Witness Name: Dr Peter Fielding
Statement No.: 1
Exhibits: PF/01 – PF/03
Dated: 02/05/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR PETER FIELDING

I, Dr Peter Fielding, will say as follows: -

Medical Career and Employment at The Countess of Chester Hospital

1. I am currently a Consultant in Paediatric Emergency Medicine and work in the Emergency Department at Alder Hey Children's Hospital. My qualifications relevant to medicine are as follows:

    - Bachelor of Science (BSc, 2012, University of Leicester)
    - Bachelor of Medicine and Bachelor of Surgery (MBChB, 2013, University of Leicester)
    - Post-Graduate Certificate in Leadership for the Health Professions (PGCert, 2015, Swansea University)

2. I became a full member of the Royal College of Paediatrics and Child Health in 2018. I qualified as a doctor and received my provisional license to practice in 2013, with full General Medical Council Registration following in 2014 (GMC Number PD). My work as a doctor to date has followed a traditional format – 2 years of Foundation Training, followed by a Specialist Training Programme, followed by a substantive Consultant post. A summary of my medical career to date is provided below, starting from my earliest working post to the most recent.

3. I undertook the Academic Foundation Programme which is a 2-year training programme covering all of the medical competencies mandated by a traditional foundation programme, but also incorporates a focus on medical education, leadership or research. I completed the following posts at the East Midlands Deanery:

- August 2013-December 2013 – Vascular Surgery, Northampton General Hospital
- December 2013- April 2014 – General Paediatrics, Northampton General Hospital
- April 2014-August 2014 – Respiratory Medicine, Northampton General Hospital
- August 2014-February 2015 - Acute Medical Unit, Leicester Royal Infirmary
- February 2015-August 2015 – Intensive Care Unit, Glenfield Hospital

4. I then commenced a Specialist Training Programme in Paediatrics in the Mersey Deanery. This programme lasted for 8 years. Each 12-month block of time is a designated "Specialist Training Year" and is referenced as ST1 for year 1 of the programme, ST2 for year 2 and so forth. Generally speaking, Senior House Officer (SHO) encompasses trainees at ST1 and ST2 level. At the tertiary specialist centre (Alder Hey Children's Hospital), ST3 is also Senior House Officer level. ST3-ST8 trainees are Registrar level (ST4-ST8 at Alder Hey Children's). During the last 2 years of my Specialist Training Programme, I completed Sub-Specialist Training in Paediatric Emergency Medicine. I completed the following posts:

- September 2015-March 2016 – General Paediatrics and Neonatology, Countess of Chester Hospital
- March 2016 – September 2016 – Paediatric Emergency Medicine, Alder Hey Children's Hospital
- September 2016-March 2017 – Paediatric Rheumatology, Alder Hey Children's Hospital
- March 2017-September 2017 – Neonatology, Liverpool Women's Hospital
- September 2017-March 2018 – General Paediatrics and Neonatology, Ormskirk District General Hospital
- March 2018-September 2018 – General Paediatrics, Arrowe Park Hospital
- September 2018-March 2019 – General Paediatrics and Neonatology, Wrexham Maelor Hospital
- March 2019-September 2019 – Neonatology, Arrowe Park Hospital
- September 2019-March 2020 – Community Paediatrics, Arrowe Park Hospital
- March 2020-September 2020 – Paediatric Emergency Medicine, Alder Hey Children's Hospital
- September 2020-March 2021 – Paediatric Gastroenterology, Alder Hey Children's Hospital

- March 2021-September 2021 – Paediatric Emergency Medicine, Alder Hey Children's Hospital
- September 2021-March 2022 – Paediatric Intensive Care, Alder Hey Children's Hospital
- March 2022-September 2022 – Paediatric Emergency Medicine, Alder Hey Children's Hospital
- September 2022-March 2023 – Paediatric Emergency Medicine Secondments, Alder Hey Children's Hospital
- March 2023-September 2023 – Paediatric Emergency Medicine, Alder Hey Children's Hospital

5. I started a substantive Consultant post in Paediatric Emergency Medicine in September 2023 at Alder Hey Children's Hospital and continue in this post to date.

6. With regards to my employment at The Countess of Chester Hospital, I was there as an ST1 level trainee, starting in September 2015 and working there until March 2016. This was my first specialist training post in paediatrics, with my only prior experience in paediatrics being a 3-month rotation during my Foundation Training Programme. When I started at the Countess of Chester Hospital, I had no prior experience of working in neonatology.

7. I worked across a number of areas in the hospital – the Children's Ward, Accident and Emergency, Delivery Suites and the Neonatal Unit – looking after children and young people from birth until 16 years (and until 18 years for mental health-related admissions). I did not have any management or additional responsibilities beyond my clinical work and training programme.

The Culture and Atmosphere of the Neonatal Unit at The Countess of Chester Hospital

8. During my time at The Countess of Chester, I was provided with direct, day to day clinical supervision by the entire consultant body. All of the consultants at that time were approachable, dedicated paediatricians and made themselves available for advice and

support at all times. If I remember correctly, the paediatric team employed a 'Consultant of the Week' system, which meant that for a one-week period, there would be a designated consultant responsible for all admissions of children that week, as well as the weekly consultant-led ward round on the neonatal unit. This role would rotate to each consultant in turn to provide continuous, named and designated cover for all children admitted at Chester at any one time.

9. My educational supervisor whilst at Chester was Dr Liz Newby. Each doctor registered to a training programme in the hospital had a named educational supervisor. Their role was to help structure, direct and assess my educational and skills development as a paediatric trainee, and to help guide and nurture my development over time.

10. The consultant team at The Countess of Chester had (and continues to have) a strong reputation amongst paediatric trainees in the Mersey Deanery for being a committed, highly-professional and welcoming team who care about their trainees and provide a good learning experience for trainee doctors. I found this to be true during my 6-month placement with the team. I felt that I was listened to and valued despite being at the most junior level of training, and I felt well supported at all times. If I had any problems or difficulties with providing care to a young person, there was always somebody available I could turn to for help. I had the support of my registrars in the team, the Consultant of the Week, or indeed any of the consultants on the team. The paediatric team was a flattened hierarchy, and consultants were more than happy to be approached for advice and help, and always happy to personally assess and manage their patients in a hands-on way. Naturally, the paediatric registrar would often be my first port of call if I wanted advice regarding patient care, but I would also feel very comfortable to approach a consultant directly. The support that consultants provided to registrars that I witnessed at Chester was also of a similar nature – supportive, timely and given without question. The consultant team were always a very visible presence on the wards and always accessible.

11. My experience of the registrar and consultant team in paediatrics at The Countess of Chester was a very positive one, and nobody ever made me feel belittled for asking for help or support – to the contrary I felt empowered to escalate my concerns and felt that they were taken seriously. To this end, I can say that the consultant team at The Countess of Chester during my placement there were one of the most supportive, passionate and

caring teams I have worked in and for, and an exemplar I try to use in my own practice when supporting junior doctors in my team today.

12. It is very difficult for me to comment on the quality of relationships between clinical staff and managers at the Trust. Being at the most junior level of paediatric training, my paediatric knowledge base was developing and I had no frames of reference against which to judge the relationships between key personnel at the Trust at the time. I was shielded from senior departmental meetings between managers and consultants as would be normal for a junior trainee, and as I have experienced at other workplaces since throughout my training. I therefore had no exposure to the managers in paediatrics at the Countess of Chester Hospital, and indeed would not recognise them or be aware of their names should I be shown them now.

13. I am able to make comment on the relationships between medical professionals within the Trust. Amongst the doctors, I feel relationships across the paediatric hierarchy were professional, respectful and positive in my experience. I never had any problems, nor were aware of any problems, in the working relationships between doctor-nurse or doctor-midwives whilst I worked at the Trust. I was vaguely aware that there had been some reports of potential bullying within the paediatric nursing team on the Children's Ward at the Trust, and that this was being dealt with by the senior paediatric nursing management team, but was only ever peripherally aware of this and did not know any specifics. I was not aware of any problems between the nurses on the neonatal unit at the Trust.

14. With regards to the neonatal unit, a registrar would be allocated to the unit each day. To my mind, if staffing allowed, an SHO would also be allocated to the unit to assist in the care of the babies admitted. The consultant of the week would be available to troubleshoot any problems and to assess babies as required, and a formal consultant-led ward round of all babies in the unit would take place once per week. During the other days, the ward round would be led by the registrar on the neonatal unit, with the registrars typically reviewing the babies in the higher acuity nurseries (nurseries 1 and 2), and an SHO starting in the lower acuity nurseries. If I had any questions about the babies on the neonatal unit, I would typically raise this with the registrar in the first instance, but could seek advice and support from senior neonatal nurses and the consultants as well.

15. When I reflect on my time on the neonatal unit now, I consider that I never really knew members of staff well on a personal or professional level. I was most concerned with learning at this stage of my career – gaining paediatric knowledge to pass my Royal College Exams, learning how to examine children and young people properly and, given I had no previous experience of neonatology before starting at The Countess of Chester, how to look after babies. As such, I was very much focused on the tasks I was set, ensuring I performed these correctly and to the best of my ability. This took up the vast majority of my bandwidth, and as such, I had less of a working relationship with the neonatal nursing team then compared to that which I enjoy now with my nursing colleagues in the Paediatric Emergency Department. I think this is also a natural situation to develop, as if neonatal nurses were worried about an unwell or deteriorating baby, they would often approach a registrar or consultant directly. This was never done in any sort of dismissive or malicious way in my experience – a nurse would make a judgement about the nature of their question or concern about the baby they were looking after, and would approach a level of doctor commensurate to their degree of concern or the complexity of the situation or task they wanted support with. As such, the neonatal nurses would work much more frequently with the registrars and consultants to address clinical concerns.

16. That is not to say that the neonatal nurses ignored me as a junior doctor on the team. Generally speaking, I found them to be supportive of me in my development, and would offer advice, answer my questions and support me in my role. Given my more junior role in the team and my relative detachment from close working relationships with the neonatal nursing team, I was naïve to any issues in the quality of relationships between staff on the neonatal unit, and therefore find this difficult to comment on. I was not aware of any explicit issues between staff on the unit, but I also acknowledge that in no way was I in a position to be made aware of any issues, formally or informally.

17. Given my junior position whilst working on the neonatal unit, I once more find it difficult to comment accurately on the culture on the unit whilst I worked there. Generally speaking, I found that the nursing team were approachable and friendly, and understood that I was a very junior paediatrician. They would ask me to help with issues I would be able to attend to at that stage of my training, and would go to the registrar or consultant for anything requiring more experience. This is entirely appropriate and happens in almost all medical workplaces I can think of, particularly in paediatrics, which is generally a more senior-delivered service compared to adult services.

18. I feel that I was treated with respect by the team on the neonatal unit, and that staff there made effort to include junior team members. There were clear guidelines for management of babies, which if I remember were based upon the tertiary-level specialist neonatal centre in Liverpool (Liverpool Women's Hospital). A ward pharmacist was available to supervise prescribing practice, ensuring this was done accurately and safely.

19. I do recall wondering whether the number of babies who deteriorated or died during my time at The Countess of Chester was high. I had no reference point to compare this against as I had never worked in neonatology before, and I remember voicing this question to one of my registrars at the time, Dr U. From what I can recall, Dr U agreed the number of collapse episodes seemed high, but that the overall feeling was that this was a bad or unlucky run, which can happen at times.

20. I do not recall any concerns I had about equipment or availability of equipment on the unit. I also do not recall having concerns about malpractice, intentional or otherwise, on behalf of a staff member on the unit, though I have often wondered since whether, with increasing experience in paediatrics and neonatology, I would have had more questions about the number of babies becoming unwell and dying on the unit.

21. From my junior position in 2015, I was not aware of the nature of professional relationships amongst different senior level doctors and managers in the Trust, and can therefore not comment on whether the nature of these relationships had any bearing on the management or governance of the hospital in 2015-2016.

22. I finished my placement at The Countess of Chester in March 2016. In the 12 months following on from this, I was based at Alder Hey Children's Hospital in Liverpool, completing 6-month rotations in Paediatric Emergency Medicine and Paediatric Rheumatology. Comparing the cultures across both places of work is not straight-forward. Paediatrics in a district general hospital operates more like its own sub-hospital – it is kept very separate from adult services. The paediatric and neonatal ward will have working relationships with other teams (e.g. X-ray, laboratories, pharmacy, delivery suite, postnatal ward and emergency department), but working in any district general hospital in

paediatrics feels like an isolated, small sub-hospital. Working at Alder Hey is different. It is the specialist children's hospital in Liverpool, an entire hospital just for children and young people. As such, the experience of working there is very different to The Countess of Chester, or indeed any other district general hospital.

23. Whilst I was working at Alder Hey, I was aware of who the executive team of the Trust were at all times. There are large photographs of them, including their name and position in the main atrium of the hospital. There are also regular email communications from the executive team, with updates about what the Trust is doing, and details of challenges and opportunities that the Trust is experiencing. In this sense, the executive team of the Trust at Alder Hey feels closer and more accessible to employees of the Trust. I also know that there are regular breakfast or lunches with the executives' sessions at Alder Hey, where members of staff can discuss any ideas or concerns with senior executives of the Trust. Initiatives such as this may have been in place at The Countess of Chester Hospital in 2015-2016, but I was not aware of any.

24. The Alder Hey teams I worked in in the 12 months after finishing at Chester also had very proactive cultures of teaching, though their levels of resource were significantly greater. I feel it is quite challenging to compare The Countess of Chester to Alder Hey in terms of culture. A fairer comparison would be to compare The Countess of Chester paediatrics team to other teams I have worked in at other district general hospitals, such as Arrowe Park. I feel overall the culture and experience of working at The Countess of Chester felt very similar to any other district general hospital I worked at in the early stages of my career, albeit I had no interaction with management at the Trust.

25. Whilst working at Alder Hey, particularly in the Emergency Department, I was more exposed to relationships between managers and clinicians. Managers worked well with clinicians, looking to facilitate clinicians' priorities in the management of patients and the overall Emergency Department in whatever way they could. I cannot compare the relationship between managers and clinicians at the two sites as I was not exposed to this at Chester. Relationships between medical professionals at the two sites was broadly similar in my mind, and I cannot recall any specific differences between the two.

26. I have not heard any specific comments or reports on the quality of care offered in the paediatric or neonatal departments at The Countess of Chester Hospital since the criminal proceedings against Lucy Letby came to light. From my own experience, generally speaking, I feel children were well looked after at The Countess of Chester, by a dedicated, professional and caring team. I did not have cause to raise concern about the practice I witnessed from the doctors during my time in the team. I was aware how to raise concerns should that have been required, and feel confident they would be taken seriously in that event.

27. Following the criminal proceedings against Lucy Letby, I have heard, via various sources (principally press reports of the criminal proceedings and Panaroma televised interviews), that concerns have been raised about the response of management at the Trust to concerns raised by the paediatric consultant body. I cannot personally vouch that any of this information is accurate and can confirm that none of this information was known to me while I was working at the Trust in 2015-2016. If, however, the information contained in the press reports in this regard are fully substantiated, then my opinion would be that any persons within a managerial role at the Trust in 2015-2016 who took any decisions which could have prevented the crimes committed by Lucy Letby from coming to light sooner, should have to explain those decisions and should be held accountable for them. I believe that any concern raised by a member of staff that another practitioner could be deliberately harming patients should be taken extremely seriously and thoroughly investigated, with steps initiated immediately to protect patients whilst any investigation takes place.

Child G

28. On 21st September 2015, I was involved in the care of Child G. Reviewing my entry in the clinical notes **[INQ000272_3144-3147]**, I can only assume that I was on the neonatal unit already, and most likely performing a ward round of the babies on the unit, when I was asked to review Child G. I cannot recall whether a registrar was present on the unit at the time with me. I would likely have been due to review Child G as part of the ward round, but it appears I have been asked to see her immediately at 10:20am due to concern from the nurse looking after Child G. I am unable to recall from memory who raised the alarm and asked me to see Child G urgently.

29. I do not have specific recollection of the event from memory, and have relied upon my entry in the medical records to produce my statement to the police . I exhibit this police statement dated 1 September 2018 as **Exhibit PF/01 [INQ0000335]**. I cannot specifically recall from memory which nurse informed me of the episode Child G had that morning. Looking at the nursing notes **[INQ0000272_3219]**, the nurse looking after Child G at the time was Lucy Letby, who has documented the episode in her notes and referenced the actions taken thereafter. I think it is therefore reasonable to assume it must have been Lucy Letby who asked me to review the baby, and who was with me when I reviewed the baby (to be clear, this is not based on memory, but is assumed from the documents made available to me).

30. When I arrived at the cotside, I found the baby as outlined in my clinical examination findings in the medical record (O/E or On Examination section of the documentation) **[INQ000272_3146]**. I have documented that Child G was settled. The baby was pale, but otherwise had evidence of good perfusion of the skin and normal hydration status. There was no evidence of any respiratory distress. I have found Child G's abdomen to be distended, and have documented that staff feel the abdomen could be more distended than usual. This likely refers to the opinion of the nurse that was with me at the time of review. I have also documented that the mum of Child G was unsure whether the abdomen was more distended than usual. During my examination of the baby, there was no evidence of any breathing distress or abnormal blue colour to the baby which had been reported moments before.

31. I have made a note of the information that had been given to me about the episode Child G had suffered prior to my review, and which indeed prompted an expedited review in the first place. In the medical record, I have written that Child G "*had an episode at roughly 10:20 where she had 2 projectile vomits witnessed by nursing staff, after which she was apnoeic for 6-10 seconds, went blue, sats decreased to 30%. Last feed 9am*" **[INQ000272_3145]**. I have also documented that the nurse then called for help, and that on going back to the child, she found the baby's colour had returned to normal, the baby was breathing and crying. From reviewing the nursing documentation **[INQ0000272_3219]** I assume the nurse who relayed this information to me was Lucy Letby.

32. From this information given to me, I would interpret that Child G has had two large vomits, following which there was a pause in breathing for between 6-10 seconds, of sufficient duration to cause the baby to drop oxygen saturation levels to 30% and to go blue in colour.

33. Following my assessment of Child G, I have mentioned in my police statement that I was worried about Child G **[INQ0000335_0006]**. There were several reasons for this level of concern. Babies have relatively few ways of showing staff that they are becoming unwell. We therefore take all potential changes in behaviour or any new symptoms seriously. A pause in the breathing, sufficient to cause such a profound drop in oxygen levels, could indicate that Child G had developed a new infection. Equally, it could have been an indicator that Child G continued to suffer with a partially treated infection from their recent stay at Arrowe Park Hospital, which was beginning to show itself again (investigations taken at Arrowe Park demonstrated an inflammatory process, but no causative organism causing infection). Equally, I was worried that Child G's abdomen could be more distended than normal and they had had two vomits. This raises the possibility of a condition called Necrotising Enterocolitis, which is a condition effecting the bowel resulting in feed intolerance. My main concern at the time was that the described episode prior to my clinical examination of the child, alongside the possibility of abdominal distension, could be the heralding signs that Child G was becoming unwell.

34. As a result of my concern, I contacted Dr Rachel Chang, a registrar on the team, for advice. I am not sure how I did this. If Dr Chang was present on the neonatal unit in another nursery perhaps, then this would likely have been a face-to-face discussion. I equally could have contacted her on the telephone, perhaps via the registrar on call bleep. I cannot recall specifically how I contacted her. After taking advice from Dr Chang, I asked the nursing team to aspirate Child G's nasogastric tube, removing stomach contents and discarding them. This prevents further vomiting episodes (and hopefully therefore any secondary breathing difficulties), and also allows the bowel some rest in the possibility of an evolving bowel problem such as necrotising enterocolitis. The nasogastric tube was left on free drainage, to remove any gastric secretions as they are produced in a continuous process. We made a plan to delay the next feed and to observe the abdomen to see if there was further progression in the amount of distension, or to see if the abdomen became uncomfortable or painful, or changed in colour (these can all be signs of necrotising enterocolitis). I performed some heel-prick blood tests, which could be compared to those taken in the early hours of the morning, to see if they gave any indication of an evolving

pathological process, or any pointers towards the cause of the episode that morning (e.g. evidence of evolving infection or inflammation, a falling sodium level which you might see in necrotising enterocolitis). I ended with a plan to review Child G in one hour's time, ideally with the results of the blood tests I had just performed.

35. With the benefit of hindsight, and the information reported in the press following Lucy Letby's criminal trial, I have since wondered if the episode described here was a result of Child G having their abdomen insufflated with air, which was a technique Lucy Letby was alleged to have used on babies. This could cause gastric distension and vomiting, and also inflation of the stomach can put pressure on the lungs and cause difficulties in breathing. My other reflection on this incident was that Child G was relatively stable according to the consultant ward round review from the day before **[INQ0000272_3143]**. This episode was therefore unexpected.

36. I do not recall attending any form of debrief about the episode which occurred on 21st September 2015. Reflecting on the fact that a debrief was not held (to my knowledge), and reading the subsequent entries in the medical notes **[INQ0000272_3150-3152]**, it sounds to me that Child G quickly settled following the episode and had reassuring assessments the day after. As such, I feel it is reasonable that a debrief was not held about the reported episode, as it did not herald any subsequent significant deterioration and it did not require intensive input from the medical team. Taken as an isolated episode, this is not the sort of incident that would lead to a debrief or any form of clinical incident reporting. In the wider context of a significant number of babies having unexpected collapse episodes however, maybe a flagging up of each unexpected collapse episode would have demonstrated a pattern of repeated unexpected collapse and deterioration on the unit.

Child J

37. On 17th December 2015, I attended the neonatal unit along with Dr Matt Neame (paediatric registrar). As per my police statement dated 30 January 2018, which I exhibit as **Exhibit PF/02 [INQ0001132]**, I cannot recall having looked after Child J during the day-time hours between 0900-1700. I assume that I was on call on this day, had been working in a different clinical area (most likely the paediatric ward) between the hours of 0900-1700, and then had the neonatal unit handed over to myself and Dr Neame at 1700. As the presumed on-call team that day, Dr Neame and I would be covering all areas of paediatrics between 1700-2100, after which the night team would start their shift. It must have been handed over to us that Child J was unwell, and I think it likely Dr Neame and I headed to the neonatal unit immediately following handover to review Child J.

38. On reviewing the clinical notes from earlier in the day on 17th December 2015 **[INQ0001065]**, Child J was clearly unwell. She had had a collapse episode earlier in the day, which required her lungs to be inflated with a neopuff device, and a period of chest compressions to be applied. She was noted to have poor perfusion of her skin, and was therefore prescribed and received a blood transfusion. Some investigations had been performed to try to explore the cause of the collapse episode. Child J had tests performed to look for evidence of infection as a cause of the episode, and she had been commenced on intravenous antibiotics. Some thought was given as to whether her indwelling lines – longer-term plastic catheters used to obtain blood samples and administer medications – could be the source of a new infection. It was also arranged for Child J to have X-rays performed of the chest and abdomen, considering whether a problem in either of these locations might have been responsible for the collapse.

39. When Dr Neame and I arrived on the neonatal unit, I have documented an examination of Child J. This was likely documentation that I have made of Dr Neame's assessment of Child J at the time (it would be unusual for a more senior doctor to document on behalf of an assessing junior doctor). As I referred to in my police statement, I would have agreed with the content of the clinical review that was performed, as I would not have documented the findings and plan if I had disagreed with them. Instead, I would have challenged anything I disagreed with, and would have documented that there was disagreement between myself and Dr Neame with regards the best way to proceed.

40. Our review found that Child J looked unwell. Her heart rate was elevated, and her capillary refill time was prolonged (pressing on the sternum gently for 5 seconds, then counting the number of seconds for the blanched skin to re-perfuse and regain its normal colour). Taken in combination, these factors suggest poor perfusion of the skin with blood, which can have a number of causes. The most likely causes in this situation would be less fluid circulating in the vasculature, or fluid leaking out of the vascular system as a result of infection. The diagnosis of sepsis relies on evidence of altered and inadequate perfusion of vital organs of the body secondary to an infective cause.

41. Child J also had evidence of increased effort of breathing, which could have represented a primary chest or lung problem, but may have also been a secondary process to try to blow off as much carbon dioxide as possible to compensate for blood acidosis created elsewhere in the body. Child J had a blood gas performed, which is a sample of blood taken which looks principally at blood pH, oxygen and carbon dioxide levels. This sample showed that her blood was acidic, and that her lactate level was raised. This was an indication that Child J was not perfusing one or more organs of her body properly with blood, and that this could be secondary to a surgical problem with the bowel, or sepsis.

42. I have documented the plan from our review, which was led by Dr Neame. Child J was commenced on a Continuous Positive Airway Pressure (CPAP) device. This is a mask that is applied to the nose or face, and delivers air/oxygen blends to the lungs under pressure. The aim of CPAP is to keep the small airways of the lungs open and prevent them from collapsing. CPAP helps to "recruit lung" by opening collapsed alveoli and small airways, and therefore increases the surface area over which gas exchange can take place, improving oxygenation and the efficiency of respiration. This intervention was made given Child J's increased effort of breathing.

43. She was also given a half-correction of sodium bicarbonate, to help to neutralise and correct the blood acidity level and return that to normal. There was a plan to repeat a blood gas following the sodium bicarbonate administration to determine whether the response to this was adequate, and to indicate whether any further treatment was required.

44. Dr Neame had discussed the abdominal X-rays performed with the surgical registrar at Alder Hey Children's Hospital, to determine whether the surgical team thought Child J's bowel or abdomen may be responsible for her deterioration. The surgical team initially could not see any immediate surgical concerns on the abdominal X-ray.

45. Child J's care was escalated to the paediatric consultant on call, which from the notes was Dr Brearey, who came to review her soon after. I have not documented in the medical notes following this review, and therefore think that I had no further involvement with Child J on that evening. I do not recall ever having attended a debrief about Child J following the events of 17th December 2015. This is from memory only, I cannot confirm that a debrief did not take place, or that I did not attend with certainty, given the amount of time that has passed.

Neonatal/Perinatal Morbidity and Mortality Meeting

46. I have been provided with documentation stating that I attended a neonatal morbidity and mortality meeting on 11th February 2016 **[INQ0005449]**. Unfortunately, I have no recollections at all from this meeting. I have no recollection of ever having seen the record of this meeting before, whether during the meeting itself or afterwards. I am therefore unable to comment on whether it is an accurate record of the meeting itself.

47. Morbidity and Mortality meetings are held frequently by all specialties in all hospitals across the country. They are a form of clinical governance – a systematic assessment of all patients who have either had a problem with their care, may have suffered some form of harm, or who have passed away while receiving care or treatment. It is a way for a team to look at the entirety of a patient's journey with their team, and look at what has happened in detail, including identification of areas of good practice and areas of practice that could be improved. The purpose is to embed learning from all cases in the team to help the future performance of a team.

48. I cannot recall how frequently morbidity and mortality meetings were held from a neonatal perspective. The period of assessment stated on the document is stated as June 2015

and November 2015-January 2016 **[INQ0005449]**. Perhaps this indicates that they were held quarterly, but this is a supposition. I cannot recall attending any other morbidity and mortality meetings in neonatology during my time at The Countess of Chester Hospital. Such a meeting would usually be chaired by a senior doctor, most often a consultant, from either the neonatal or obstetric team. A more junior doctor would usually be asked to prepare a case to be presented in advance, and would be invited to share a detailed and time-lined narrative of a patient's involvement with the team, and then this would be discussed collectively by the attendees at the meeting, and outcomes agreed by the team. I can only apologise that I cannot recall the specifics of how this meeting was run at The Countess of Chester, and cannot recall who chaired the meeting I attended.

49. I cannot recall any specifics about the discussions that took place in the meeting on 11th February 2016. I cannot recall who attended from the obstetric or midwifery team, nor whether any of the neonatal nurses attended the meeting.

50. I cannot recall whether anybody raised concerns at this meeting about the number of deaths on the neonatal unit. I can only assume not, as I think this would be something that I would be able to recall had it happened.

51. The record of the meeting refers to the death of Child C on 14th June 2015. In the 'Discussion and Learning from the Case' section, it is stated '*Sudden collapse ?cause. Observations prior to arrest stable*'. I believe that this statement was a reference to the fact that Child C had appeared to be well prior to the collapse episode preceding death, and that this death was not expected or anticipated based on how the baby had been in recent times. I cannot recall whether the cause of the collapse episode was discussed, although I assume it must have been. The fact that the record of the meeting records the event as a '*Sudden collapse ?cause*' would indicate to me that the consensus following discussion was that it was not possible to explain medically what had caused the collapse on review of the case. I cannot recall whether anybody at the meeting raised concerns about the circumstances of the death.

52. From memory, I cannot recall having attended any other neonatal morbidity or mortality meetings during my time at The Countess of Chester Hospital.

Response to Neonatal Deaths

53. I can recall a moment during my 6-month placement at The Countess of Chester Hospital in which I was reflecting upon my neonatal experience and realised that the level and amount of neonatal mortality and morbidity was higher than I expected. I was surprised that babies who had appeared well at one moment could suddenly deteriorate the next at such a frequency. I was also wondering how I would be able to develop the skills over time to be able to manage babies on the neonatal unit as a more senior paediatrician when their clinical course seemed so unpredictable. I cannot recall exactly when this was during my 6-month placement. At that point in time, I did not have any previous experience in neonatology, and was therefore lacking a barometer or benchmark against which to compare my experience at Chester.

54. I do remember asking Dr U, a registrar working at the trust at the same time as me, whether the amount of seriously unwell babies was normal in his experience. From what I remember, he told me that there did seem to have been a large number of babies becoming suddenly unwell, but that sometimes these things can happen in runs and the team seemed to be having bad luck at that moment. I knew that babies could become suddenly unwell – a neonate who develops sepsis will suddenly deteriorate for example, but I was surprised by how stable babies who were beyond the precarious period of extreme prematurity were having collapse episodes. Equally, I was aware that the consultants and registrars that I was working with were dedicated, competent clinicians who cared deeply about the quality of their work, and I had never witnessed any bad medical practice during my time at The Countess of Chester, so I felt reassured by this. Having no frame of reference to compare my experience to made it difficult for me to contextualise my time at the Trust. I have sometimes wondered since if I had worked there with the same amount of paediatric experience that I have now in my career, would I have had more questions and concerns about what was happening? I challenge this thought with the fact that at no point did I suspect that the collapse episodes could be being induced through malicious acts of a staff member at the time. It seemed impossible to me that somebody who had dedicated their life to training to look after vulnerable babies and families could be causing them harm. I had not seen anything on the neonatal unit to make me suspect poor practice, never mind a deliberate attempt to harm.

55. I am not sure whether I had access to data prepared by MBRRACE-UK, the National Neonatal Research Database, NHS England or any other organisation about the mortality rate or number of serious adverse incidents on the neonatal unit. At my level of training, I know that this would not be the focus of my efforts. At that stage of my career, I was learning the basics of paediatric and neonatal care, trying to gain the knowledge to pass my Royal College membership exams and learning how to assess and manage paediatric patients. My focus was on developing the skills I would need throughout my career, and trying to provide each family I cared for with the best care I could manage, while reflecting on my own experiences and the practice of more senior doctors to help guide my development. The assessment of performance data in most specialties in medicine would usually be done by more experienced doctors and departmental managers. I was concentrated on more basic learning at the time to develop the skills I would need as a paediatrician.

Reviews of Deaths and Adverse Events

56. The Countess of Chester Hospital, if I remember correctly, had the usual systems in place to report clinical incidents. This consisted of a computerised system to report adverse events, clinical incidents or near misses, which I think was the Datix System at Chester. This allows staff members to report any situations where a problematic factor interferes with the delivery of best-practice care. Reported incidents are then analysed by senior doctors and managers in a department to determine whether actions are necessary to keep patients safe and to facilitate the delivery of good quality healthcare.

57. I also think the Countess of Chester had a risk register, which is a managed list of acknowledged issues that may be affecting the performance of a team or service at any one time, and what measures have been actioned to mitigate against each risk. An example may be that a team operates a paper-based referral system, through which some referrals have become lost and a patient's care has been delayed as a result. I cannot recall whether any risks relating to the paediatric or neonatal department were present on the register, but I think I remember this system being in place at the Trust.

58. Departmental morbidity and mortality meetings were one of the ways that deaths or deterioration in health of babies would have been looked at. These meetings were shared with the obstetric and midwifery teams, to look at all factors relating to a baby's pre- and peri-natal experiences to try to identify what happened to each baby who had a poor outcome or passed away, and if possible to identify why it happened. Learning points for each case would be identified if possible, to help identify areas where practice could be improved. From what I have heard, the paediatric consultant team were reviewing the mortality and morbidity data from the neonatal unit themselves to try to work out what was happening on the unit, independent of these meetings. I was never involved in any discussions between local networks of hospitals or neonatal providers about adverse events or deaths of babies on the neonatal unit at Chester.

59. I was not involved with the investigation of deaths on the neonatal unit. As far as I can remember, other than discussions with the coroner or involvement with the governance tasks outlined above, I do not think it was usual for doctors to be involved with investigating deaths. To my mind, the issuing of a death certificate on the neonatal unit would usually be done by a senior doctor, which was most often the consultant. I think in most cases, even if the cause of death was clear, the deceased baby would be discussed with the coroner to determine whether a post-mortem examination was required. If the cause of death was unexplained or not reasonably certain, then the coroner would advise a post-mortem examination to clarify this. The other involvement that doctors would have in investigating deaths would be participation in the mortality and morbidity reviews. This would explore each case in detail, to determine what had happened and what the team thought the cause of death was in each case.

60. I do remember attending a formal cold debrief session following an unsuccessful resuscitation attempt for a baby on the neonatal unit. A cold debrief is one which takes place a few days after the event, as opposed to a hot debrief which takes place immediately after a critical event. Unfortunately, I can no longer recall which of the babies this related to. From what I remember, I had performed chest compressions on the baby during the team's attempt at resuscitation. The debrief focused on the quality of the resuscitation effort, and I recall that it was felt that the resuscitation provided was of good quality, despite the fact that it was unsuccessful. The debrief also focused on how the team worked together, and on team psychological welfare following such a traumatic incident. I do not recall the cause of the collapse being discussed at this meeting.

61. Reflecting on events which I now know to have been attacks by Lucy Letby, I cannot recall any specific incident which I believe should have led to a discussion that I was part of at the time. I form this opinion based upon the fact that, at the time, I had no suspicion of foul play whatsoever on behalf of a staff member at the Trust, and I cannot recall any resuscitation or stabilisation attempt that I was part of as appearing suspicious at the time. As such, I recall no situations in which I had information to contribute to any debrief or discussion which could have brought the true nature of the collapse episodes and deaths to light any sooner.

Awareness of suspicions

62. At no point during my 6-month placement at The Countess of Chester was I aware of the suspicions or concerns of others about the conduct of Lucy Letby. Nobody discussed any concerns about Lucy Letby directly with me. The first I was aware of the concerns was when Lucy Letby was arrested by the police, and the subsequent news coverage on TV and in newspapers.

63. I did not use any formal or informal process to report any suspicions or concerns about Lucy Letby, or any concerns about the safety of babies on the neonatal unit. I did not have any concerns at the time about a member of staff harming babies.

Safeguarding of babies in hospitals

64. As a paediatric trainee, there is a significant requirement to gain skills and competence in the safeguarding of babies, children and young people. This comes in a number of forms. Firstly, each Trust you work at has mandatory training modules that you have to fulfil every 6 months – one of these modules is always on safeguarding children, and most also have a module on safeguarding adults too. We have regional teaching sessions every month, and one session will be dedicated to safeguarding every 12 months or so. We have to demonstrate different levels of safeguarding experience in our training portfolios for different stages and seniority of our training. This is mostly fulfilled through completing e-

learning packages and attending certified courses and training days. Our training portfolios mandate that every year, we have at least two safeguarding learning assessments completed with a more senior doctor, in which we discuss a case that you have been involved with in which safeguarding was a key component. The discussion then looks at learning points about what worked well and what could be improved. As registrars, we undertake a 6-month placement in community paediatrics, during which we gain experience in performing child protection medical assessments and safeguarding report writing.

65. As an ST1 trainee at The Countess of Chester, I had completed my Trust mandatory training in safeguarding children. If I remember correctly, I think safeguarding was also covered in the local induction package that new starters at the Trust attended. Both of these sessions were delivered at the very start of my time at the Countess of Chester Hospital. I do not recall being given specific training on what to do where abuse on the part of a member of staff towards babies or children in hospital is suspected. Despite this, I am confident that had I suspected such behaviour, I would have known how to escalate my concerns to senior safeguarding figures at the Trust (Neonatal Clinical Lead, Designated Officer and Named Nurse for Safeguarding and Head of Nursing for Children and Midwifery), and where I could have gone for support and advice.

66. The Royal College of Paediatrics and Child Health have a 'Child Protection Companion' toolkit which offers evidence-based information and guidance on best-practice in the safeguarding of children. This is a useful resource to help keep safeguarding knowledge up to date, and to practice safeguarding in an evidence-based way.

67. The professional medical indemnity companies (such as the Medical Defence Union and Medical Protection Society) are companies that the vast majority of doctors will be members of, and who can provide support with any issues that a doctor may be encountering at work that may have medicolegal consequences. They offer advice lines through which difficult situations can be discussed and advice sought.

68. There is also guidance provided through each local authority about the Local Authority Designated Officer (LADO), who is the person at the local authority who would investigate

safeguarding concerns raised against an adult who has caring responsibilities towards a child.

69. Had I had concerns that a member of staff was harming babies on the neonatal unit, I would have raised this initially with the clinical lead for neonatology (Dr Brearey), for advice and support. I would continue to escalate my concerns until I felt they had been adequately addressed – with escalation to the Trust designated officer for safeguarding and the named nurse for safeguarding as options for further support. I did not turn to any professional body for advice in respect of events at the Countess of Chester Hospital.

Suspicions and contacting external bodies

70. As far as I am aware, there were a number of processes that could be used to raise concerns at The Countess of Chester in 2015-2016. I will outline these below:

a. Discussion with line manager – for me, this would be my clinical supervisors (the paediatric consultant body) or my educational supervisor (Dr Liz Newby).

b. Discussion with the clinical lead for neonatology (Dr Brearey).

c. Discussion with the designated doctor or named nurse for safeguarding at the Trust

d. Discussion with Freedom to Speak up Guardians. I believe they were in operation in 2015-2016 at The Countess of Chester, but do not know who they were.

e. Discussion with senior executive team directly e.g. medical director, chief operating officer or chairperson.

f. Whistleblowing outside of the Trust e.g. to the Police or Royal College of Paediatrics and Child Health.

71. As an ST1 trainee in 2015, I do not think I had received any training in the processes or organisations involved in reviewing a child death, such as a Child Death Review, Sudden Death in Infancy/Childhood (SUDI/C) or the Coroner's Office. I was however aware of all

of these processes, and believe I would have been able to raise concerns outside of the Trust appropriately had I held them.

72. I was also aware that concerns could be raised outside of the Trust if I held concerns and felt that the Trust had not properly addressed them. At the time, I believe the external organisations I was aware of would have been the Care Quality Commission, The General Medical Council and the Police. As I did not hold concerns at the time, I did not raise any concerns with such external agencies about Lucy Letby.

73. I did not provide any information to the Coroner about the deaths of the babies named on the indictment.

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

74. I did not raise any concerns about Lucy Letby to anybody in the Trust, managerial or otherwise. I am however, extremely concerned by the reports in the media about how managers at the Trust handled the concerns raised by the paediatric consultant body about Lucy Letby. It concerns me that Trust managers would ignore concerns from experienced paediatricians that Lucy Letby should not be on shift, and make executive decisions to overrule them and keep Lucy Letby on neonatal nurse rotas. I would have thought that any member of staff who was suspected by colleagues to be harming babies would be taken off shift pending a full investigation into the concerns. It is also worrying that the paediatric consultant body had to take their concerns outside of the Trust, for fear they were not being taken seriously. Doctors and nurses are strongly held to account for their decisions and behaviours by the appropriate regulatory bodies. I feel the same level of scrutiny should be applied to Trust managers who might be found to be involved in delaying and obstructing full disclosure of the criminal concerns raised against Lucy Letby.

Reflections

75. A question that has been posed following the crimes committed by Lucy Letby is whether the presence of CCTV cameras on the neonatal unit could have prevented the crimes that were committed. This is a very difficult question to answer. CCTV would likely be considered a strong deterrent to commit any form of crime on a neonatal unit by the vast majority of staff. Despite this, I fear that if a member of staff is so minded as to want to harm patients, then CCTV would not deter them in their aims or prevent a crime from being committed. I think a person capable and willing to harm a baby would not be put off by CCTV. I don't think such a person could be expected to think rationally in that sense. I also think they could take steps to try to avoid cameras. Such a person may use their body to obstruct cameras, making it difficult to pick up what they are doing (e.g. interfering with equipment or administering medications).

76. I also think there would be negative knock-on effects of CCTV on the neonatal unit. Firstly, I feel families would worry that they are being spied upon or observed by staff. Being present on a neonatal unit for new parents of a potentially unwell baby is an extremely emotionally-fraught occasion. Families are scared, confused, happy to see their baby but too frightened to touch them. It is often an overwhelming experience. Parents can feel silly or embarrassed initially when talking or reading to their baby on a unit full of other parents and staff. All of these sentiments may be heightened by fears from parents that they are being watched and potentially judged by staff, to the point where it could conceivably interfere with bonding between parents and their baby. When families are introduced to a neonatal unit, staff go out of their way to try to make families feel comfortable, at home and settled on the unit, and I feel the presence of cameras may work against families feeling comfortable. For example, would a new mum be less likely to want to use a breast pump on the neonatal unit if she feels she will be recorded while doing this? Would parents or carers feel able to ask questions if they fear a "silly" question will be recorded? Will parents feel able to show and express their emotions properly?

77. I also feel that the presence of CCTV on the unit could potentially have a negative effect on staff. Staff may feel that CCTV may be used by senior colleagues or managers to judge their clinical performance – e.g. all conversations and interactions with families analysed and all clinical procedures scrutinised. This may lead to increased pressure on staff and

contribute to burnout. Staff may feel that CCTV makes them feel untrusted, under suspicion and under surveillance at all times. We already have significant problems with recruitment and retention of NHS staff, and presence of CCTV recording them constantly may make people less likely to want to work in the NHS. Staff may fear that CCTV will be used against them by management. A member of staff performing a clinical procedure on a baby may feel under more pressure as they are being recorded, which could mean they perform less effectively than they would otherwise have done. I also worry that CCTV cameras would result in large volumes of requests from parents and carers to have access to footage or to review footage. I feel a lack of trust could develop between staff and families, and an adversarial atmosphere could ensue on the neonatal unit. Staff and families need to have close working relationships to provide the best possible care for babies wherever possible.

78. It is very difficult for me to provide an answer to the question of whether CCTV would have prevented Letby's crimes. I feel a person who is conflicted enough to want to harm babies would not be deterred by CCTV, and the 99.9% of staff who would never dream of harming a baby do not require any deterrent. I fear CCTV may adversely affect privacy for families on the unit, which is already difficult to provide on busy units. I also worry staff would feel under increased pressure, which could negatively affect their own performance.

79. In a similar manner, it is hard for me to see how security systems could be put in place, such as a system monitoring access to drugs and babies on a neonatal unit, which could prevent somebody intent on harming a baby from doing so. Most hospital areas already have systems to monitor access to drugs. At Alder Hey in the Emergency Department, we access medications via an Omnicell, which requires a fingerprint of a registered system user to access, and each medication removed is itemised against the patient it is removed for. Once the Omnicell is opened however, a different medicine could be removed if a practitioner desired, or a medicine could be removed and stockpiled to be used in a different situation if a practitioner so desired. Part of the difficulty here is that systems cannot be too cumbersome or long-winded to gain access to drugs as they are needed quickly in emergency situations, and clunky processes could mean timely access to drugs is not possible. There are robust systems for a second checker of medications when they are prepared, to ensure they are prepared and administered properly. However, a staff member intent on harming a patient would deliberately not follow these inbuilt checks and procedures.

80. I think the best way to detect deliberate criminal actions of staff would be some sort of system that constantly monitors performance and outcome data for each neonatal unit, and benchmarks it against other similar units to try to detect centres which are not performing as well as expected. Such centres would then be required to review their performance and seek to understand why they are not performing as expected. This already happens in neonatal units generally, but could be made into a regular and formalised process that is overseen by an external agency to support units to interrogate their performance.

81. Neonatal units could also keep more detailed records of which staff are involved in neonatal collapses and deaths, and which of these episodes were perhaps expected or predictable based upon the pre-existing health of the baby at the time of a collapse. This data may help to demonstrate patterns of certain staff members being involved in disproportionate numbers of such episodes, and could act as a stimulus for further investigation. I do not believe any measure is perfect, and it is difficult to find any sort of system which will pick out a member of staff who is deliberately trying to harm babies.

Any other matters

82. There is no other evidence which I am able to provide from my knowledge or experience which is of relevance to the work of the Inquiry. I have reviewed the statements I made to the Police, which I have previously exhibited as **Exhibit PF/01** and **PF/02** in addition to my statement dated 6 April 2018 **[INQ0001133]** which I exhibit as **Exhibit PF/03**, and I am happy they are accurate. 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.

Request for documents

83. I do not have any documents or other information which are potentially 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 PD PETER FELDWICK.

Dated: 02/05/2024.