Witness Name: Gail Cara Beech
Statement No.:1
Exhibits: GCB1, GCB2
Dated: 22 May 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF GAIL CARA BEECH

I, Gail Cara Beech, will say as follows: -

Personal details

1. My full name is Gail Cara Beech. This is the name I use for professional purposes, and I use my married name for non-professional reasons.

Medical Career and employment at the Countess of Chester Hospital

2. My qualifications are BSc (Hons) in Anatomy in Relation to Medicine (First Classification) which I was awarded by the University of Leeds, UK, in 2008, and MBChB with Honours which I was awarded by the University of Leeds, UK, in 2010. I became a Member of the Royal College of Paediatrics and Child Health, UK, in 2014.

   My medical career to date is as follows:

   - August 2010 to August 2011 – Foundation Year One doctor at Arrowe Park Hospital, Wirral, with 4-month placements in General Paediatrics, Department of Medicine for the Elderly and Acute Medicine, and Urology.
   - August 2011 to August 2012 – Foundation Year Two doctor at Arrowe Park Hospital, Wirral, with 4-month placements in Ophthalmology, General Practice and Emergency Medicine.
   - August 2012 to February 2013 – ST (Specialty Trainee) 1 doctor in paediatrics in General Paediatrics at Arrowe Park Hospital, Wirral.
   - February 2013 to August 2013 – ST1 doctor in paediatrics at Alder Hey Children's Hospital, Liverpool, with 3-month placements in paediatric Endocrinology and paediatric Nephrology with General Paediatrics on calls.
   - August 2013 to February 2014 – ST2 doctor in paediatrics at Alder Hey Children's Hospital, Liverpool, with 3-month placements in paediatric Oncology and Haematology with General Paediatrics on calls, and Emergency Medicine.

- February 2014 to September 2014 – ST2 doctor in paediatrics at Arrowe Park Hospital, Wirral, in Neonatology.
- September 2014 to September 2015 – ST3 doctor in paediatrics at Countess of Chester Hospital, Chester, in General Paediatrics and Neonatology.
- September 2015 to March 2016 – ST4 doctor in paediatrics at Liverpool Women's Hospital, Liverpoool, in Neonatology.
- March 2016 to September 2016 – ST4 doctor in paediatrics at Alder Hey Children's Hospital, Liverpool, in paediatric Oncology and Haematology with General Paediatrics on calls.
- September 2016 to September 2017 – I&S accrued annual leave.
- September 2017 to September 2018 – ST5 doctor in paediatrics at Whiston Hospital, Prescot, in General Paediatrics and Neonatology, working less than full time at 60%.
- September 2018 to September 2019 – ST5 doctor in paediatrics at Countess of Chester Hospital, Chester, in Community Paediatrics with General Paediatrics and Neonatology on calls, working less than full time at 60%.
- September 2019 to January 2020 – ST6 doctor in paediatrics at Countess of Chester Hospital, Chester, in General Paediatrics and Neonatology, working less than full time at 60%.
- January 2020 to November 2020 – I&S accrued annual leave.
- November 2020 to March 2021 – ST6 doctor in paediatrics at Countess of Chester Hospital, Chester, in General Paediatrics and Neonatology, working less than full time at 60%.
- March 2021 to March 2022 – ST6 doctor in paediatrics at Alder Hey Children's Hospital, Liverpool, in paediatric Respiratory medicine with General Paediatrics on calls, working less than full time at 60%.
- March 2022 to September 2022 – ST7 doctor in paediatrics at Alder Hey Children's Hospital, Liverpool, in paediatric Intensive Care medicine, working less than full time at 60%.
- September 2022 to March 2023 – ST7 doctor in paediatrics at Arrowe Park Hospital, Wirral, in General Paediatrics, working less than full time at 60%.
- March 2023 to September 2023 – ST8 doctor in paediatrics at Leighton Hospital, Crewe, in General Paediatrics and Neonatology, working less than full time at 60%.
- September 2023 to November 2023 – Post Completion of Training doctor in paediatrics at Wrexham Maelor Hospital, Wrexham, in General Paediatrics and Neonatology, working less than full time at 60%.
- November 2023 to present – High Dependency Unit Locum Consultant at Alder Hey Children's Hospital, Liverpool.

3. As above, for the time that I was at the Countess of Chester Hospital in 2015 (until September), the position I held was as an ST3 doctor in paediatrics. In this role, I had no management or additional responsibilities.

4. I left the hospital in September 2015 to move to another training post elsewhere, but have worked at the hospital on several occasions since, as detailed above.
   I am currently in a locum consultant position on the High Dependency Unit at Alder Hey Children's Hospital in Liverpool, as detailed above.

The culture and atmosphere of the neonatal unit (NNU) at the hospital in 2015-2016

As I left the hospital in September 2015, anything I say regarding my time at the hospital in the period 2015 to 2016 only relates to the time which I was there within this period i.e. January to September 2015.

5. Junior doctors in training, as I was during this time period, do not have a 'manager'. However, I would regard my clinical supervisor to fulfill the same role in relation to me as a manager would. My clinical supervisor at this time was Dr Stephen Brearey, and as such, he would be the first person that I would report to. After Dr Brearey, the next person I would have reported to (if needed) would have been Dr Ravi Jayaram as clinical lead for Paediatrics at the Trust at the time.

6. As a junior member of the team at this time, I had no insight whatsoever into the relationships between clinicians and managers, or nurses and midwives with managers. I cannot recall noticing anything which stood out as unusual to me about the relationships between doctors, nurses, midwives and other medical professionals. I enjoyed working at the hospital at this time (and the other times I have been there since), which would infer to me that I thought the working relationships between these people were good.

7. I cannot specifically recall the quality of relationships on NNU but based on my experience throughout my career, relationships *would* affect the quality of care being given to babies, with positive relationships impacting positively and vice versa. As I cannot recall the quality of relationships on NNU, I cannot comment on their effect, but I do not recall knowing about or seeing anything suggestive of negative relationships, as I believe this would be something I would remember. My recollection is that I did not think there were any issues with the care being given to babies on the NNU.

8. There is not a specific culture that I can recall on the NNU in my time there during this period and so I cannot describe it. To me, it felt like a 'normal' hospital environment similar to every other hospital I had worked in before.

9. I cannot comment specifically on whether professional relationships affected the management and governance of the hospital during the specified period as I was a very junior member of the medical team, and so had no direct involvement with them other than to undertake projects which would fall under the very broad umbrella term of governance such as working on audits.

10. When I returned to work at the hospital after June 2016, the most noticeable difference for me from when I was there prior to this date was that there was a consultant-led ward round on the NNU daily compared to twice per week before this date, and a named consultant responsible specifically for the NNU every day, rather than it being covered by the consultant also on duty for General Paediatrics. This felt like a positive change and was reassuring to me as a junior doctor as it felt like there was less responsibility on me, (although I had never previously felt overwhelmed with responsibility prior to this change as there was always a consultant available for me to discuss patients with). It felt to me like the permanent staff on the NNU (consultants and nursing staff) had even stronger relationships than they had before because they were going through a lot with regard to what had happened and all had a mutual understanding of this.

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

Child A

11. I do not recall finding out how Child A had died but as I said in my police statement included at **Exhibit GCB1 [INQ0000044, page 7]**, based on usual practice, this is likely to have been at the morning handover of the patients on the NNU. As I worked during the day on PD June 2015 and this was a Sunday, I presume that I was off work on PD June 2015 as the usual rota pattern at this time would be that if you worked the weekend days, you would have the Monday off work and return to duty on the Tuesday. If it was not specifically mentioned at the morning handover on 9 June 2015 that Child A had died, then it may have been the case that I noticed his name was not on the NNU patient list and I therefore

asked what had happened to him, as this is something I would be likely to do, but I cannot recall accurately. I also cannot recall at all what was said.

12. It is difficult to say whether for me Child A's death was expected or unexpected. He had a number of medical issues including prematurity and required respiratory support amongst others, which put him at a higher risk of death than other healthy neonates without these issues. However, when I finished my shift on PD June 2015, he was stable with no signs that he was imminently going to die and so finding out on 9 June 2015 that he had died is likely to have been a surprise to me. However, from my clinical experience at the time, I knew that things could change rapidly with preterm neonates and he had not been very old when I had finished my shift on PD June 2015, so issues which would make him more likely to die may have become apparent in the time after I had left, as is sometimes the case with neonates newly admitted to NNUs.

13. I was not on shift when Child A died and so I was not fully aware of the circumstances surrounding his death, so I therefore did not have any concerns about it.

14. I cannot specifically recall having any conversations with other staff about Child A's death, although from my usual practice, it is likely that I did speak to one or some of my junior doctor colleagues about it because the death of any neonatal or paediatric patient is unpleasant and thankfully not frequent, and so to speak to others is a way of coping with it.

15. I cannot specifically recall attending any discussions or debriefs in respect of the death of Child A. With hindsight, it would have been beneficial for me to be involved for my own learning because I had managed the baby at his delivery which was only a short time before he died.

Child B

16. I cannot recall when and how I first became aware of the incident involving Child B on the night shift of 9 -10 June 2015. If I was present at the morning handover of NNU patients on 10 June 2015, then from usual practice, it is likely that this is where I first became aware of it as it was probably discussed by the doctors present at this handover. The discussion would most likely have been led by those present at the time on the night shift who I assume would have described what had happened.

17. I cannot recall attending any discussions or debriefs about the incident relating to Child B on 9-10 June 2015. I do not think I should have been involved in any as I was not present and from reading my notes on 9 June 2015 **[INQ0000698, pages 22-25]**, she was stable and making progress, which infers that the incident overnight was quite acute (although I do not have access to the documentation in the medical notes about it from the time).

Child C

18. I do not recall how I found out that Child C had died but it is very likely that it was on 15 June 2015 as 14 June 2015 was a Sunday and as I had worked the weekend before (which I know because I had been at Child A and Child B's delivery on PD June 2015), I did not work the weekend of 13 and 14 June 2015 too. As would be usual, it is likely to have been at the morning handover on 15 June 2015.

19. Child C's death was an unexpected event to me personally as he had overall been making progress and the last time I had seen him on 12 June 2015, he had been very stable. However, there were several risk factors which meant that he was a very vulnerable neonate, such as his very small size (800 grams), prematurity and requiring respiratory support, amongst others.

20. I did not have any concerns about Child C's death as I was not present at the time, other than it being unexpected to me. I remember discussing it with Dr Sally Ogden at the time as I recall that she was upset by his death. I did not raise any concerns with anyone as I knew, as above, that he had risk factors and I also knew that a consultant was involved with the death so they would be aware of the circumstances.

21. I do not have any recollection of what was discussed in the Neonatal Mortality Meeting on 29 July 2015 regarding Child C's and Child D's deaths as I do not specifically recall attending the meeting due to the lapse of time.

22. Although I do not have any recollection of what was discussed in the Neonatal Mortality Meeting on 29 July 2015, I do not believe that deliberate harm was discussed as I am certain that I would have remembered if it had been because it is so unusual. I also believe that incompetence was not discussed in relation to a named person or people because again, I feel that I would have remembered this. There are always learning points discussed at these meetings.

23. I do not recall any discussion from the meeting so I do not recall a discussion about any overall increase in the number of deaths/unexplained collapses on the NNU, but I do not think this was discussed as I do not recall being aware of this until a much later date.

24. As I do not recall any discussion from the meeting, I do not recall any discussion about any possible similarities or connections between the deaths of Child A, Child C and Child D and the collapse of Child B, but I also do not think that this happened because I feel like this is something I would have remembered it if did.

25. I do not recall attending any other formal discussions or debriefs in respect of the death of Child C, but as previously, I recall that myself and Dr Ogden spoke informally about it as we were both upset by it. I cannot remember what we said, however. As I was not present at the death, I do not think I should have been involved in a debrief or discussion about it.

Child E and Child F

26. I cannot recall any discussion at any time (including on 4 August 2015) regarding Child E's death.

27. I cannot recall when and how I became aware that Child F had low blood sugar readings on the night shift of 4-5 August 2015 but from usual practice, this is likely to have been at the morning handover from the night team to the day team on 5 August 2015. Both teams would have been present (the out-going night middle grade and 'senior house officer' (SHO) grade doctors, and the day team consisting usually of at least one middle grade doctor covering each of general paediatrics and neonates, a consultant and at least one SHO covering each of general paediatrics and neonates). It appears from the medical notes **[INQ0000859, pages 22-27]**, that Dr David Harkness was the night middle grade doctor and Dr Ogden was the day middle grade doctor covering neonates. My police statement included at Exhibit GCB2 **[INQ0000898, page 5]** says that I was on an on-call shift on that day, so as would be usual for the on call-person, I was very likely to have been on general paediatrics during the day shift until after the afternoon handover. Dr Ogden has documented that Dr Murthy Saladi reviewed Child F at 10:00 **[INQ0000859, page 25]**, and so I presume from this that he was also present at the morning handover.

28. I cannot recall from memory anything about Child F, so I do not recall either being surprised or concerned about his blood sugar readings or clinical presentation on 5 August

2015. My documentation in the medical notes from that date **[INQ0000859, page 27]**, is minimal and so it appears that I had very little involvement with him on that date. I did not raise any concerns with anyone as I would have documented them if I had.

29. I do not recall attending any discussions or debriefs in respect of the death of Child E and do not think that I should have done as I was not present at the time.

30. I do not recall attending any discussions or debriefs in respect of Child F's clinical condition or low blood sugars on 5 August 2015, which I think is appropriate because I was not directly involved at the time. From the medical notes which I have been sent at **[INQ0000859, pages 20-28]**, I cannot see any reference to low blood sugars on 4 August 2015.

31. I do not recall ever being aware of any discussions about any similarities between the death of Child A on 8 June 2015, Child B's collapse on 9-10 June 2015, Child D's death on 22 June 2015 and Child E's death on 4 August 2015.

32. I do not know how many deaths occurred on the NNU between 2015 and 2016.

33. I do not know if I had 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 did not try to look for any of this as I did not have any concerns.

34. I do not recall having a good knowledge of the way in which lessons were learned about adverse incidents or deaths in the hospital at the time. I know that I was aware of incident reporting and that each incident report would be looked into, as well as shared learning being done in the form of morbidity and mortality meetings for example, but I do not think my knowledge extended any further than that at the time. I was not involved in discussions with any local network of hospitals about adverse incidents or deaths of babies.

35. I was never worried about the number of deaths on the NNU. I had not worked at a level 2 NNU prior to this. My only experience previously of working on an NNU was at a level 3 NNU (where babies have different medical problems requiring a higher level of care, thus making them more likely to die), and so I did not have anything to compare it to.

36. I was not aware of how deaths on the NNU were usually investigated, other than what I heard discussed at neonatal morbidity and mortality meetings. I presumed that consultants participated in investigations, as well as other doctors who were present when babies died if needed (to provide more information or statements, for example). I knew from medical school that post-mortems could be requested by the Coroner in certain circumstances, and I also presumed that the consultants were able to request them if they felt they were necessary.

37. I did not attend any discussions or debriefs in respect of the deaths of the babies named on the indictment shortly after their deaths. I do not think I should have been involved in any as I was not present at any of the deaths and had no concerns about them, but as stated above, I think it would have been beneficial for me to attend a debrief about the death of Child A as he died only a short time after I cared for him I&S

38. I did not attend 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. I was not present at any specific event, I had no concerns and I was such a junior member of the team that I think it is appropriate that I was not involved in any discussions.

39. I was not aware of the suspicions or concerns of others about the conduct of Letby until not long before the first media reports about her. Another junior doctor friend who was working at the hospital at the time told me that Letby had been seconded to a non-clinical role 'for her own protection' as she had been on duty when several deaths had occurred. However, I did not know any more than this until it was reported in the media. No one ever discussed any concerns directly with myself.

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

Safeguarding of babies in hospitals

41. I always keep up to date with safeguarding training appropriate to my level of work, but I cannot specifically recall it being mentioned during any of this training about abuse on the part of a member of staff towards babies or children in hospital. General advice has always been to escalate to a colleague more senior than myself regarding any concerns about anyone (not specifically a member of staff) and so this would apply to staff members also.

42. I am not aware of my professional body assisting with safeguarding guidance or advice specifically in the context of suspicion or abuse by a member of staff towards babies. For help or advice in this situation, I would turn to my colleagues and my defence organisation. I did not turn to any professional body for advice in respect of events at the hospital as I did not have any concerns at the time, for the reasons outlined above in my statement.

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

43. As far as I was aware, the main process for raising concerns myself within the hospital that was in place in 2015 would be to speak to my clinical supervisor or to complete an incident form, depending on what the concern was regarding. Whistleblowing and freedom to speak up guardians were not avenues which I was aware of in 2015.

44. Prior to 2015, my knowledge on the process used and organisations involved in reviewing a child death was limited to a knowing that there was a process to follow in the event of a Sudden Death in Infancy/Childhood, and that there were certain deaths which needed to be discussed with the Coroner's Office. I do not think that I was aware of the Child Death Review process then. I think this training was adequate for my level as at this level, I would never have been left to deal with a child death by myself. I always had multiple senior colleagues who I trusted and could have raised any concerns or suspicions to.

45. At the level of training I was at in 2015, I did not consider any external scrutiny bodies with whom concerns could be raised as I was at a junior level. I would only have ever escalated concerns to my immediate senior colleagues, such as the consultants. I did not express concerns or suspicions to anyone because I did not have any.

46. I was requested to provide a written statement to the Coroner about my involvement in the care of Child A, which I submitted **[INQ0008856]** for the coronial investigation. I was also asked to attend this in person but was excused **Irrelevant & Sensitive**. Other than my own statement, I am not aware of what information was provided by the Trust to the Coroner.

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

47. I did not raise any concerns about Letby with those with management responsibilities at the Trust.

Reflections

48. As I did not have any concerns at the time, my knowledge about the crimes of Letby is from what I have seen in the media. From this, it seems that many of the things which she did were subtle and therefore I think would have been difficult to see on CCTV such as injecting air into intravenous lines or through feeding tubes, for example. However, the presence of CCTV, if she was aware of it, may have acted as enough of a deterrent to stop her from committing any crimes.

49. I do not have any knowledge of the security systems relating to the monitoring of access to drugs which were in place at the time, other than the universal practices relating to the storage, counting and documentation of Controlled Drugs. I also presume (as is usual practice) that drugs were locked away with access by keys held by the nursing staff. If a more robust system had been in place such as the signing in and out of every single drug, and checking amounts of each drug at least daily, rather than just Controlled Drugs, then this may have assisted in the prevention of deliberate harm. However, I am not aware of anywhere that did this as routine practice at the time or even now. Also, as a member of the nursing team, Letby would have had access to both drugs and the babies no matter what security systems were in place and so I think it would be difficult to have prevented it just by using different systems.

50. It is difficult to for me to say what recommendations I think the Inquiry should make to keep babies in NNUs safe from any criminal actions of staff, as my main source of information on the criminal actions committed is from media reports, as stated previously. However, as a clinician, my main recommendation would be to have someone independent or an independent body to whom clinicians can report concerns to when they feel they are not being listened to by a Trust. I also think that although as stated above, CCTV would be unlikely to pick up subtle things, its presence may act as enough of a deterrent to stop staff from commiting criminal actions.

Any other matters

51. I do not have any other evidence to give which is of relevance to the work of the Inquiry.

52. I have reviewed my statements and consider them accurate to the best of my knowledge. However, I do wish to add a comment in respect to Child C and the x-ray I reviewed at 12:55 on 12 June 2015 at **[INQ0000108, page19],** which was done to check the position of a long line which I had placed. I cannot be certain as I did not document it in the medical notes at the time, but I was shown this image during the trial of Letby and was questioned about it several times, which made me remember that I may have asked Dr Brearey to review this x-ray later on during the same shift. He did not have anything different to say about it other than what I had said, which is likely to be the reason that I did not document anything, if I am correct in thinking it was for this patient. This definitely happened with a neonatal patient at this hospital, and I think it was Child C but cannot be certain.

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

Requests for documents

54. 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

Dated: 24.05.2024 | 10:17:23 BST