Witness Name: Doctor S
Statement No.: 1
Exhibits: INQ0000643; INQ0001397; INQ0001561
Dated: 1/5/2024

Doctor S

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR Doctor S

I, Dr Doctor S (married name Doctor S), will say as follows: -

1. I make this statement to assist the Thirlwall Inquiry, and in response to a (Rule 9) request for information from the Inquiry.

2. May I at the outset express my condolences and sympathies to all family members and friends who have been impacted by the conduct at the root of this Inquiry.

3. I have where indicated, and for ease of reference, referred to the accounts that I gave to the police, which will be annexed to this statement.

4. If anything is unclear, or if further information is required, I am of course ready to assist the Inquiry further.

Medical career and employment at the Countess of Chester Hospital ('the Hospital')

5. I am a consultant paediatrician with I&S I&S. I have been in this post since I&S.

6. I obtained my primary medical qualification (MBChB) in I&S from I&S I&S

7. I undertook my foundation training between I&S, with the I&S I&S.

8. I commenced specialty training ('ST') in I&S under I&S I&S. I completed the MRCPCH examinations in I&S I&S. My ST rotations, including training rotations at the Hospital, were as follows:

   - I&S; I&S; ST1 Neonatology

- I&S; ST1 Paediatric Emergency Medicine & Rheumatology
- I&S; ST2 General Paediatrics & Neonatology
- I&S; ST2 General Paediatrics & Neonatology
- I&S; ST3 Paediatric Neurology
- I&S; ST3 General Paediatrics & Neonatology
- I&S ST4 Neonatology
- I&S the Hospital; ST4 General Paediatrics & Neonatology
- I&S; the Hospital; ST5 Community Paediatrics (On-call covering General Paediatrics & Neonatology)
- I&S; ST5 General Paediatrics
- I&S I&S; ST6 Neonatology
- I&S; ST6-7 Paediatric Neurology
- I&S; the Hospital; ST7 General Paediatrics and Neonatology
- I&S I&S; ST8 General Paediatrics
- I&S

9. My role at the Hospital in 2016, during my ST7 rotation in 'general paediatrics and neonatology', and under the clinical and educational supervision of Doctor V included:

    - leading daily ward rounds of paediatric and neonatal patients, with consultant support
    - managing patient flow through the children's assessment unit
    - running of general paediatric ward and level 2 neonatal unit at middle grade level
    - assisting and leading paediatric and neonatal resuscitations

- attending high risk deliveries and initiating neonatal life support where needed
- supervising and reviewing the clinical work of junior colleagues
- liaison with tertiary centres and other members of the multi-disciplinary team
- attending regular outpatient clinics (registrar and consultant lists)
- managing the day-today running of the middle grade rota (ST3-ST8 trainees) with support from Dr Saladi – allocating trainees to different clinical areas in daytime hours, (neonatal unit, paediatric ward, out-patients)
- undertaking child protection medicals out of hours.

<u>The culture and atmosphere of the neonatal unit ('NNU') at the Hospital in 2016</u>

10. Whilst I was on a training rotation with the Hospital at this time, my lead employer was I&S I&S

11. My training programme directors were I&S and I&S My head of school was I&S.

12. My clinical and educational supervisor for this training rotation was Doctor V The college tutor at the Hospital was Doctor ZA and the clinical service lead was Dr Ravi Jayaram.

13. I would describe the relationships between clinicians and professionals during this rotation as good. I personally did not have any issue from what I saw as a trainee doctor. I always felt very well supported and happy with the whole team. I enjoyed going to work and felt I had very good training at the Hospital during my time there. I had good relationships with both the neonatal team and paediatric team.

14. From my experience of working on the NNU, I did not have any concerns regarding the care given to babies. I only experienced what I saw, which was that a good/very good level of care was being given.

15. I do not recall anything specific regarding the culture on the NNU between March and September 2016.

16. I cannot comment on whether professional relationships affected the management and governance of the hospital in 2016. I was a trainee on rotation at this time.

17. I do not recall any change in the quality of relationships or the culture of the NNU after June 2016. I recall, as a group, being informed that there was going to be an external investigation from RCPCH (Royal College of Paediatricians and Child Health) into the increased number of deaths, and that the NNU was to be downgraded to a level 1 unit whilst this happened. I felt I just got on with my role, with my focus being on progressing

with my training and to ST8 – my final year of training, and on providing the best care to patients that I could.

18. In terms of the culture at the Hospital, as compared to other hospitals that I worked at as part of my training rotations: I would say that the culture at the Hospital was one of the most supportive, friendly and approachable places to work within the region. Trainees would, and still do, request to work at the Hospital due to the positive culture within the paediatric and neonatal departments. I was always very pleased to be allocated to the Hospital for rotations during my training and never felt unsupported by the consultants or any other member of the team. The culture in a particular rotation elsewhere throughout a lot of 2015 unfortunately fell well short of that in the Hospital. I was delighted to be returning to the Hospital in March 2016.

19. I felt I had excellent working relationships with staff at the Hospital; better than some at other hospitals during my training in 2015.

20. I had not heard of any problem regarding the quality of care, quality of management, supervision and/or support for doctors at the Hospital in 2016. I had heard that there were some unusual or complex collapses/deaths, but there was nothing regarding the quality of care/support for trainees.

<u>Whether suspicions should have been raised earlier and whether Lucy Letby should have been suspended earlier</u>

Child N

21. I was involved in the care of Child N on 15 June 2016. I refer to my statement at exhibit INQ0000643_0001-2 for the circumstances leading up to my involvement; what I saw when I arrived at Child N's cot; and both my involvement in Child N's care and that of other practitioners.

22. There were some clinical signs / symptoms that were of concern. The inability to intubate Child N caused me concern at the time. I considered myself as experienced in neonatal intubation, as were the two other consultants who tried to intubate Child N. The ST3 in attendance was competent. The anaesthetic consultant in attendance, although not experienced in neonatal intubations, had the clinical competence to perform this procedure. I had not been in the position before where no one in the team was able to intubate.

23. Furthermore, there was an area of swelling visualised when attempting to intubate. This swelling had some fresh blood around it and was located just below the epiglottis in the

upper airway. I was not able to explain the cause of the swelling. Fresh blood was of concern due to Child N having haemophilia; there was therefore a risk of significant bleeding.

24. With the benefit of hindsight, I do not recall anything else of concern, clinically, in respect of Child N.

25. My recollection of the reason that Child N was transferred to Alder Hey Hospital on 15 June 2016, was for intensive care management and tertiary level (highly specialised) input.

26. I cannot recall if I attended any subsequent discussions or debriefs regarding Child N.

27. I spoke to Dr Brearey the following day. Dr Brearey asked whether I had noticed anything unusual. I cannot recall the detail of this conversation beyond what I stated to the police (INQ0000643_0002-3).

Child O and Child P

28. Child O and Child P were triplets.

29. I was involved in the care of Child O on PD June 2016, a triplet born on this date. My statement to the police at INQ0001397_0002 sets out the circumstances in which I was assigned to and involved in the care of Child O.

30. At page 3 to my police statement (INQ0001397_0003), I set out my involvement with Child O and their condition at birth.

31. Child O's mother was not able to come through to the NNU, but I did speak to Child O's father. I cannot recall the particulars of the conversation beyond that which is documented at the top of page 4 to my statement (INQ0001397_0004).

32. Whilst I noted in my statement that I handed over to Dr Huw Mayberry at around 2030hrs, I cannot recall the specifics of what was discussed at the time.

33. I first became aware of the death of Child O and Child P when I arrived for my night shift on 24 June 2016. I refer to my statement at INQ0001397_0005. I believe that it was one of the paediatric nursing staff that told me. Doctor U informed me that two of the triplets had collapsed and their abdomens had become distended, but no other details.

34. The deaths were a total shock to me. Any death of a patient that you look after comes as a shock. These deaths were particularly shocking because they appeared to be healthy babies (of course, babies that are premature and require intensive or high dependency care can and do deteriorate, and the clinical picture can change quickly).

35. I cannot remember any one specific conversation regarding this 'shock', nor do I recall discussions with anyone regarding the similarity of the circumstances of death. I cannot remember if I attended any discussions or debriefs in respect of Child O and Child P.

36. I do not remember any change in the way the nurses and doctors on the NNU interacted with each other following the deaths of Child O and Child P. I always felt I had a good relationship with both the nurses and doctors and ward managers.

Child Q

37. I was involved in the care of Child Q on the night shift of 24 to 25 June 2016, and would refer to my statement at INQ0001561_0001-2 for the details of my involvement.

38. There were no clinical signs that caused me concern, and with the benefit of hindsight I cannot see anything of clinical concern.

39. As stated in my statement, I would not have been able to predict (from Child Q's presentation) that they would deteriorate so suddenly that morning. I cannot recall when I found out about Child Q's subsequent collapse; my assumption is that I found out when I returned to work for a night shift on 25 June 2016.

40. I cannot recall being a part of any subsequent discussions or debriefs regarding Child Q.

Response to neonatal deaths

41. I do not think that my involvement (with the babies noted in the indictment) was such that I would have had, or would have raised, concerns about the number of deaths on the NNU. I was not present at any of the resuscitations leading up to the death of the babies.

42. As a trainee, on a 6-month rotation, covering the paediatric ward, neonatal unit and out-patients along with an on-call rota, I was not aware of the exact numbers or the difference between the death rate at the Hospital and any national rates / average. This would have been information known/discussed at consultant/managerial level and I would not have had awareness or oversight of this data unless it was presented at a meeting such as a morbidity and mortality meeting.

43. My worry, as previously documented, was the lack of explanation and unexpectedness for some of the deaths/collapses. The case of the triplets heightened my worry. However, I was not present at any of the resuscitations and therefore I cannot comment on the detail of any concerns at the time of their deaths.

Reviews of Deaths and Adverse Events

44. As a trainee at the time, I was not sure how adverse incidents or deaths at the Hospital were reviewed. I remember attending some morbidity and mortality meetings with *obstetrics and gynaecology*; however, I do not remember the specific cases discussed or the dates of these meetings.

45. I do not recall attending any discussions or debriefs (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of the deaths of the babies named on the indictment shortly after their deaths. I do recall being told that there was going to be an external review of the number of deaths of the babies on the NNU.

46. I am unsure how deaths on the NNU were usually investigated.

47. I was not involved in discussions with any local network of hospitals about adverse incidents or deaths; this would not have been within the remit of my role.

48. I do not recall attending any discussions or debriefs following clinical events for the babies named on the indictment, and in respect of which charges for attempted murder against Lucy Letby were ultimately brought.

Awareness of suspicions

49. My recollection is that I became aware that others had some concerns about the potential conduct of Lucy Letby in the last couple of months before I moved rotation (so July and August 2016). I cannot remember the specific details of how I became aware; however, I recall having some awareness, from general discussion within the team, that Lucy Letby had been present at the time of many of the collapses and resuscitations of the babies. After the collapse of Child Q, I recall having awareness that Lucy Letby was not doing her usual nursing duties on the NNU.

50. In the months after I left the Hospital, I was working in my last year of training and looking out for consultant job opportunities. A job was advertised at the Hospital that I was interested in. Unfortunately, at this time, my application was not accepted as the interview date was just outside of the required 6 months from CCT (Certificate of Completion of Training). The same job was advertised in Spring 2017 and I applied for this and was offered an interview. I recall having an informal conversation with one of the consultants at the Hospital, Dr Susie Holt, in the months between late Autumn and Spring 2017, although I cannot remember the exact date. I recall her briefly telling me that things had been quite difficult at the Hospital as Lucy Letby was not working in her usual role due to the coincidence that she had been at several of the unexpected collapses and that as a consultant group, they felt this needed further investigation to ensure there was no malpractice. I recall her saying that there had been some pressure for Lucy Letby to return

to her clinical duties on the NNU; however, the feeling was so strong from the consultant group, that a comment was made that she would go to a police station herself to report the concerns if senior management did not take the concerns seriously, or if they allowed Lucy Letby to return to her clinical duties.

51. I withdrew from the interview process as I was I&S and did not feel that it was the right time to be committed to a consultant job that would commence I&S I&S, and when there were some unknowns about what had happened to the babies involved in the indictment. A consultant job was then advertised for I&S which was closer for commuting purposes, and I was subsequently offered that role. I remain in this role today.

52. I did not use any formal or informal process to report any suspicions or concerns about Lucy Letby, or any concerns for the safety of babies on the NNU. I did not have any firm suspicions or concerns about Lucy Letby, or any wider systemic problem, during my time on training rotation at the Hospital.

Safeguarding of babies in hospitals

53. In my current role/position, all staff employed by the Trust, have access to clear advice regarding freedom to speak up and there is a Trust wide guideline detailing this. The guideline is found on our Trust Intranet. This freedom is without fear of being disciplined or discriminated against if we speak up about any concerns we may have about an issue at work and may include concerns or suspicions about the conduct of staff towards patients. This guideline was re-enforced/highlighted to the medical and nursing teams following the verdict of the trial where Lucy Letby was found guilty of for several counts of murder and attempted murder. We have had debrief sessions involving the Women's & Children's departments, led by our senior management team, including our Medical Director. There was also representation from the Freedom to Speak Up Guardians (FTSU) working within my current Trust. FTSU Guardians are an independent service and work with the Executive Team to protect patient safety and the quality of care, improve the experience of all staff and promote learning and development. Speaking up is confidential and available whether you need to raise a concern or require some impartial advice on an issue at work.

54. Mandatory training is an essential part of the role of both a junior doctor and consultant. Evidence of participation in mandatory training is needed for the appraisal and GMC revalidation process. Safeguarding training is included in mandatory training. During 2016 and my time at the Hospital, I re-validated my Level 3 Safeguarding training. I am currently up to date with Level 3 and Level 4 Safeguarding.

55. In terms of support and guidance regarding issues of safeguarding, at the material time (at the Hospital) I would have turned to my clinical and educational supervisor, training programme director / head of school, my lead employer, my medical defence organisation and/or the British Medical Association (the BMA). I would still turn to some of these bodies today, as well as my colleagues, supervisors and managers. Given the extent of my involvement and awareness of the issues relating to the indictment, and that I rotated to another Trust in September 2016, I did not at the material time turn to anyone for advice.

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

56. I cannot recall the processes and procedures for raising concerns at the Hospital in 2015/2016. However, if I had any immediate concerns, I would have escalated them to my clinical or educational supervisor in the first instance.

57. In terms of training on the processes used and organisations involved in reviewing a child death, such as Child Death review, Sudden Death in Infancy/Childhood (SUDI/C) and the role of the coroner:

    SUDI/C training is given during paediatric training and there are policies/local guidelines available in Trusts. I cannot specifically remember formal training on this during my rotation with the Hospital; however, I was aware of the process. The use of this process, in my experience, is in patients that present to the hospital, rather than patients that are born on the neonatal unit.

58. Training on how to speak to the coroner/reporting a death has widely been part of Trust inductions since I was a foundation doctor back in I&S. I would regularly speak to the Coroner's Office in my foundation years as a junior doctor, working on an adult respiratory ward, and I would have considered myself familiar with the process in 2016. In paediatrics, death is much less common than in adult medicine. In a specialty such as paediatrics, my experience as a trainee was that death certificates, discussions with the coroner, discussions with family regarding post-mortems and so on, would usually be led/done by the consultant paediatrician in charge or responsible for the patient.

59. It is only since becoming a consultant that the process of Child Death Review and Child Death Overview Panels (CDOP) have been more understood. As a trainee, sudden death is not a common experience that you see; therefore, apart from reading policies and having some training, you may not be involved in the actual process until completion of training. Trusts have a CDOP representative; therefore, again, you may not know about that as a trainee unless you have encountered a sudden death.

60. As a trainee in 2016, with regular rotation changes, my first port of call to raise concerns would be my clinical or educational supervisor. In the absence of appropriate support or advice, I would escalate to the clinical director of the department. Further escalation would likely have been to the training programme director, the head of paediatric school, or lead employer (I&S at the material time). I would not have immediately considered external scrutiny bodies, such as the CQC or GMC, given there would be internal processes for raising concerns in the first instance.

61. I did not provide any information about Lucy Letby, or express concerns or suspicions about the deaths or injuries to the babies named on the indictment, to any external bodies. I had no firm concerns or suspicions related to Lucy Letby at my time of working at the Hospital.

62. Babies, especially preterm babies on a neonatal intensive care unit do become unwell, and quickly. They are at risk of complications including respiratory distress, sepsis, and abdominal pathology. However, when a baby collapses or passes away, it is usual to have awareness of the cause of deterioration and futility in resuscitation attempts is often due to an obvious cause (for example sepsis or significant congenital abnormality). When the answer is not obvious or clear, this is when the sense that something is not quite right becomes apparent. For me, working at the Hospital, it was walking into my night shift (to learn that two of the triplets had passed away) when I felt uneasy and that something wasn't right. I had absolutely no evidence or facts pointing towards someone, or specifically Lucy Letby, doing any harm as I wasn't there for the resuscitations. I cannot remember when or how I learnt that Lucy Letby had been present at the resuscitations for these babies. I do remember that, sometime after the weekend of 24 June 2016, the trainee doctors were told that there was going to be an external body attending the Hospital (I recall this was to be the RCPCH) to look at the higher than usual death rate. We were also informed that the NNU would temporarily work as a level 1 unit whilst this investigation was in progress. In my mind, it was reassuring for me that a problem had been noticed within the department, and that there would be an investigation into possible causes and the practice of the department. I left the Hospital at the beginning of September 2016 to start my final year of paediatric training at ST8 level with I&S

63. I do not recall ever providing any information to the coroner about any of the deaths of the babies named in the indictment. I was not present at the time of death for any of the babies that passed away.

<u>The responses to concerns raised about Letby from those with management responsibilities within the Trust</u>

64. Whilst I was working at the Hospital, I did not raise any specific concerns regarding Lucy Letby save for those already stated above.

Reflections

65. CCTV may be a deterrent for those intent on committing crimes, and those crimes apparent in this case. Those intent on committing such crimes may, however, still find a way to conceal their actions. CCTV may also introduce issues of maintaining privacy and confidentiality for families and their children. Healthcare professionals do not go to work to cause harm. Lucy Letby is, in my view, a grave exception.

66. I do not think that systems relating to the monitoring or access to drugs and babies in NNUs would have prevented deliberate harm being caused to the babies named on the indictment. They may act as a deterrent; however, if someone has such vicious intent, I believe that this measure alone would not prevent such crimes.

67. In order to keep babies safe, hospital managers should listen to, and take seriously, the concerns of clinicians. Surely it is better to investigate and not find a problem, rather than not investigate and miss such horrific incidents. Hospital managers should be accountable for decisions made by them. The empowerment of healthcare professionals, to be able to speak up without fear of being disciplined or discriminated against, is also important.

Any other matters

68. I do not have any other evidence that I am able to give from my knowledge and experience which I believe is relevant to the work of the Inquiry.

69. I do not have anything I wish to amend in relation to the statements I have made previously, and which are annexed to this statement.

70. I have not given any interviews or made any public comments about the actions of Lucy Letby, or the matters of investigation by the Inquiry.

71. I do not have any documents or other information that I believe are potentially relevant 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.

Signed: Personal Data **Doctor S**

Dated: 1/5/2024