Witness Name: Katarzyna Anna Cooke
Statement No.: 1
Exhibits:
Dated: 25 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF KATARZYNA ANNA COOKE

I, Katarzyna Anna Cooke, will say as follows: -

Personal details

1. My name is Dr Katarzyna Anna Cooke.

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

2. I have been a doctor for the NHS since 2015. I have had full GMC registration with a licence to practise since July 2015. My professional qualifications are MBChB (2008) and MRCPCH (2019).

3. I am a Specialty Registrar in Paediatrics, a position I have held since August 2017. I am currently employed by the Lead Employer (St Helens and Knowsley Teaching Hospitals NHS Foundation Trust) as a Specialty Registrar in Paediatrics at ST6 level.

4. I graduated, trained, and worked in Poland as a doctor in Paediatrics for five years before moving to the UK in 2014. As a Paediatric Trainee, I work on a rotational basis around NHS Trusts in the North West. Up until 2021, I was a Paediatric Trainee in West Yorkshire and Humber. I&S I transferred to the North Western Deanery.

5. I was employed by the Countess of Chester Hospital (COCH) in December 2015 and worked there until January 2017. During my employment at the COCH, I was a Trust doctor in the role of a Senior House Officer, which is the equivalent to level 1 training in paediatrics. I did not hold any management or additional responsibilities.

6. I was employed by COCH between 14th December 2015 and 31st of January 2017. I am currently working at Neonatal Intensive Care Unit at St Mary's Hospital in Manchester. I have held the post of a Specialty Registrar in Paediatrics at ST6 level since September 2023.

7. From recollection of memory, the NNU at COCH in 2015 - 2016 was a welcoming and pleasant place to work.

8. I have no recollection of the name of my managers at that time. Usually, I would report my concerns to the Consultant on-call/in charge or my Clinical Supervisor. My supervisor at that time was Dr Suzie Holt.

9. My impression of all the relationships such as that between clinicians and manager, nurses, midwives and managers, and other medical professionals was that they were appropriate.

10. From recollection of memory, I do not recall any problems with quality of the care being given to the babies on the NNU and/or concerns regarding the quality of the relationships on the NNU.

11. I would describe the culture on the NNU as appropriate and professional.

12. I have no recollection of professional relationships affecting management and governance of the hospital in 2015-2016.

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

Child N

13. From the medical records, I noted that at 19:34 on 3 June 2016, the most recent levels of serum bilirubin (SBR) and CRP (infection level), as well as Child N's blood group and no presence of maternal antibodies (DAT negative). I made a plan to continue monitoring the serum bilirubin and review phototherapy with the result of the level of SBR taken at midnight. I also made a plan to await the blood cultures result. That is a routine note of acknowledging recent blood test results and outlining a management plan.

14. From recollection of memory, I did not attend any discussions or debriefs (formal or informal) in respect of the collapse and death of Child N on 3 June 2016 and/or 15 June 2016. I have no recollection of my involvement in the collapse and death of Child N. Therefore, I would not have been involved in a debrief or discussions about this incident.

Child O and Child P

15. My professional opinion at the time was that I would not have anticipated Child O's collapse. I described it as unexpected as the clinical course of Child O was uncomplicated and Child O was making good progress. It is very unlikely to anticipate collapse of a baby who is well with low risk in perinatal history. At the time of my clinical judgement, it was an unlikely event to happen. I did not discuss these views with anyone else other than the statements I provided to the Police.

16. I was not aware of any concerns or suspicions of other doctors or nurses in relation to the circumstances of Child O's death.

17. From recollection of memory, I did not attend any discussions or debriefs (formal or informal) in respect of the collapse and death of Child O on 23 June 2016. I think that holding a debrief is a good practice following death of a patient or resuscitation. As a junior member of staff at that time, I would have appreciated to be a part of a debrief following the resuscitation of patients I cared for.

18. From documentation provided, I note at 10:00 on 23 June 2016, I conducted the Ward Round in a systematic manner. I note there were no nursing concerns regarding Child O at that time. I prepared a plan about further management of Child O. At 18:00 on 23 June 2016, I documented Dr Gibbs' review of the patient. I noted the examination findings and plan regarding further management of Child O.

19. I understand that the reason for Dr Gibbs' review of Child P and Child R was concern regarding Child O's collapse and death (given that they were triplets). This was a routine practice.

20. Dr Gibbs had not expressed any concerns about the care of Child O or any concerns and or suspicions he had regarding the circumstances of Child O's death. I have not discussed the circumstances of Child O's death with Dr Gibbs.

21. From recollection of memory, we were urgently called to Child P's room on 24 June 2015 due to concerns regarding desaturation and bradycardia. I took part in cardiac compressions following Child P's collapse. I have no recollection of who was present.

22. It was my professional opinion at that time that, Child P's death was unexpected. I described it as unexpected as the clinical course of Child P was uncomplicated and the baby was making good progress. I did not discuss this with anyone else.

23. Understandably, I would have been concerned regarding the unexpected death of two neonatal patients. I did not have any suspicions and resuscitations of both Child O and Child P were managed by senior colleagues at that time.

24. I was not aware of concerns or suspicions of others regarding the deaths of Child O and Child P. I was first made aware when I was contacted by the Police to provide the statements. I was not aware of anyone raising concerns about Letby's involvement in the care of Child O and Child P. I was aware of concerns regarding increased mortality of babies on the NNU and investigations of various external agencies.

25. From recollection of memory, I did not attend any discussions or debriefs (formal or informal) in respect of the collapse and death of Child P on 24 June 2016. As I have already mentioned, holding a debrief is good practice following death of a patient or resuscitation. As a junior member of staff at that time, I would have appreciated to be part of debriefs following the resuscitation of patients I cared for. That would be expected as a standard practice following death of a baby.

Response to Neonatal Deaths

26. I remember that the NNU was undergoing external investigations regarding the number of deaths on the NNU and so naturally, you would be worried when hearing this. However, I was not aware of the details of the investigations.

27. I have no recollection of having access to data prepared by MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other

organisations about the mortality rate and number of serious adverse incidents on the NNU.

Reviews of Deaths and Adverse Events

28. I have no recollection of how adverse incidents or deaths in the hospital were reviewed. I was not involved in any discussions with any local network of hospitals about adverse incidents or deaths of babies. I was a very junior member of staff at that point and was not involved in any of these processes.

29. I have no recollection of how deaths on the NNU were usually investigated. I was a very junior member of staff and was not involved in any of these processes, or when post-mortems were requested.

30. From recollection of memory, I did not attend any discussions or debriefs following clinical events for the babies named on the indictment. I will mention again that arranging a brief is good practice following death of a patient or resuscitation. As a junior member of staff, I would have appreciated being invited to a debrief following the resuscitation of patients I cared for. That would be expected as standard practice following death of a baby.

Awareness of suspicions

31. I was not aware of the suspicions or concerns of others about the conduct of Letby. I became aware of suspicions and concerns from media following Letby's arrest. Nobody had discussed concerns about Letby with me prior to that.

32. I did not use any formal or informal processes to report any suspicions or concerns about Letby or any concerns for the safety of babies on the NNU because I did not have any.

Safeguarding of babies in hospitals

33. I have completed Level 3 safeguarding training as per the requirement of Royal College of Paediatrics and Child Health. From recollection of memory, the training does

not specify what to do in circumstances where one has suspicion of harm caused to patients by staff.

34. My professional body can assist me with safeguarding guidance if and when required. I do not know if they provide advice in the context of suspicion or abuse by a member of staff towards patients. If ever encountered that situation, I would turn to my supervisor.

35. I did not turn to any professional body in relation to any of the babies as I was unaware of the suspicions about Letby.

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

36. I have no recollection of what the processes and procedures were for raising concerns within the hospital that were in place in 2015 – 2016, such as whistleblowing and freedom to speak up guardians.

37. At that time, I had no training on the process used and organisations involved in reviewing child death such as Child Death Review and Sudden Death in Infancy/Childhood (SUDI/C). I did not have formal training about reporting deaths to the Coroner, but I was aware of the coronial process.

38. At that time, I think that it would have been appropriate to raise concerns with external bodies such as NHS England, local commissioners, Monitor, NHS Improvement, the Care Quality Commission, Child Death Overview Panels, the Police or the General Medical Council. However, as a very junior and minimally involved member of staff, I had no concerns or suspicions to express to any of these external bodies. I also did not provide any information about Letby.

39. I did not provide any information to the Coroner (in writing or by telephone) about any of the deaths of the babies named on the indictment.

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

40. I did not raise any concerns regarding Letby with those with management responsibilities at COCH.

Reflections

41. CCTV monitoring of patients is not a routine practice on any NNU that I have worked in before. I am unsure if the crimes of Letby could have been prevented by CCTV monitoring.

42. I am not sure about whether security systems relating to the monitoring of access to drugs and babies on the NNUs would have prevented deliberate harm being caused to the babies named on the indictment.

43. I have not previously seen babies being harmed on the NNU and so I don't feel I can make any recommendations to the Inquiry.

Any other matters

44. I have no other evidence, or knowledge or experience that is relevant to the work of the Inquiry.

45. I have reviewed my previous statements and confirm that they remain accurate.

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

Request for documents

47. I do not have any documents or 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 Katarzyna Cooke

Dated: 30th of April 2024