Witness Name: Dr Rachel Chang
Statement No.: ...
Exhibits: ...
Dated: ....

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR RACHEL CHANG

I, Dr Rachel Elizabeth Ng Chang (nee McEnaney), will say as follows: -

1. I provide the information within this witness statement to assist the Thirlwall Inquiry into events at the Countess of Chester Hospital and their Implications ('the Inquiry'), having been requested to do so within a letter from the Solicitor to the Inquiry dated 27 February 2024.

2. At the outset I highlight that the information I have provided below regarding my involvement in specific patient cases (Child G, Child I, and Child J) is largely taken from the information contained within my earlier witness statements to Cheshire Police. Due to the passage of time, I recall little in the way of specific information from those events, so I have summarised the information within my police statements, to assist the Inquiry.

Qualifications and professional experience

3. I qualified MbChB (Hons) from the University of Liverpool in July 2011. I am a General Practitioner and have been a member of the Royal College of General Practitioners (MRCGP) since February 2019. I also hold a Diploma in Child Health from the Royal College of Paediatrics (2016) and a Diploma of Obstetrics and Gynaecology from the Royal College of Obstetrics and Gynaecologists (2017).

4. Following qualification, I completed my foundation years between August 2011 and August 2013 at Southport and Ormskirk District General Hospitals. I covered multiple specialties, including General Medicine, General Surgery, Paediatrics, Obstetrics and Gynaecology and General Practice.

5. I commenced Specialty Training in Paediatrics in August 2013. I completed 6 month posts at Whiston and then Liverpool Women's Hospitals as ST1 (August 2013-August 2014), spent a year in Alder Hey as ST2 (August 2014-September 2015), before my ST3 year

with a 6 month post at the Countess of Chester (late September 2015 – April 2016) and returning to Whiston Hospital for approximately 6 months (April – September 2016).

6. I started GP training in September 2016 and during this training I gained my Diploma in Child Health and Diploma from the Royal College of Obstetrics and Gynaecologists.

7. As stated above, I have held MRCGP since February 2019. From then I&S I&S I worked as a salaried GP in St Helens and Liverpool respectively. I had also run a community pilot clinic as part of my role as a GP with Extended Remit in Paediatrics (GPwER) from August 2020 until December 2021 with funding from ST Helens CCG with support of Whiston Hospital Paediatric Department.

8. I am currently working in a subspecialist role in Paediatrics (GP with Extended Remit), employed by the Mersey and West Lancashire NHS Trust to perform 7 sessions per week. I have worked in this role for the last 5 months, I&S. I also do ad hoc GP sessions for local GP surgeries to maintain my GP registration on the Performers List.

Role at the Countess of Chester ('the Hospital')

9. I worked as an ST3 (Registrar) in Paediatrics during the period September 2015 – April 2016. My role at the Hospital was my first registrar post.

10. As a registrar in Paediatrics my work was not confined solely to the Neonatal Unit ('NNU'). I covered the general paediatric wards as well. When covering the NNU as a registrar I would also be covering the Maternity Ward, paediatric wards and A&E, depending on clinical need. On usual day shifts I would be on a rota to undertake official duties on the the NNU and the Maternity Ward, or the paediatric wards and A&E. However, in practice, I would have cross-covered any of these areas if there was a clinical need. During on call shifts I would cover all of the above.

11. The main responsibilities of my role were to attend handovers, review children medically and decide on appropriate management plans for them, field questions from nurses and more junior doctors, and to escalate issues or concerns to the responsible Consultant. As the Registrar on duty, I had primary responsibility for the NNU unless the Consultant was present. Essentially as the Registrar, I was responsible for overseeing medical care on the NNU.

12. My responsibilities did not include overseeing the nursing care on the NNU. The nursing team had their own roles, responsibilities and reporting structure, though we worked collaboratively with them as part of the Multi Disciplinary Team ('MDT').

13. I left the Hospital in April 2016, when I rotated to my next training placement at Whiston Hospital.

Culture and atmosphere

14. At the time of my role at the Hospital, I was a trainee doctor under the Mersey Deanery. My Lead Employer Trust was St Helens and Knowsley Hospital Trust, so I was not employed by the Hospital. I had a clinical supervising consultant at the Hospital as part of my training provision. This was **Doctor V** Consultant Paediatrician. If I had any personal/professional queries or concerns, then I could report these to her. Equally if I had concerns about a particular patient then I would have reported these to the consultant on call / named consultant for that patient.

15. In terms of the NNU more specifically, I could have escalated any concerns I had about the unit to Dr Stephen Brearey as the Clinical Lead for the NNU.

16. I cannot recall the lead nurses or nurse managers name from memory now. However I know that at the time, they would have been identifiable on any given shift. If I felt an issue needed escalation to them, then I could (and would) have done this.

17. In my experience, the consultants at the Hospital were excellent, and I never felt any hesitation in being able to approach them to escalate issues or concerns.

18. I do not recall who the managers were at the Hospital. As an ST3 I would have had little involvement with the management team. I do not recall witnessing the relationships between clinicians and managers. My greater contact was with the senior clinicians such as consultants.

19. My only real recollection of the relationships at the Hospital were those between doctors and nurses/allied healthcare professionals. I only ever had good working relationships at the Hospital, and I always felt that people there were open and approachable.

20. It seemed to me that there was a strong professional culture at the Hospital. This was particularly apparent with the consultant body. I felt the most supported in my placement there; they were always positive, reassuring and on hand whenever I asked for or needed support. In that respect it was the best paediatric placement I had. I always felt supported, and always felt that there was a consistent consultant presence on the NNU. I felt that the quality of care was always of the highest standard.

21. From my limited recollection, my experience of relationships on the NNU was also a positive one. I was well-supported within a group of professionals and I learnt a lot during

the placement. I cannot comment on the effects of any other personal or professional relationships on the NNU.

22. Insofar as the culture on the NNU was concerned, I always felt that we were working cohesively as a team. It was a busy unit (which was consistent with all of my paediatric placements), so it was important that there was always good communication between the doctors and nursing staff. I can only comment on my own experience, but I felt the nursing staff were highly skilled and competent, and that they enjoyed working as part of the larger MDT. I did not make any lasting or close friendships during my work on the NNU, but felt that I had good professional relationships with everyone I worked with there.

23. During the 6 months of my placement at the Hospital, I was not aware of anything to suggest that professional relationships were affecting the management and governance of the Hospital or the NNU. As I rotated to Whiston Hospital in April 2016, I cannot comment upon whether there were any significant changes in or after June 2016.

Handovers

24. I provided a written witness statement to Cheshire Police on 30 April 2018 to assist their investigation **[INQ0000336]**. Within that witness statement I provided information at pages 4-5 regarding handovers at the Hospital, as follows:

> *I would consider the handover processes at Chester as being of good standard. The Consultants were very proactive in making sure everyone was up to date. The 'hot week' Consultant would encourage everyone to attend the morning handover. The 'hot week consultant' was a different consultant each week who was the consultant rota'd to cover the wards for all new admissions and general care for the babies on the NNU. The night registrar would be at the morning handover and would inform everybody of what happened during the night shift. The team would then start ward rounds with the 'hot week' consultant after this handover. After the ward round on the Paediatric unit, the 'hot week' consultant would call another handover or go onto the neonatal unit, and then there would be an evening handover for the on call staff.*

25. In my experience, handovers at the Hospital were very similar to handovers in other district general hospitals. Given the level of senior presence (particularly the frequent attendance of Consultants at most handovers) the handovers at the Hospital were often more thorough than at other places I have worked. The debriefing processes were also similar to those at the other places I have worked.

Debriefs

26. Debriefs are discussions that may take place amongst clinical staff following a clinical incident. I described the system of debriefs at the Hospital in my witness statement dated 30 April 2018 **[INQ0000336]** at page 6, stating:

> *With regard to debriefs, they do occur but not always formally. If for instance there is a death of a baby there will be an immediate debrief with anyone who is present. After a couple of days a Consultant would catch up with you and discuss what happened possibly during a weekly ward round. There were formal debriefs that would be instigated by Consultants. The staff involved with a particular baby that died would get an invite to a debrief.*

27. As with handovers, my impression of the debriefing processes at the Hospital were also similar to those at other places I had worked. As an example, I had done a pure neonatal placement at the Liverpool Women's Hospital as an ST1 (2013 - 2014) and I do not recall being aware of any particular differences between the debriefing processes on NNU and those at the Liverpool Women's. Although I think it is likely that I would have attended debriefs at the Hospital, unfortunately I do not have any specific recollection of this.

Child G

28. I was involved in the care of Child G on 7 and 21 September 2015, and I provided information regarding my involvement to Chesire Police in my witness statement dated 30 April 2018 **[INQ0000336]** (at pages 6-11) and within a police interview on the same date **[INQ0007609]** (at pages 20-49). I refer to this information as an accurate account of my understanding of my involvement in Child G's care in September 2015. I do not recall the specific events now, and the information I provided to police was almost entirely based upon my review of the medical notes of Child G, as I had limited recall at that time.

29. I have not received Child G's medical notes for the purpose of providing this statement for the Inquiry, but I summarise below the account I provided previously to police within my witness statement of 30 April 2018. I have also included further commentary below in response to questions raised for the purposes of the Inquiry.

7 September 2015

30. This is described more fully at pages 7 – 8 of my earlier witness statement **[INQ0000336]**. In summary of that information, I believe I worked a 08:30 – 17:00 shift, and that Child G had been unwell with vomiting and collapses before I attended. My involvement included

inserting a long line into Child G, enabling administration of inotropic drugs and boluses of fluid. I documented this at 15:00.

31. I also made an entry in the notes at 16:20 that afternoon, which summarised matters for the doctor attending on the next shift, and indicated I had updated the parents as to what had taken place, and the plan for Child G. The plan included Child G's transfer to Arrowe Park Hospital.

32. I have been asked about the morning handover on 7 September. I do not have any memory of the morning handover on 7 September 2015. I commented within my police interview **[INQ0007609]** about how Child G was, but this information was taken from the written notes.

33. I have also been asked whether I recall being surprised or concerned at Child G's episode the night before I came on shift. I cannot recall any particular feelings of surprise from myself or others about this. Similarly, I have no recollection of feelings of concern with regard to this episode, beyond my concern about the immediate need to care for and stabilise Child G (as the initial line had failed at 08:00 shortly before I came on shift). I do not recall anyone else expressing concerns about Child G's deterioration during the morning either.

21 September 2015

34. This is described more fully at pages 8 - 11 of my earlier witness statement **[INQ0000336]**. In summary of that information, I believe I commenced my shift at 08:30. Child G had returned, physically stable, from Arrowe Park Hospital on 16 September 2015.

35. My first involvement with Child G on this date appears to have been providing advice to the SHO, Dr Fielding, following a projectile vomit and apnoeic episode she had experienced during his ward round that morning. This advice may have been by telephone – I do not recall.

36. Thereafter I reviewed Child G in person at 11:50, when she was reported to have been 'not herself'. I documented that Child G's tummy was soft and distended, on which basis I recommended a partial screen for sepsis. There is reference to review of Child G's condition by Dr Gibbs (the Consultant), who recommended a broad spectrum antibiotic.

37. I made a further entry at 15:30 recording a further desaturation of Child G noted by Dr Fielding, requiring bagging (neopuffing) due to poor respiratory effort. The notes then

indicate that, by 15:30, Dr Gibbs inserted a cannula into Child G's left foot (this would have been due to failure of the earlier cannula). I cannot remember if I was present or not when Dr Gibbs fitted the cannula.

38. I made no further entries within the notes that day, which suggests I had nothing further to do with Child G. The nursing notes suggest that she was stable and recovering.

39. I have been asked whether I or other members of staff were surprised by Child G's deterioration at 10:20, and whether I had any concerns about this. I cannot recall any feelings of surprise or concern regarding Child G's condition on the morning of 21 September, beyond my concern to treat and stabilise her. I cannot recall having any concern about her treatment beyond the concern I would have for any vulnerable patient whose condition was unstable and whose condition required careful management.

40. Baby G was born at 23 weeks' gestation baby and so was born very prematurely. Babies born at this level of prematurity/edge of viability are inherently extremely vulnerable and can become unstable, as they are physiologically extremely premature. Her deterioration at 10:20 would not have been surprising to me, as deteriorations of this (or similar) nature are often seen within this highly vulnerable patient population.

41. Similarly, when I reviewed her at 11:50 I was not surprised at her presentation. My only concern was to treat and stabilise Child G, but I cannot recall having a particular concern regarding her treatment.

42. I have also been asked to comment upon debriefs regarding Child G on the NNU. I do not recall attending a debrief in relation to Child G's care regarding either events on 7 or 21 September 2015. This does not mean I did not attend such a debrief. I cannot recall if a debrief was called, and, taken in isolation and without the benefit of hindsight, these events did not stand out to me as particularly unusual, given the vulnerability of patients with Baby G's level of prematurity.

Child I

43. I was involved in the care of Child I on 15 and 23 October 2015, and I provided information regarding my involvement to Chesire Police during a police interview on 15 January 2019 **[INQ0007610]** and within my witness statement dated 20 May 2019 **[INQ0000536]**. I refer to this information as an accurate account of my understanding of my involvement in Child I's care in October 2015. I do not recall the specific events now, and the information I

provided to police was almost entirely based upon my review of the medical notes of Child G, as I had limited recall at that time.

44. I provide below a brief summary of the more detailed account I provided previously to the police within my witness statement of 20 May 2019. I also include further commentary in response to questions raised on behalf of the Inquiry.

15 October 2015

45. This is described more fully at pages 2 - 7 of my witness statement for the police **[INQ0000536]**. In summary of that information, I believe I started my shift on 15 October 2015 at 08:30. The Registrar who was coming off the night shift had had a difficult run of nights with Child I, as she had been repeatedly unwell on successive nights.

46. I carried out the ward round on the morning of 15 October at about 09:00. Child I had been very unwell overnight and we suspected that this was due to possible sepsis. However this was not a confirmed cause. Child I was **PD** days old, having been born at 27 weeks' gestation.

47. Following the ward round, I discussed Child I with the Neonatal Transport Team ('NTT'). The NTT are a consultant-led team of neonatal ITU doctors, who are able to provide advice about management of acutely unwell babies, as well as being responsible for transporting these patients to other hospitals when this is required. I contacted the NTT on 15 October because they were able to provide advice regarding Child I's management, and also because I wanted to notify them in case we needed to transfer Child I to a tertiary unit (such as Liverpool Women's Hospital or Arrowe Park Hospital).

48. I made a further entry in the notes at 10:40 following an episode of desaturation. I attended to review her and I described this attendance on Child I in detail at pages 5-6 of my witness statement of 20 May 2019 **[INQ0000536]**. I refer to that description as an accurate account of my involvement. During this attendance I performed CPR on Child I.

49. It may assist for me to clarify information provided near the bottom of page 5 of my witness statement of 20 May 2019 **[INQ0000536]**, as follows:

> *The nurses were quite happy that they were keep [sic] the airway stable and was in the same position as it had been since it was inserted so it was I who started compressions.*

50. By this I meant that the nurses were happy that the ET tube was the correct measurement for Child I's mouth, and that it was in the same depth as it had been originally placed (which meant that an ET tube displacement was not the cause of Child I's desaturation). I would not have performed compressions if the tube had moved or was the wrong measurement – instead I would have re-intubated Child I.

51. I have been asked whether I had concerns about Child I's clinical condition when I saw her on 15 October. From review of the notes, I believe I had concerns about Child I purely because she had been so unwell the previous night, after 2 cardiac arrests. My concerns were about her clinical condition, rather than any untoward conduct or lack of care. I commented within my witness statement of 20 May 2019 **[INQ0000536]** as follows:

> *To be fair, Child I had had almost regular events where she would be really sick and then 'bounce back'. Matt Neame had been resuscitating poor Child I every nightshift, then every morning at handover I'd be like 'Oh my God, Poor Child I and poor you', and then we'd have a day shift of where we would say 'Oh she's not been too bad' as she had seemingly recovered quite quickly.*

52. I never questioned why Child I had been so unwell on the nightshifts compared to her relative stability during the days. During my previous neonatal placements some babies were just repeatedly unwell, as they were fragile and unpredictable at times.

53. I never had any concerns about the treatment Child I was receiving from any of my medical or nursing colleagues at the time. My perception at the time was that I was working in a highly dedicated, professional and supportive team at the Hospital. My colleagues all seemed capable and conscientious, and it did not occur to me to question their capability or their motives.

54. Child I was discussed at every handover (like all the children were) where multiple peers and consultants were aware of the events. I do not recall any discussion about potential incompetence or harm being caused by staff members. As stated above in relation to Child G, babies born prematurely can be inherently vulnerable and unstable, and Child I was similarly vulnerable due to her medical and surgical history.

55. Although I could not explain her deteriorations by reference to an abnormal investigation result (for example), I had had previous experience where similarly vulnerable, premature babies had died in a neonatal setting. I cannot speak for others, but for my part, it had not

entered my mind as a possibility that incompetence or deliberate harm might be causative of Child I's night-time deteriorations, for the reasons I have provided above.

23 October 2015

56. The next date of my involvement with Child I was on 23 October 2015. This was the night she died, and I have described this more fully at pages 7 - 13 of my witness statement for the police **[INQ0000536]**. I do not repeat this description below, but summarise below my involvement, as well as responding to the further questions raised on behalf of the Inquiry.

57. I was working a night shift but I did not see Child I until after she had experienced a collapse at around midnight, at which time I was crash called. I left an obstetric delivery of another premature baby in order to attend NNU.

58. During my attendance we resuscitated Child I and intubated her, and also called Dr Gibbs (the on-call Consultant), who attended.

59. Following Dr Gibbs' arrival and his assessment of Child I, he made the decision to extubate her. I was then recalled by the Consultant Obstetrician with the delivery I had left in theatre.

60. Having returned to theatre, I was again recalled some time later to attend the NNU, as Child I had arrested again. I attended and contributed to efforts to resuscitate Child I. I called for Dr Gibbs and he attended again. Despite our efforts, unfortunately we were unable to help Child I, and she was confirmed to have passed away at 02:30.

61. I was extremely upset after Child I's death. My notes of my involvement in the resuscitation efforts were written in retrospect at 03:50 on 23 October (page 1541 of **[INQ0000429]**).

62. In the period immediately following Child I's death that night, I discussed my involvement with Dr Gibbs, as he had been there at her death. During this discussion I was mainly reviewing everything I had done in the deterioration/resuscitation to make sure I had investigated everything and corrected every potential reversible cause.

63. At that time, he reassured me that we had done everything we should. As I had encountered similar scenarios with other premature babies in the neonatal setting (both at the Hospital and at Liverpool Women's Hospital), this scenario did not stand out to me as

being so remarkable that it warranted escalation. I was aware that Dr Gibbs was referring the case to the Coroner.

64. I have been asked to clarify the comments I provided within my police statement **[INQ0000536]** at page 12 in relation to Child I's death:

> *…not having an obvious reason why it has happened…I have never really known, and will never know why it happened. It is an upsetting event in my career that I have thought about intermittently. I don't know how or why it happened, the Coroner didn't know why it happened and the debrief held after her death couldn't explain why it happened either.*

65. Child I deteriorated and died on 23 October 2023. I was the Registrar on the night shift and Dr Gibbs was the Consultant on-call. Although I could not explain why this had happened by reference (for example) to an abnormal investigation result, I had encountered previous examples of similarly vulnerable, premature babies dying in the neonatal setting. My understanding was that, sadly, this could happen as one of the consequences of their prematurity and the effect of previous deteriorations in weakening their reserve (therefore weakening their ability to cope with further episodes).

66. It is important to highlight that, at the time of the police investigation, I had been shocked and distressed to understand from police that one of my former colleagues on the NNU was suspected to have intentionally harmed the children we were caring for. The comments I have referred to above reflected my sense of disbelief at the time of the police investigation, that this was considered to be the explanation for Child I's death.

67. At the time of Child I's death I was working at ST3 (junior doctor) level, so I was still learning a great deal through my work. The main focus of my thought process following the incident was about whether I had missed anything in respect of Child I's condition, and whether I had done everything I could for her. I did not consider potential errors made by my colleagues. As I commented above, I never had any concerns about the treatment Child I was receiving from any of my medical or nursing colleagues at the time. I felt that I was working in a highly dedicated, professional and supportive team. It had never occurred to me to question the capability or motives of my colleagues.

Debrief

68. I have been asked about the formal debrief into Child I's death. Though I discussed my involvement with Dr Gibbs, I do not recall attending a formal debrief regarding Child I, nor do I have any recollection of being asked to attend one. This does not mean that a formal debrief did not occur. I am sorry that I do not have a clearer memory of this.

69. Ideally all staff involved in an episode where a child dies should be at the debrief but this is very difficult to coordinate in a timely fashion when the multiple professionals are involved are all working on different shift patterns. It is better for debriefs to be held closer to the event if possible, when the events are fresher in people's minds.

Mortality meeting

70. I have been referred to Dr Brearey's email of 24 November 2015 regarding the neonatal mortality meeting on 26 November 2015 **[INQ0005628]**, and the notes of that meeting **[INQ0003288]**, which do not list me as attending. I do not recall being asked to attend the neonatal mortality meeting, and my email address was not included in Dr Brearey's email of 24 November 2015. However this does not mean I was not asked to attend.

71. Unfortunately I do not have access to my email account from that time, so I have been unable to establish whether I received separate communication regarding the meeting. I do not recall whether or not I attended the mortality meeting on 24 November 2015, but if I did not attend, I have no recollection of why this was (due to the passage of time).

Child J

72. I was involved in the care of Child J on 27 November 2015, and I provided information regarding my involvement to Chesire Police within my witness statement dated 28 June 2018 **[INQ0001123]**. I refer to this information as an accurate account of my understanding of my involvement in Child J's care on 27 November 2015. I do not repeat that information but summarise it below and include further commentary in response to questions raised on behalf of the Inquiry.

73. On 27 November 2015 I was working a day shift and conducted ward rounds on the NNU. My notes for Child J start at 09:30 that morning and are included at pages 321-323 of the clinical record **[INQ0001065]**.

74. Within my notes I documented my review of Child J, which I described within pages 1-5 of my statement dated 28 June 2018 **[INQ0001123]**. From my ward round review and the history of her care, Child J appeared more stable than she had previously been. I documented a plan with regard to the short-term future care of Child J, which is summarised at pages 5-6 of my statement to police **[INQ0001123]**).

75. I conducted a further review of Child J with Dr Brearey at 13:20 and I wrote the notes of that review (page 323 of the clinical record **[INQ0001065]**). This completed my involvement with Child J on this date.

76. I have been asked whether I was surprised at the deteriorations Child J had experienced over the preceding night shift, particularly the seizures, when I reviewed her on 27 November 2015. The only recollection of my reaction was of worry rather than surprise.

77. I had been involved with Child J from her birth, and had grown to get to know her and her parents quite well due to this. I was worried about her continuing to have blood at her stoma site when I went to review her. I was seeking advice from the surgical team at Alder Hey Children's Hospital (who had performed that surgery), to review all the images we had taken during the previous shift and when I had started my shift.

78. I have been asked whether I had any concerns about the events in relation to Child J. I had no concerns regarding the conduct of my colleagues or the team. My only concern related to her clinical condition, and ensuring that she was being investigated and treated to the best of our capability. Child J was a complex baby and had undergone surgery previously. I felt it would be sensible to discuss her care with the surgical team who had performed her previous operation. Nothing in relation to her case gave rise to a concern on my part in relation to the conduct or competence of the clinicians caring for her.

Statistics of the NNU

79. I have been asked to reflect on my police interview on 30 April 2018 **[INQ0007609]**, and specifically about what I meant by my comments at page 45 that the deaths of children on the NNU were 'thought about' by staff.

80. Whilst I was working at the Hospital I was not aware of a statistically higher mortality rate on the NNU than elsewhere. I and my junior doctor colleagues would discuss individual cases and would share difficult experiences with each other in a supportive way. The focus

of those discussions was primarily upon the clinical care and management of specific patients.

81. When I referred within my police statements to questions such as 'it was thought about, like why is this happening?' I was not referring to a collective suspicion about the root cause of multiple significant events. Rather, I was trying to describe the reflective process that all doctors engage in, often in discussion with colleagues, in order to process and learn from our professional experiences.

82. I cannot recall any specific conversations with staff when I was working at the Hospital. During the police interview I think I was trying to explain that I had noticed that babies did get sick there frequently, but I went on to explain that I had thought this was just an unfortunate period, where difficult cases came along at the same time. There were times when I had similar experiences during my placement at the Liverpool Women's Hospital.

83. I have also been asked as to whether I or anyone else had any discussions about the possibility of escalating concerns about the deaths of children on the NNU. I cannot recall any specific conversations with staff when I was working there, but I do not recall anyone suggesting that concerns regarding the deaths of children on NNU should be escalated.

84. As a junior doctor during my first placement of my ST3 year, I had relatively little experience against which to compare events. I had completed one pure neonatal unit placement during my ST1 year, in Liverpool Women's Hospital. In hindsight, this did not provide a helpful frame of reference by which to compare my experiences at the Hospital, as it was a tertiary unit. However, at the time, my experiences at the Hospital did not seem to be so unexpected or remarkable as to require escalation. I had confidence in my colleagues and the medical team.

85. I have been asked to comment about any discussions that I took part in, or was aware of, after my departure from the Hospital, about unexpected collapses and deaths on the NNU.

86. I have not been interviewed by anyone other than police since my departure from the Hospital in April 2016. I cannot recall any specific conversations about the NNU once I had left, but I have occasionally talked to other paediatric trainees in passing or, on occasion, socially afterwards, as they reflected they had had difficult and busy placements there too. I cannot recall any details of these conversations or who they were with particularly, but any comments would have been general. I do not recall any comments being made about escalation of concerns.

87. I have been asked whether I have ever been involved in discussions in which staff factors have been discussed as possible reasons for the unexpected collapses and deaths on the NNU. I cannot recall any such discussions, either during my employment at the Hospital or since. Although I have discussed the deaths and collapses with colleagues whilst I was working at the Hospital and with former colleagues since then, those discussions tended to be general in nature. At the time of the discussions I was not aware that a healthcare professional was suspected of being responsible for the unexpected collapses / deaths. I would have remembered if someone had suggested this, as I would have been completely shocked to hear this.

88. I do not know the exact number of deaths that occurred on the NNU between 2015-2016. I did not have access to data prepared by MBRRACE-UK NNRD, or any other data about infant mortality rates at that time. As an ST3 this is not something that I would have been expected to be aware of.

89. I was not involved in discussion with management or local networks about any adverse incidents/deaths, and I have no knowledge of any such discussions. As an NHS Trust I presume they would have used a DATIX incident reporting system, although I do not recall if I ever used this at the Hospital.

90. I have been asked if I was ever worried about the number of deaths on the NNU. I was not worried at the time, although had a sense that the placement was very intense and busy due to the number of unwell babies/events happening there at the time. It was my first registrar post. Every paediatric placement I had completed in the region up to that point had been very busy. My experience at the Hospital seemed to me to be consistent with this. I thought this was a difficult period on the NNU, and I had limited prior experience by which to contextualise this.

91. I have been asked how deaths on the NNU were usually investigated. I do not recall the specifics of how deaths were investigated on the NNU but they were led by the Consultant present at the death of the baby, alongside Dr Brearey as the Departmental Lead. I was not specifically involved in any auditing process. I am aware from medical records that Dr Gibbs requested a post mortem for Baby I, and that post mortems were requested if there was uncertainty about causes of neonatal deaths.

92. I have been asked about whether I attended discussions between doctors on the NNU and other medical staff in respect of the deaths of the babies named on the indictment shortly

after their deaths. Aside from the immediate discussion I had with Dr Gibbs regarding Child I (which I have described within my witness statement dated 20 May 2019 **[INQ0000536]**), I do not think I was involved in any discussions or debriefs of other children named in the indictment. I have no recollection of other such discussions.

93. I feel unable to comment on whether discussions or debriefs should have taken place following other clinical events that have transpired to be attacks by Lucy Letby. For my part, I had no idea that this was happening. I never had any suspicion of any wrongdoing or harm being caused by any individual on the unit and regrettably, at the time, I thought her to be a competent member of the nursing team. I do not recall anyone expressing concerns about her (or any other member of the team on the NNU) to me at the time.

Safeguarding of babies in hospitals

94. I have been asked about the extent of safeguarding training I have received. I have been provided with safeguarding training with regard to babies and children throughout my post graduate training posts. This is often provided departmentally, or via the speciality training school. I also complete annual online training now as a GP.

95. I cannot recall having received specific training on what to do if abuse is suspected by a member of staff, but I know that if I had such a concern I would be able to raise this and immediately escalate to the doctor and lead nurse for safeguarding in whatever role I am working in (there is a named lead at the Trust I work in, and also in our local GP network, if I am working in primary care). I am uncertain whether my professional body would support me with safeguarding guidance or advice if I suspected abuse by a member of staff towards babies, but if I had such a concern I would have no hesitation in escalating the concern.

Speaking up regarding suspicions

96. I have been asked to comment about processes and procedures for raising concerns within the Hospital in 2015-16. I cannot recall the formal processes and procedures for raising concerns at the Hospital in place at this time. As a trainee I would always initially escalate via the consultants if I had concerns, whether that be the acute consultant on-call at the time, or my clinical or educational supervisor.

97. I can recall having been provided with formal training by the Mersey paediatric deanery on Sudden Death in Infancy/Childhood (SUDI/C), and how to report to cases to the Coroner. I cannot recall formal training about child death reviews (although I may have received this). I felt the training I received was sufficient to know when to raise suspicions, although due to the vulnerability of many of the patients on the NNU, and the complexity of the issues relating to their care, I would have deferred to the on-call consultant as to the applicability of SUDI/C in any case.

98. It is important to reiterate that I never had any suspicion that Lucy Letby, or any other colleague, was harming babies. This was the reason I did not escalate concerns to any governing or professional bodies.

99. After my rotation to Whiston Hospital I heard rumours that concerns had been raised with regard to increased infant mortality at the Hospital and that investigations were going to be undertaken by the Neonatal network and the Royal College of Paediatrics, but I was never involved in any reporting or discussions, and did not know anything more specific than this.

100. I was not involved in providing evidence to the Coroner on any cases named in the indictment. As I had no concerns about Lucy Letby or any of my colleagues during my time at the Hospital, I did not consider there was a need to escalate anything to the Hospital management or elsewhere.

Reflections

101. I have been asked to comment as to whether measures such as CCTV, security systems, or changes to drug monitoring could have prevented the harm caused by Lucy Letby. I feel unable to comment on whether any such changes could have prevented the deliberate harm she inflicted on our patients. The departmental guidelines and monitoring/security at the Hospital seemed to me to be just like the monitoring in every other NHS workplace I had been in previously. It seemed like a well-run, secure unit, with a dedicated clinical team. As much as I would welcome any changes that could have prevented the harm she caused, it is hard for me to identify any practical measures that would be effective in preventing this type of criminal act in the context of an acute care setting.

102. I have no further information or documents that I believe to be relevant to the work of the Inquiry, beyond the information I provided to the police and in the context of the criminal proceedings. Those accounts are accurate save for the clarifications I have provided above. I have never spoken publicly about the case, aside from my evidence at the criminal trial in February 2023.

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** _____Dr Rachel Ng Chang_____

Dated: _____30/04/2024_____