Glasgow Medical School. I subsequently completed my Foundation Programme Training over two years across Hospitals in NHS Lanarkshire and NHS Greater Glasgow and Clyde. I then commenced the National Paediatric Training Programme in the Mersey Deanery in the North West of England in August 2011, rotating between Liverpool Women's Hospital, Alder Hey Children's Hospital, The Countess of Chester Hospital, Leighton Hospital and Whiston Hospital. I then returned to Scotland in July 2015 to continue my Paediatric Training Programme in NHS Greater Glasgow and Clyde. I was accepted to the Neonatal GRID Training Programme in February 2017 and began subspecialising in Neonatal Medicine at this point until I obtained my Certificate of Completion of Training in December 2019.

3. I worked at the Countess of Chester Hospital between February and August 2013 and again from February until July 2015. Between February and July 2015, I was a Paediatric Registrar within the department. I was appointed as a Consultant Neonatologist at the Royal Hospital for Children in Glasgow in October 2019 and took up my post in March of 2020. I have been in this role since that date.

Culture and Atmosphere on the Neonatal Unit at the Countess of Chester Hospital in 2015

4. I believe that my Educational Supervisor between February and July 2015 was Doctor ZA. They were the clinician who would act as my 'line manager' for any issues that needed addressing as part of the placement. Any day-to-day clinical issues that I had would be addressed by the Consultant, who had responsibility for the acute inpatients at that time. If I had any issues, I would speak to either of these individuals directly. I do not recollect undertaking or witnessing any interactions between hospital managers and clinicians or nurses/midwives. However, I believe the team working between Doctors, Nurses and Midwives at the hospital was excellent and I do not remember any specific issues with regards to this. As such, I don't believe that the quality of relationships affected the quality of care given to the babies on the Neonatal Unit at that time.

5. I believe that we had a supportive culture on the Neonatal Unit between February and July 2015. As previously mentioned, I think there was an excellent team working and good working relationships between the neonatal nursing staff and medics working on the Neonatal Unit. As a Registrar, the Consultants working on the Neonatal Unit were supportive and approachable, and I do not recall ever feeling unsupported in any way. I cannot comment as to whether professional relationships affected the management and governance of the hospital in 2015 as this would have been led by more senior clinicians than me and not an area that I was exposed to at that time.

6. The Countess of Chester's culture was comparable to all other units that I worked in at that time. As I have stated, I felt the Consultants were supportive and approachable and the nursing staff were hard-working and conscientious. I do not recollect any specific concerns that the culture or working relationships were different from any other hospital that I had worked in previously, such as Liverpool Women's Hospital and Alder Hey Hospital.

7. I do not remember any specific concerns regarding the quality of care, quality of the management, supervision and/or support of doctors during the time I worked at the Countess of Chester Hospital, either in 2013 or 2015. I always enjoyed coming to work at the hospital and don't remember any specific changes in those feelings between working there in 2013 and again in 2015. I do not remember hearing any specific

comments or concerns regarding the nature of relationships between clinicians and managers, nurses, midwives or any other medical professionals.

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

Child A

8. I have previously given a full statement to Chester Police outlining my involvement in the medical management of Child A. I believe that I would have been informed of Child A's death the following day as I was on shift at that time – however I cannot be certain of this. I would describe Child A's death as unexpected as they were clinically stable prior to their acute deterioration but I had no specific concerns around the nature of their death as I was not present at that time.

9. I have no recollection of the comments made in Dr MacCarrick's statement **[INQ0000052]** outlined below.

> *"I remember one of the registrars, Dr Brunton, questioning whether the UVC insertion was connected to [Child A's] death. This was during informal discussions amongst some of the trainees after handover. Dr Brunton raised the question when he learned that the UVC had been inserted on the day of [Child A]'s death. However, on discovering that it had never been used to administer medication, he revised his impression, and assured me he did not think the UVC was associated with [Child A]'s death."*

10. If the alleged conversation above did take place in the manner she has outlined, I do not remember having any specific concerns regarding the position of either the umbilical venous line (UVC) or peripherally inserted central catheter (PICC line). As clinicians, we are always looking for a potential explanation or reason for an unexpected event occurring and it appears from her statement that I was hypothesising that this may have been a potential cause. This had already been considered by the Consultant on Call, who had been involved in the acute resuscitation and is documented in the Child A's medical notes. The revised opinion that I allegedly gave to Dr MacCarrick later was ultimately correct however, as I believe from the press reports surrounding the trial of Lucy Letby that the post-mortem results have proven that there was no evidence that the position of either of the lines had a role in the death of Child A.

11. I do not recall attending a debrief for Child A and do not recall any further informal discussions that had taken place regarding Child A at that time.

Child C

12. I have previously given a full statement to Chester Police outlining my involvement in the medical management of Child C. I believe that I would have been informed of Child C's death on 15th June 2015 as I was on shift at that time – however I cannot be certain of this.

13. From the clinical course described in the medical notes that I have seen as part of my supporting bundle, I would describe Child C's death as unexpected, although I was not on shift in the hours leading up to their passing. I had no concerns regarding Child C's death and therefore did not raise any concerns at that time

14. I do not recall attending a debrief or any further discussions regarding Child C.

Child D

15. I have previously given a full statement to Chester Police outlining my involvement in the medical management of Child D. I do not have specific clear recollections of what I saw on that night due to the passage of time and therefore I need to rely on the copious medical notes that I have written for Child D.

16. When I was initially asked to attend at 1:40am, I noted that there were significant areas of light brown/dark brown and black lesions tracking across the trunk. Given that the rash itself was unusual, in conjunction with the short episode of increased support for Child D's breathing, I contacted the Consultant on Call, Dr Elizabeth Newby, and asked her to attend. I clearly had concerns that this was an unusual pattern of behaviour for a baby who had been clinically stable previously, hence the reason for Child D to have a review by the On-Call Consultant, which Dr Newby promptly undertook that night.

17. It was completely unclear to me as to why Child D had suffered dramatic deteriorations in her clinical condition punctuated by periods of being completely stable. As discussed previously, I contacted Dr Newby to discuss and review the care of Child D at approximately 01:40. I discussed the blood results and ongoing management plan with her at approximately 02:35am and contacted her a final time when Child D's heart

stopped at approximately 03:55. Dr Newby re-attended at 04:07, as would be standard practice in such clinical situations.

18. Whilst it was clear that Child D's episodes of deterioration and subsequent death were completely unexplained, I was aware that a formal process would be undertaken to investigate the circumstances surrounding Child D's death and as such, I did not have any specific concerns and was confident that all avenues would be investigated surrounding the case. At the time of the episodes of deterioration, I escalated these appropriately to the Consultant on Call as would be expected of a doctor of my standing at the time.

19. I cannot recall if I was aware that Child B collapsed on the nightshift of 9th - 10th June 2015 as I was not on shift at this time. Whilst I was aware that there had been three deaths on the Neonatal Unit within a few weeks, I cannot recall any discussions regarding similarities between the clinical presentation of the cases at that time.

20. As outlined above, whilst I was aware that sadly three babies had passed away on the Neonatal Unit in a relatively short space of time, I did not have enough knowledge or experience of neonatal medicine at that time in my career to conclude that these cases may potentially be linked in any way. I left the Trust not long after the death of Child D, so I was not aware of the further collapses and deaths on the Neonatal Unit until I was contacted by Chester Police as part of Operation Hummingbird.

21. As outlined in my previous statement to Chester Police, I cannot recall if a debrief was held following the death of Child D. I would have expected a debrief to have been held at some point regarding the death of Child D. If a debrief was held then I would have been expected to be invited as I was involved in the resuscitation efforts of the baby at the time of their death. However, if it occurred on a day that I was not on duty, then it may not have been practical for me to attend as I lived in Liverpool at that time.

22. As outlined in my previous statement to Chester Police, on 20th October 2015, I was contacted by Dr Newby via an email stating that the post-mortem for Child D had shown congenital pneumonia and following concerns raised by the family, this was being investigated as a Serious Untoward Incident by the Trust and that the coroner had also asked for a report into the care Child D had received. I subsequently replied later that day with my up-to-date contact details including my new mobile number and postal address. Dr Newby confirmed later that day that she had received this and no further action was required from me at that time. I was never contacted by anyone to take part

in any further investigation or process regarding Child D. I followed up my initial email with a further email to Dr Newby on 18th February 2016 asking for an update on the status of the investigation into the death of Child D as I had not heard anything since October 2015. Dr Newby confirmed on 22nd February 2016 that she had not heard anything further and that the Trust had completed a detailed review, which was passed to the coroner at that time. I was never contacted again regarding Child D until Chester Police contacted me as part of Operation Hummingbird.

23. Given that I left the Trust on 21st July 2015, I was unaware of any further meetings or discussions regarding Child D, including the Neonatal Mortality Meeting held on 29th July 2015 and the Obstetric Secondary Review Team and Neonatal Review Team Meeting held on 28th August 2015. I was not asked to participate in either of these meetings. I was not involved in any other meetings or discussions regarding Child D's death at that time.

The Coroner

24. To the best of my recollection, I was contacted by Dr Jayaram in February 2016 via email explaining that a statement was required for the Coroner in relation to Child A. I subsequently completed this statement on 19th February 2016, which started by outlining my credentials and training to date, as well as my involvement in the management of Child A (document **INQ0008854**)

25. I did not mention a rash on Child A to the Coroner as I never witnessed a rash on Child A at any point when I reviewed them. However, I was not present when Child A collapsed and died. I did not make any links to the Coroner in my statement regarding the deaths of Child C and D and the collapse of Child B as it had never been suggested that these incidents could be linked in anyway. As previously stated, I left the Trust approximately four weeks after Child D's death and was unaware of any ongoing concerns regarding the Neonatal Unit at this point.

26. I do not recall discussing what should be included in my statement with any senior doctors or managers prior to its submission to the Coroner. I was no longer working at the Trust at this time so had very little interaction with any clinicians at the Countess of Chester Hospital after July 2015. I cannot comment on the information provided by the Trust to the Coroner regarding the death of Child A as I have never seen this information. I was only ever contacted to give a statement to the Coroner about Child

A, and I have never been contacted by the Coroner regarding any of the other babies named in the indictment.

Response to Neonatal Deaths

27. Whilst I was naturally upset following the deaths of all the babies on the Neonatal Unit in June 2015, I do not recall having specific concerns or worries regarding the number of deaths at that time. Following the death of Child D, I believe that there were no further deaths or serious unexplained collapses on the Neonatal Unit until after I had left the Trust on 21st July 2015. Whilst in 2015 I would have been vaguely aware of reporting tools such as MBRRACE-UK, NNRD (National Neonatal Research Database) and NNAP (National Neonatal Audit Programme), these dashboards do not report collected data regarding deaths and serious incidents in a Neonatal Unit in real time, and as such, would have reported on the deaths and serious incidents at the Countess of Chester Hospital long after I had left the Trust.

Reviews of Death and Adverse Events

28. I cannot comment on how either adverse events or deaths were reviewed in the Countess of Chester Hospital in 2015 as I have no recollection of ever being involved in any review process. As previously stated, I passed my updated contact details to Dr Newby on 20th October 2015 in case my assistance was required in the Serious Untoward Investigation into Child D, but I was never contacted. I was not involved in any discussions with any perinatal networks regarding adverse incidents and/or deaths of babies. To the best of my recollection, post-mortem requests and coroner referrals were always handled by the Consultants working in the department and as such, I was not involved in this process. I cannot recall attending any discussions or debriefs for any of the children who died on the indictment. I would have expected a debrief to have been held regarding the death of Child D. If a debrief for Child D was held, then I would have expected to be invited as I was involved in the resuscitation efforts of the baby at the time of their death. However, if it occurred on a day that I was not on duty, then it may not have been practical for me to attend as I lived in Liverpool at that time.

Awareness of Suspicions

29. I was unaware of any suspicions or concerns regarding Lucy Letby and never had any other concerns around the care of the babies on the unit at that time.

Safeguarding of Babies in Hospitals

30. Over the course of my Paediatric Training, I completed all the required safeguarding modules as laid out in the Royal College of Paediatrics and Child Health (RCPCH) curriculum for trainees at that time. This included Safeguarding Level 3 training at Alder Hey Children's Hospital in 2014 and subsequent updates in 2019 - 2020. However, I do not recall any modules that specifically focused on abuse by a member of staff to a baby. As mentioned above, the RCPCH does provide safeguarding training although I am unsure if they have specific modules on suspected abuse of babies/children by members of staff. If this situation was suspected in my own hospital, I would initially turn to my consultant colleagues, senior neonatal nursing staff colleagues as well as the senior management team within the Women and Children's directorate; all of whom I have an excellent working relationship with. I did not discuss the events at the Countess of Chester Hospital with anyone from the RCPCH or GMC.

Involvement of Police and Other External Bodies

31. I cannot recall the formal processes for whistleblowing and speaking up regarding concerns in 2015 - 2016 at the Countess of Chester Hospital. However, given my position as a Paediatric Registrar at that time, if I had any concerns, then I would always initially approach either my Educational Supervisor or the Consultant who was on clinical service that week with any issues that I felt needed their input, either clinically or non-clinically.

32. As previously outlined, in 2015 I had recently completed my Safeguarding Level 3 training which was conducted by the Child Protection team at Alder Hey Children's Hospital. I believe that during that course, there was some mention of the organisations involved in the reviewing the death of a child. I believe that the training that I had at that time was appropriate for my skillset as a Specialty Trainee Year 4 in Paediatrics. As outlined above, if I had concerns from my interactions with patients or staff members, then I would escalate these to the most appropriate senior clinician at that time. I cannot recollect if the training in 2015 was sufficiently comprehensive enough to help a person understand when to raise concerns or suspicions regarding a colleague who is harming patients.

33. In 2015, I would have been aware that several professional organisations could have been approached if specific concerns were identified that needed to be addressed. These include the Care Quality Commission, GMC, NHS England and the local Child Death Overview Panel. However, I never had any specific concerns and I believe that I had left the Trust prior to any further external professional bodies being involved.

Responses to Concerns Raised about Lucy Letby from those with Managerial Responsibilities within the Trust

34. I never raised any concerns regarding Lucy Letby to anyone within the Trust, either clinical or managerial, at any time as I never had any concerns regarding her conduct in June 2015.

Reflections

35. In my opinion, I do not think that installing CCTV would have prevented the crimes that Lucy Letby committed. It is also my opinion that installing CCTV on Neonatal Units will do more harm than good and may undermine the principles of Family Integrated Care that most units now aspire to. Additionally, I would be concerned around the governance surrounding the recording and reviewing of video footage, as well as the potential negative effect that installing CCTV may have on nursing and medical recruitment numbers in the future. I do however think that enhanced monitoring of the removal of drugs from secure units would be beneficial and would create a better governance system around who accessed what drug and when.

36. In my opinion, having higher numbers of well-trained nurses on every shift in a Neonatal Unit will reduce the chance for any criminal actions of staff to go unnoticed. As such, I would urge the Inquiry to make a recommendation for a nationally agreed neonatal safe staffing level enshrined in law in relation to both capacity and acuity rather than acuity only on a Neonatal Unit. Whilst we have agreed definitions regarding optimum nursing staffing levels based on acuity from the British Association of Perinatal Medicine, I do not believe that this covers the minimum number of nurses required based on capacity, as well as the potential for unexpected admissions within a unit.

37. I believe that the statements I previously provided (included at **Exhibits ANJB1 [INQ0000050]**, **ANJB2 [INQ0008854]** and **ANJB3 [INQ0000051]** are accurate and I have nothing further to add to them.

38. I have not made any public comments about the actions of Lucy Letby or the matters under investigation by this 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.

Signed: PD

Dated: 25/4/2024.