Witness
Name: Christopher Wood
Statement No.: 1
Exhibits: CW/1 - CW/8
Dated: 10/5/24

Personal Data

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR CHRISTOPHER WOOD

I, Dr Christopher Wood, will say as follows: -

1. My full name is Dr Christopher Mark Wood. My primary qualifications are MBChB – University of Manchester 2011. MRCGP (2021) – Royal College of General Practitioners.

2. My work history is as follows;

Dates	Speciality	Grade
1/8/11 - 6/12/11	Lower GI and General Surgery, Royal Blackburn Infirmary	FY1
7/12/11 - 3/4/12	Ophthalmology, Royal Blackburn Infirmary	FY1
4/4/12 – 31/7/12	Gastroenterology and General Medicine, Royal Blackburn Infirmary	FY1
1/8/12 – 4/12/12	Trauma and Orthopaedics, Royal Blackburn Infirmary	FY2
5/12/12 – 2/4/13	Emergency Medicine, Royal Blackburn Infirmary	FY2
3/4/13 – 6/8/13	General Practice, Waterfoot Health Centre	FY2
7/8/13 – 4/2/14	Palliative Medicine, Wirral Hospice St Johns	GPST1

5/2/14 – 5/8/14	General Practice, Spital Surgery, Spital	GPST1
6/8/14 – 2/12/14	Obstetrics & Gynaecology, Arrowe Park Hospital	GPST2
3/12/14 – 1/3/15	Emergency Medicine, Arrowe Park Hospital	GPST2
1/4/15 – 4/8/15	Paediatrics/Neonates, Countess of Chester Hospital	GPST2
5/8/15 – 31/1/17	General Practice, Claughton Medical Centre	GPST3
5/3/17 – 5/2/19	Locum – Emergency Medicine, Arrowe Park Hospital	Locum
8/4/17 – 5/2/19	Wirral Hospice St Johns	Specialty Doctor
10/4/16 – Present	North West Hyperbaric Unit, Murrayfield Hospital	Specialty Doctor
6/2/19 – 4/6/21	Targeted GP Training Scheme – St Catherines Surgery	GPST3
26/6/21 – Present	GP locum – NW England	GP
1/11/22 – Present	GP Out Of Hours – Wirral Community Trust	GP

3. In 2015 I was based at the Countess of Chester Hospital for a split paediatrics and neonates placement as part of my GP training. This was entirely clinical with no management or further responsibilities. I left the hospital in August 2015 as set out above. I currently work as a locum GP as well as regular work in the Urgent Treatment Centre in Arrowe Park Hospital and occasional work in the North West Hyperbaric Unit. I have passed membership exams for the RCGP though am not a current member.

The culture and atmosphere of the neonatal unit

4. Having been asked about my recollection of the management of the neonatal unit (NNU) during my time at the Countess of Chester, I do not recollect the names of anyone in a management role during my brief time there. I directly reported to the registrars and consultants on a daily basis. Any reporting would have been done via these doctors. According to my records, my Clinical Supervisor was Dr Brearey. I do not recall having any personal dealings with management so I am unable to comment on issues regarding communication between these roles and doctors / other ward staff.

5. During my period of time at the hospital I tended to spend more time on the paediatrics side rather than neonates. As a GP trainee this was more in keeping with my strengths as well as being more useful for my future career. The Paediatric / Neonate specialist trainees would tend to volunteer more often to review babies on the NNU. I recall the Neonatal nurses being relatively friendly albeit it perhaps a little dismissive of the opinions of junior doctors rotating through the department (perhaps understandably so in a very specialised field).

6. In terms of how professional relationships affected the management and governance of the hospital in 2015, I cannot recollect any specifics that would allow me to speculate upon this.

7. I recall that I never really got to know any of the nursing staff on the NNU particularly well during my 4 months in Neonates / paediatrics. This differed somewhat to other placements I have done. However the placement at the Countess of Chester was split then with less than half of the time spent on the NNU especially as time was spent reviewing babies on the maternity wards also.

8. I have never really had much interaction with management in any of my placements so feel unable to comment about any issues that may have arisen. Junior doctors reported to the consultants and contact with managerial staff was relatively uncommon. I recall the rota was organised by one of the junior doctors on the placement which was unusual as in every other placement I worked in this would usually be handled by administrative staff. I found the registrars and consultants very supportive however, probably more so than a lot of placements I have worked in.

9. I do not recall any specific comments or reports at the time concerning the quality of care; the quality of the management or supervision and/or support of doctors at the Countess of Chester Hospital. I recall feeling that the quality of care provided from medical staff was high but I had never worked in a NNU or paediatric unit before to compare this with.

Child A

10. At the time of Child A's collapse on PD June 2015, I was in a neighbouring room on the ward when either an alarm was sounded or shouting attracted my attention (I cannot recall which). When I arrived, my registrar (Dr Harkness) was already leading the resuscitation. I briefly assisted with this but with several experienced neonatal nurses in attendance I instead switched to 'scribing' – maintaining a record and ensuring that drugs were administered at the correct times.

11. I have been asked to elaborate on a phrase used in my police statement on 2 May 2018 **[INQ0000060],** which I exhibit as **Exhibit CW/01** stating that '*the death came as a shock*'. This was presumably because Child A had been doing well prior to this point. The circumstances will have presumably been discussed briefly over a coffee in the staff room at the end of the shift but I cannot recall anything that was said. Looking at the exhibit it would appear that these events occurred right at the end of the shift and the doctors working the night shift arrived during resuscitation efforts and will have been involved. I believe there was some discussion about Child A's death at the following morning handover but I cannot recall who was there or what was said.

12. I have been asked about the following reference within my police statement (**Exhibit CW/01**) when it is noted that I recalled a registrar saying "*we may never find out what has happened. The post mortem result may not provide the answers.*" I do not recall who stated this to me only that it was one of the registrars.

13. If there was a formal debrief following Child A's collapse between NNU doctors / other staff then I was not invited – it could have occurred on a day when I wasn't in work but I am not aware of one occurring. I do think that this should have occurred however. I think that the death of Child A was the first neonatal resuscitation I had been involved

in and a debrief would be important for staff wellbeing as well as learning from the process. I vaguely recall discussion about the post mortem results prior to a morning neonatal ward round. I do not recall who was present.

14. I have been asked to comment upon the following statement I made "*I remember one of the things the team, were interested in was the post mortem results, which we were provided with probably a month or so later*" **[INQ0000060]**. I think that these were discussed but cannot remember the circumstance or who was present.

15. I gave a statement to the coroner detailing my involvement in this case **[INQ0008947]**, I do not recall being asked any specific further questions at the inquest. I think I was contacted directly by (possibly) someone from the hospital legal department.

16. I do not recall being aware of other's concerns or suspicions regarding the death of Child A. Nor did I have any suspicions of 'foul play' myself.

Neonatal Mortality Meeting

17. I have been asked about a Neonatal Mortality Meeting that I am recorded to have attended **[INQ0003297]** on 29 July 2015. I did not recall this meeting occurring until reading the meeting record – this may be what I was referring to when I mentioned the death of Child A being discussed prior to a neonatal ward round. I cannot recall who led the meeting and do not know if these are a regular event or held specifically after a death and I am unsure if I attended any others during my time at the hospital. I don't think anyone raised specific concerns about any of the babies' deaths at the meeting as this would likely 'stick in mind' but I cannot say with any certainty. I do not recall attending any follow up meetings. I am not sure whether I was made aware of the post mortem results of Child D. As a 'junior doctor' at the time however I would not necessarily expect to receive these.

Child E and F

18. I was alerted to the situation with Child E when the crash bleep sounded. I was on the paediatric unit and ran to the NNU. Resuscitation was already underway when I

arrived. As with Child A, I started maintaining a record and ensuring the correct drugs were administered when due. I cannot recall who else was present or what they were doing aside from what I documented.

19. In my police transcript **[INQ0007449]** I said in relation to Child E's death '*it really seemed to come out of the blue*' – Child E had seemed well leading up to this and wasn't 'on the radar' as a child of particular concern. There are only two doctors working a nightshift generally and after the death it took a while to sink in. This was my final set of shifts of my placement and I recall the deaths of these neonates affecting me more than any adult I had attended to in my career by that point. At the time, I don't recall any specific concerns (i.e. foul play) regarding Child E's death– more that we were hoping to find a 'cause'. Following the resuscitation attempt, the events will have been briefly discussed with the consultant and registrar (I believe Dr Harkness) though I do not recall what was said other than perhaps offering support. I believe I then had to go back to the paediatric unit to continue working.

20. I do not recall attending any debrief following Child E's death. I started my next job the day after finishing at the Countess of Chester but do not recall being invited back to discuss this. I would have welcomed the opportunity if offered and feel that anyone involved should be invited to such a debrief / discussion.

21. I have been asked about a 'handover document' produced by the Senior House Officer (SHO) which I referenced in my police statement on 15 February 2019 **[INQ0000224]**, which I exhibit as **Exhibit CW/02** - this was a rolling document listing all the children on the unit. I believe it was maintained on one of the computers in the 'doctors room' and updated at the start / end of each shift. It would detail any outstanding tasks and a brief summary and would be printed for use by the doctors taking over. When handing over between day / night shifts – the doctors would meet and highlight any outstanding jobs and babies of concern. I presume this would have happened on the days in question but I cannot recall.

22. Perhaps naively the idea that these deaths were deliberately caused by a member of the medical team didn't cross my mind. I only recall the idea that these were 'unusual' as they were more frequent than would normally occur in the unit.

23. In my statement **[INQ0000224]** (**Exhibit CW/02**) I stated that I "*could not recall the specific handover at the start of my night shift on 4 August 2015, but presume there would have been some discussion in relation to the death of Child E*". I am unable to recall anything further to this and cannot recall any specific discussions during the night shift on 4-5th August. I was not aware of any discussions between medical staff involving concerns or suspicions about the death of Child E. I do not recall attending any discussion or debrief (formal or otherwise) in relation to Child E. As I have previously stated, I do believe that such a debrief would have been important and I would have attended if invited.

24. Reviewing my police statement dated 15 February 2019 (**Exhibit CW/02 [INQ0000224]**) we were called to attend to Child F by a nurse (I do not recall who) as they were vomiting. It would appear that Child F had a rapid heart rate and had blood stained vomit. I would have been assisting the registrar, Dr Harkness as documented in the medical records. I have been asked to elaborate on Child F's low blood sugar readings. I cannot recall when I first became aware of these other than what was written in the medical records. From these, I can see that this was first documented by Dr Harkness at 02.30. My registrar was largely dealing with this. I recall there being some surprise / frustration as perhaps the blood sugars were not responding as would be expected but I cannot recall any further detail. My experience with this was limited (coming from a background of GP training and adult acute care). I am not aware of any debrief or discussions around this but this occurred on my final shift in this unit / hospital.

25. I have been asked if I know which consultant stated the following (from my police statement) *"And there was certainly a comment from one of the consultants that, 'look, this is really unusual, and that actually we normally perhaps see three, three babies passing away in a year, but there's been that many inside of only a few months.'* I do not recall which consultant stated this unfortunately. I had an awareness of the further deaths that occurred after I left the hospital from comments that were made during the Coroner's Inquest of Child A.

26. I have been asked to expand on comments concerning 'gossip' around these deaths. I cannot recall any further information about this – as previously mentioned I do not

recall suspecting that anyone from the medical staff would intentionally harm the babies. I was not aware of how many deaths occurred on the NNU in 2015, only those that occurred during the 4 months that I was working there.

27. I have been asked if I have access to data prepared by MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other organisations about the mortality rate and number of serious adverse incidents on the NNU. I do not believe I have seen this data.

28. Regarding how lessons were learned about adverse incidents or deaths in the hospital, from the information I have reviewed it would appear that there were Neonatal Mortality meetings and informal discussion. I am not aware of any other ways of learning from these incidents. I was not involved with any local networks of hospitals about adverse incidents and/or deaths of babies.

29. I was worried about the number of deaths only because it was suggested that they were more numerous than normal and perhaps occurring in babies who seemed to be doing well. I was there for only 4 months and had no significant prior NNU experience so wasn't personally familiar with what would normally occur. I had confidence that the consultants knew what they were doing however. At the time, I had no real awareness of how deaths were investigated. I was not aware of any concerns regarding Letby. I was more familiar with the nursing staff on the paediatric ward however. I cannot recall when post mortems were requested or the procedure for requesting these. This was not something that a 'Junior Doctor' would tend to be involved in.

30. Other than the Mortality meeting referenced earlier, I cannot recall attending discussions or debriefs (informal or otherwise) between doctors on the NNU or other medical staff in respect of the deaths of babies named on the indictment shortly after their deaths. I feel that any member of staff involved in a resuscitation effort (successful or not) should be invited for a debrief about this.

31. I do not recall attending any discussions or debriefs following clinical events for the babies named on the indictment and in respect of which charges for attempted murder

against Letby were ultimately brought. In hindsight, I feel that there should be discussion about any collapse or 'near collapse' of any baby and formal debrief about any death or significant resuscitation effort. Looking back at the night shift of 4-5th August, this was felt to be perhaps sepsis but the low blood sugars were seemingly unusual. I now understand there is a different explanation for this. A debrief of the nights events would have been useful but I do not know if I would have had any suspicion of 'foul play' being a cause for this.

32. I was not aware of the suspicions or concerns of others about the conduct of Letby and did not report any suspicions or concerns for the safety of babies on the NNU in any way as I did not suspect any wrongdoing.

Safeguarding of babies in hospitals

33. Safeguarding training is a regular part of any hospital induction and certification to Level 3 required to qualify as a GP. This is predominantly online but I also attended a course during my training. I do not know when this was. The training encourages anyone with concerns to raise these.

34. The GMC (General Medical Council) and RCGP (Royal College of General Practitioners) has safeguarding guidance and would be my first port of call if I had a query relating to this. I did not seek the guidance of any professional body for advice in respect of the events at the hospital.

Speaking up

35. I am not familiar with the procedures for raising concerns within the COCH in 2015. In the first instance I would probably have approached one of the registrars or consultants. I do not recall attending any specific training of this nature whilst I was there.

36. I do not recall having any training on the process used and organisations involved in reviewing a child death such as Child Death Review, Sudden Death in Infancy/Childhood (SUDI/C) and the Coroner's Office whilst at the Countess of Chester hospital and this was my only neonates / paediatrics placement.

37. I have been asked "What did you consider were the external scrutiny bodies with whom concerns could be raised, if any?". At the time I doubt I would have had much awareness of these specifically. I would raise concerns primarily with the registrars or consultants. If I had further concerns which were not addressed then I would probably firstly seek advice from my indemnity provider (MDDUS). I did not provide any information about Letby or express any concerns about the deaths to any external bodies as I had no specific concerns or wrongdoing at the time.

38. I have been asked whether I provided information to the Coroner about any of the deaths of the babies named on the indictment. As previously mentioned, I attended a Coroner's inquest concerning the death of Child A. I think the information given at the time seemed complete.

39. I have been asked if I raised any concerns about Letby with those with management responsibilities at the Trust. I did not.

Reflections

40. I have been asked if I feel that CCTV monitoring would likely be a significant deterrent to the crimes of Lucy Letby. Yes I believe this would likely be the case.

41. I have been asked about security systems being used to prevent harm to babies on the NNU. Tighter monitoring of access to the drug room, regular stock checks and CCTV monitoring of individual babies and the drug room / preparation areas may prevent deliberate harm being caused to the babies named on the indictment in my opinion.

42. Though I was not aware of these concerns at the time, I now understand that the consultants did have concerns that were perhaps not taken heed of. I recall the

consultants being very competent and highly regarded. One would hope that if they raised concerns then they would be treated extremely seriously and acted on immediately to prevent further harm. The suggestion of CCTV monitoring of babies sounds sensible also.

43. I believe that my police statements, which I have previously exhibited as Exhibit **CW/01** and **CW/02** and I also exhibit my police statements dated 2 April 2019 **[INQ0013883]**, 30 July 2021 **[INQ0000061]** and 20 November 2022 **[INQ0000893]** as **Exhibits CW/03**, **CW/04** and **CW/05**, remain accurate to the best of my knowledge at the time given the lengthy timescales involved between the events, the statements and the present day.

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

45. I do not have any documents or other information that would likely be relevant to the Inquiry.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: Personal Data

Dated: 10/5/24