Witness Name: Jessica Burke

Statement No: 1

Exhibits: JB1

Dated: 28 May 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR JESSICA BURKE

I, Dr Jessica Burke, will say as follows;

Personal Details

1. My name is Dr Jessica Lucy Burke.

Medical Career and employment at the Countess of Chester Hospital

2. I qualified as a doctor in July 2011, with MBCHB awarded by the University of Liverpool. I then completed my provisional GMC registration foundation 1 year and from August 2012 became fully registered with the GMC.

3. Since September 2014 I have been enrolled in the paediatric speciality training programme in the Mersey North West region. I gained full membership of the Royal College of Paediatrics and Child Health in February 2017.

4. I commenced my medical career with 2 years of foundation training as follows:

    a. 4 months paediatric ENT at Alder Hey Children's Hospital;
    b. 4 months adult respiratory medicine at Whiston Hospital;
    c. 4 months general and orthopaedic surgery at Whiston Hospital;
    d. 4 months general practice in Appleton Village Surgery, Widnes;
    e. 4 months of acute adult medicine at Whiston Hospital; and
    f. Finally, 4 months of general paediatric medicine at Whiston Hospital.

5. I spent a year as a staff grade junior doctor working between A&E and general paediatrics at Whiston Hospital and some time spent abroad.

6. I commenced paediatric speciality training in September 2014 with my placements as follows:

    a. 6 months general paediatrics in Leighton Hospital;
    b. 6 months tertiary neonatal medicine in Liverpool Women's Hospital;
    c. 6 months paediatric nephrology (renal) at Alder Hey children's Hospital;

d. 6 months general paediatrics at the Countess of Chester;
e. 6 months of general paediatrics at Whiston Hospital;
f. 6 months of general paediatrics at the Countess of Chester;
g. 6 months of paediatric gastroenterology at Alder Hey Children's Hospital;
h. 6 months of general paediatrics at the Countess of Chester;
i. 6 months of tertiary neonatal medicine at Liverpool Women's Hospital;
j. 3 months of community paediatrics at Alder Hey Children's Hospital;
k. 9 months of general paediatrics at Arrowe Park Hospital;
l. 12 months of paediatric nephrology at Alder Hey Children's Hospital; and
m. 24 months of paediatric rheumatology at Alder Hey Children's Hospital.

7. This brings me to my current posting in general paediatrics at Wrexham Maelor Hospital where I have been since March 2024.

8. During my first period of work at the Countess of Chester hospital, from March 2016 to September 2016, I was in the role of speciality trainee 2 (ST2) which is at the more junior level of trainee doctor (previously described as an SHO) as opposed to the more senior level of a middle grade (also called registrar) doctor. As ST2, I was at the more experienced end of the SHO spectrum.

9. My role included ward cover on the paediatric, postnatal and neonatal wards under the guidance of the more senior trainee doctors and the consultants, assessing and making provisional plans for new patients admitted to hospital under paediatrics before they would be reviewed by senior colleagues and attending deliveries of babies where a paediatric doctor was required, and to be accompanied or joined by senior colleagues if any significant resuscitation at birth was required. I did not have any managerial responsibilities during this placement.

10. I subsequently completed a further 2 placements at the Countess of Chester, each of 6 months duration. I next worked at the Countess of Chester Hospital from March 2017 to September 2017 as an ST3 (speciality trainee level 3 doctor) which is the most junior level of "middle grade" doctor now functioning at the level of registrar.

11. I worked at Chester again March 2018 to September 2018 as an ST4 (speciality trainee level 4 doctor), again as a middle grade doctor but with a further year of experience. I am currently placed at Wrexham Maelor Hospital where I have been since March 2024. This is in the role of an ST8 (speciality trainee level 8 doctor). ST8 is the final year of speciality training before one would qualify as a paediatric consultant.

The culture and atmosphere of the neonatal unit (NNU) at the Hospital in 2016

12. During clinical shifts as an ST2 doctor, my first point of escalation would have been the middle grade doctors (previously termed registrars) who were allocated to the same work area. During clinical shifts, above the middle grades would be an on-call consultant who one could escalate to. The on-call consultants would change over weekly on a rolling rota. Complex or long-term patients tended to be allocated a lead consultant who within normal work hours could also be asked for advice on patient specific issues.

13. Beyond the immediate clinical team, I was also allocated an education and clinical supervisor who performed the overall training supervision for my placement and could be contacted for issues around wellbeing, feedback, or any concerns. My supervisor during that

placement at the Trust in 2016 was Dr Saladi. There was also a safeguarding lead consultant who could be contacted for advice around safeguarding concerns in addition to the on-call consultant and I believe from memory the safeguarding lead consultant at that time was one of the community paediatric consultants.

14. In addition, from memory the Trust had an incident reporting system via the Trust internet where concerns could be raised to colleagues beyond the department which was standard in my experience of hospital trusts.

15. As a junior doctor who had only joined the team in March 2016, I did not have any interactions with or observations of the managers and could not comment of the relationship between clinicians and managers. Similarly, I could not comment on the relationship between nurses, midwives, and managers.

16. My memory of the relationships between doctors, nurses, midwives and other clinicians was that they were positive. I came to the Trust in March 2016 having been told that the paediatric department had a positive reputation in that it was busy but supportive, friendly and a well-run department so a good placement. My memory of the consultant team was that they demonstrated a hands-on approach, being a visible presence on the wards, supporting trainees, readily leading and assisting particularly on complex cases and assisting with the junior's work load during periods of high clinical demand.

17. I remember that quite a few of the middle grade doctors at the Trust during that period were relatively senior and in the final few years of training before becoming consultants themselves. Therefore, my impression of them was that they were very competent and experienced at their level of training. I remember the junior doctor team seemed friendly with a culture of helping each other out during shifts to assist where workload was busier in certain areas and fostering an environment that welcomed discussion of cases that had confused or upset us.

18. My memory of my impression at the time was also that the doctors seemed to have a good relationship with the nurses, with both the paediatric ward and neonatal unit having a good number of experienced nurses. As a junior member of the team who moved during those 6 months between the paediatric ward, the children's assessment unit / bay, the neonatal unit (NNU), delivery suite and the post-natal ward, I did not feel at that time that I knew many of the nurses or midwives particularly well.

19. I should comment that having subsequently worked at the Trust for 2 further placements in 2017 and 2018, I did get to know some of the nurses better. However, at that time in 2016 my relatively peripheral view as someone new to the team was that the nurses and doctors got along.

20. From my memory of the doctors' relationships on NNU, I remember between the juniors there being a positive attitude of all helping each other out and that if one area of the department was quieter in terms of clinical demand, doctors would readily move to help out in areas that were busier. I have memories of when the NNU became very busy at times that junior doctors from elsewhere in the department would readily and frequently come to help with the workload which I felt positively impacted the quality of care on NNU.

21. I do not have any strong memories of relationships between doctors and nurses on the NNU. However, I have an impression gained during that 2016 placement and from the reputation I had heard before joining the Trust in 2016 that the NNU was busy but a functional team.

22. I do not have strong memories of the quality of relationships on the NNU affecting the quality of care being given to baby, other than that I had the overall impression and memory of my paediatric placement at Chester that there was an ethos of teamwork and supporting each other in our roles and that one would expect this to reflect positively in the care that was given.

23. As a junior doctor who moved between clinical areas during those 6 months at the Trust (the paediatric ward, the children's assessment unit, the neonatal unit and delivery suite and the post-natal ward), I would have only spent around one quarter of my time on the neonatal unit so would find it difficult to have a strong impression of the NNU culture. I remember thinking that the doctors all readily came to help out there when it was busy which helped during periods of high clinical demand.

24. It would be fair to say that after being called to assist in a resuscitation of the unexpected collapse in Child P on 24th June 2016, from that date I felt quite anxious and sad when I was on the neonatal unit but I put this down to my own distress of having been called to assist in the resuscitation for a baby who did not survive. I cannot remember whether the culture changed on the unit after that event occurred.

25. My experience of the nursing culture on the NNU at the Trust in 2016 is fairly minimal due to be being an ST2 trainee and as such not spending a significant amount of time on the NNU. My memory may be influenced by the fact that I spent a two further subsequent placements at the Trust, in 2017 and again in 2018 and on these occasions, I was in the role of a middle grade doctor. On these subsequent experiences in 2017 and 2018 due to my greater level of responsibility, I did spend more time on NNU and interacting with the nursing team there. On these occasions in 2017 and 2018 my memory is that the culture on the NNU was supportive, providing robust clinical care, all working efficiently, and responding calmly and as a team when under high clinical demand or in emergencies.

26. As a middle grade in 2017 and 2018 I remember feeling comfortable working with the nursing team on NNU and confident that we were able to deliver a good standard of care on the NNU in part due to their hard working ethic, reflective practice, low threshold to escalate and attention to detail.

27. From my memory, I did not have any experience or exposure to be able to comment or form a judgement on whether professional relationships affected the management and governance of the Countess of Chester Hospital in 2016.

28. Prior to joining the Trust in 2016, my prior two placements had been a Neonatal Speciality placement at the Liverpool Women's Hospital and then Paediatric Renal medicine (Nephrology) at Alder Hey Children's Hospital. These were speciality jobs within tertiary level hospitals which makes them somewhat different to the general paediatric and neonatal departments at the Countess of Chester. The Liverpool Women's was a much larger neonatal unit with a higher neonatal clinical intensity being the normal and the team allocated to the neonatal unit there was therefore much larger.

29. A positive asset which the Liverpool Women's had over Chester was the presence of a large number of skilled advanced nurse practitioners (ANPs). The ANPs at the Liverpool Women's

are employed long term and in my impression they were a consistent presence of skilled clinicians involved in the day to day running of the NNU whereas the junior doctors would rotate every 6 months. In contrast at Chester, the neonatal nurses and consultants would have been the only two consistent groups providing care on the neonatal unit. At the time I felt that the educational opportunities and support for trainee doctors were enhanced by having ANPs as part of the team at the Liverpool Women's and this probably fed into improving care for the patients.

30. In retrospect I now also wonder whether the culture of having ANPs who are employed long term and do not rotate benefits the care in terms of another consistent clinician group who can potentially recognise patterns or changes and identify outlying events over a longer period than the 6 months that most junior doctors spend on one placement.

31. My time at Liverpool Women's hospital was my first experience of tertiary neonatal medicine and my memory of the culture there was that it felt controlled, with evidenced based practice and protocols being paramount and that there was a very high attention to detail because of the extremely premature infants they cared for and the NNU nurses there were highly specialised to look after this group of patients.

32. When I moved to Chester, my memory was that many of the protocols seemed similar if not the same as Liverpool Women's but that a higher proportion of their neonatal unit babies were shorter admissions and were either more moderate preterm infants or term babies. This would be expected for a district hospital NNU where the extreme preterm babies would be transferred to a tertiary unit either before delivery or soon after.

33. My experience of the Liverpool Women's was that at any one time there would be a greater number of clinicians available including out of hours compared to a district general hospital like Chester. Similar to Chester, I found the consultants at the Liverpool Women's very supportive of trainees, with attention paid to trainees' well-being and educational opportunities in addition to delivering high standards of clinical care.

34. My clinical experience with the renal team at Alder Hey was different to Chester so maybe harder to draw comparisons in that it was a much smaller team looking after a patient group of highly complex but usually long term patients, the majority of whom at any one time would be cared for on an outpatient basis. The much smaller clinical load of inpatients on renal compared to the NNU allowed for very detailed senior led discussion and review of each patient's clinical progress and parameters if not on a daily basis, then at least few times per week. The paediatric renal team practised in a very senior led manner with most clinical decisions being consultant led which I feel is understandable with it being such a specialised area.

35. Similarly to Chester and the Liverpool Women's, I also felt well supported with a small but very approachable consultant team during my time in paediatric renal medicine and by supportive middle grades.

36. After Chester, I was then placed at Whiston Hospital covering general paediatrics and a neonatal unit. My role was now different compared to Chester as at Whiston I was in the role of a middle grade doctor. As such, I remember having greater responsibility and less consultant supervision of the care I delivered on their neonatal unit but this would be expected with me stepping into a more senior position.

37. I remember at Whiston at that time, that less of their junior level trainees (SHOs) were in paediatric training (only one out of about 10 compared to Chester who had 3 or 4 paediatric trainees out of about 10 SHOs). I think as a result there was a culture whereby the SHOs went to the neonatal unit much less often at Whiston and SHOs were not allocated to the NNU there routinely for ward rounds or daily duties. This meant that doctor cover on the NNU at Whiston at that time during the daytime tended to be one paediatric middle grade, or if available but not always 2 paediatric middle grades as opposed to Chester which from memory almost always allocated one middle grade and one junior trainee to the ward round on NNU.

38. From my memory at that time, Whiston operated a similar system to Chester in that once a week a consultant would complete the ward round on the NNU. My memory of Whiston was that their neonatal unit was less busy than the NNU at Chester, but that the paediatric A&E at Whiston was quite a lot busier than that at Chester, so Whiston allocated an additional twilight middle grade doctor most days. Overall, I remember thinking this led to fairly comparative workload for junior doctors between the two hospitals. I remember a similar team working attitude of junior doctors at Whiston whereby if a middle grade on NNU was very busy with high clinical demand, then colleagues from the paediatric side of the department would readily come to help and offer support.

39. In Whiston as in Chester, I had an experienced and very approachable consultant as my clinical supervisor who I feel confident would have supported me had I experienced any concerns during my placement there.

40. My memory of before I joined the Countess of Chester in 2016 was that I had heard from other trainees in the region that it was a busy district hospital including a busy neonatal unit but that trainees would be well supported and that the consultants were very hands on so that the departments delivered a good standard of clinical care, and it should be a fulfilling place to work. I remember hearing that the consultants liked to be involved in the clinical care on the wards and would stay late to help delivering care if needed.

41. I do not remember hearing or knowing of any comments or reports on the quality of the management. I do not remember hearing or knowing of any comments or reports of the nature of relationships between doctors, nurses, and management.

Whether suspicions should have been raised earlier and whether Letby should have been suspected earlier

42. From my memory, I had a period of annual leave and non-working days in June 2016 which ended with me returning to work at the Countess of Chester on 24th June 2016. I remember coming to morning handover which would have usually started at 0830 on 24th June 2016 and for the first time hearing that a set of triplets had been born a few days earlier but that one of them had died unexpectedly the day before.

43. I cannot remember exactly who told me that information, but I think it may have been being spoken about between other colleagues when I first entered the handover room before the official handover began. I cannot remember details of what was said but remember that this was the first time I learnt of the existence of the triplets and that the team present in the handover room that morning were shocked and upset about the death of Child O the day before.

44. I cannot remember if any details were shared either on me entering the room or during the morning handover about the death of Child O, I only remember there being discussions relating to the care plans for the babies currently on the neonatal unit which included Child O's brothers Child P and Child R. I cannot now remember specifically which doctors or other members of staff were present at that morning handover but in my police statement [**INQ0001471_0003**] I have stated that at the time I provided my statement I remembered Doctor V and Doctor U being present. I cannot now remember any details specifically of what was discussed at that morning handover with regard to Child O, Child P and Child R so would rely on my police statement.

45. In my police statement provided in 2018 [**INQ0001471_0003**] I have stated that at that time I remembered hearing in this handover that when Child O had become unwell that his siblings had not been flagged up as being unwell and that there had not been apparent medical concerns regarding his siblings at that time. I do remember that during that morning handover on 24th June 2016 I was expecting to spend the day covering the paediatric side of the department, not the NNU. As junior trainees (SHOs) we would have been allocated one area to cover and I would not have expected to provide care on the NNU that day unless there was an emergency or clinical demand became very high in that area.

46. I remember the handover for the neonatal unit and paediatrics were held as a joint handover, with the night team handing over usually first the neonatal unit and then the paediatric ward to all those day team members coming on. During the handover, the junior doctors would usually each have a printed list of the patients with a brief summary of their clinical issues and care plan, but only for the side of the department they were expected to cover.

47. Whilst I do not have specific memories now of that handover, I would have expected to have had a written handover sheet of only the paediatric side of the department but would have listened to the night team handover the NNU to my day colleagues who were covering NNU that day.

48. I have a general memory of the mood in the handover room being one of shock and sadness that morning on account of Child O passing unexpectedly the day before. I do not now have specific memories about what was discussed in that morning handover 24th June 2016 about Child P and Child R's care. In my police statement [**INQ0001471_0004**] I have included that at the time I provided my police statement, I remembered hearing at that handover that at the point Child O had passed away, his triplet brothers had previously completed their antibiotic course started on day **PD** of life but that due to their brother's deterioration and death, they had been "re-screened" to check for infection and started on second line antibiotics as a precaution and had their feeds stopped.

49. Screening for infection involves sending sets of bloods and sometimes other samples to look for infection particularly in the bloodstream (sepsis) and then starting a patient on antibiotics. In an infant less than 3 months age, it is standard that the antibiotics started would be intravenous antibiotics and that the samples sent would include a blood culture to look for bloodstream infection (sepsis).

50. The term "second line" refers to the choice of antibiotic combination used. There are first line antibiotics chosen empirically if a baby is receiving their first infection screen as either a precautionary measure or in response to symptoms before any culture results indicate particular antibiotics should be used. If a patient becomes unwell either whilst on first line antibiotics or soon after stopping first line antibiotics, it would be standard practice to then start the patient on a different combination of antibiotics, so called second line antibiotics, on the assumption that they may have an infection which is either resistant to or has arisen despite the first line antibiotics.

51. The choice of what antibiotic combination is used as first line and second line is usually a standardised protocol for any given NNU decided between senior paediatric/ neonatal doctors and infectious diseases doctors.

52. I have said in my police statement [**INQ0001471_0004**] that at the time I provided that statement in 2018, I had remembered hearing in the morning handover on 24th June 2016 "that Child P and Child R had their feeds stopped as a result of the clinical deterioration and death of Child O". I also stated in my police statement in 2018 that "*I do not remember how any of the 3 babies had been fed or whether or not I was told this information during handover, as I had not been involved with their care at all up to this point*". I still do not have any memories now of how any of the triplet siblings were being fed prior to their feeds being stopped.

53. I have also provided in my 2018 police statement [**INQ0001471_0004**] that in preparing for my police witness statement I had had the opportunity to review the patient notes and have seen documented that staff had felt "*on 23.6.16 that Child O's abdomen had become quite full around the time he had deteriorated*". I was not involved in the clinical care of Child O and do not have any specific memories about his abdomen or feeding being referenced in the handover on 24th June 2016.

54. Whilst at the time I provided my 2018 police statement [**INQ0001471_0004**] I remembered that the handover included the information that Child P and Child R's feeds had been stopped as a result of what had occurred with their brother as described in paragraphs 52 and 53 of this current statement, I do not now have any strong memories of these discussions at the handover and I do not have any further memories about what was discussed in that morning handover on 24th June 2016 and so would rely on the statement I gave to the police in 2018.

55. I recall starting the ward round on the paediatric ward 30 assisting Dr U who was the registrar leading one ward round in that department. I cannot remember exactly what time the ward round started but most commonly the ward round started as soon as morning handover finished around 0900.

56. I cannot remember what time, but I would estimate within the first one hour of the ward round starting, I remember my bleep and Dr U's bleep activating and announcing to us that there was a neonatal emergency on the NNU. This means that a message has gone to the hospital switchboard that there is an emergency on NNU, and switchboard have then relayed that message to every bleep on the paediatric and neonatal emergency group which included me carrying the paediatric SHO bleep that day. The aim of this would be to alert clinicians to attend the department where the emergency is occurring in case more help is required in addition to those clinicians already present.

57. From my memory, doctor U and I ran round to NNU together. I remember and have provided in my statement [**INQ0001471_0005**] that we were directed into nursery 2 where Dr Ukoh was providing breathing support to a baby which I then found out was Child P. We were told by someone, but I cannot remember who, that the emergency call had been put out for Child P who was in a cot on the right hand side of the nursery as one stood with the door behind you and with the outside window in front of you on the far side of the room.

58. From my memory, Child R was in either a cot or incubator on the left-hand side of the room. This is the first time I met any of the triplet brothers. I cannot remember if there were any other babies in the room in addition to babies P and R.

59. In my police statement [**INQ0001471_0005**] I have also stated that at the time I provided that statement, I remembered that another SHO, Dr Kath Cooke, was present but that I was not sure where she was exactly when I arrived.

60. Also in my police statement [**INQ0001471_0005**] I had at that time remembered a nurse called Lucy (Letby) who I understood was looking after Child P was also present and that I thought that at the moment I arrived in room 2 on NNU that Lucy (Letby) was outside room 2. I do not have any memories now at this time of where Dr Kath Cooke or Letby were at the moment I arrived at room 2 on NNU.

61. In my memory, Dr V arrived at a similar time that Dr U and I had arrived on NNU and in my statement to the police [**INQ0001471_0006**] I stated that I thought she had arrived at a similar time but that I could not remember if she was on the NNU when we arrived or whether she arrived just behind us.

62. Also, in my statement [**INQ0001471_0006**] I have said that I suspect there were other colleagues also in the room on my arrival, but that Dr Ukoh is the only one I have a clear memory of. The same is true from my memory now that I think there will have been other colleagues including nursing staff in the room, but my only clear memory is seeing Dr Ukoh providing respiratory support to Child P as I walked into room 2 on NNU.

63. In my memory and in my statement [**INQ0001471_0006**] Dr Ukoh was providing ventilation breaths to Child P via a facemask when I arrived. For clarity this means using an oxygen and air delivery system and via a facemask applied to the baby's face, breaths were being delivered to Child P to inflate his lungs and provide respiratory support. This is usually done if a baby is either not breathing at all or is breathing but the breaths are not felt to be effective.

64. As in my statement [**INQ0001471_0006**] from my subsequent experience in neonates both at Chester and elsewhere, this breathing support equipment is usually called a Neopuff.

65. From my memory and from my statement [**INQ0001471_0006**], Dr Ukoh was keeping Child P's airway open with head positioning and delivering the ventilation breaths himself at that stage but if a baby is not breathing it would be usual to request more clinicians attend to assist if available. For example, if a baby continues to not breath or not breath effectively, there are more definitive ways to securely keep their airway open and deliver breaths such as inserting airway adjunct equipment or intubating the baby, but for these to be set up one would ideally have a larger team to optimally prepare for these procedures, continue maintaining an open airway for the baby with good head position and deliver effective ventilation breaths via the Neopuff, and to assess for other issues that may need addressing as part of the ongoing resuscitation.

66. My memory of what follows and from my statement [**INQ0001471_0006**] was that as the most junior member of the team present, I relied on being told by the senior doctors present what actions they wanted me to take and that this predominantly involved me collecting and preparing equipment requested by them, prescribing medications that they requested and at times contributing to the rotating team of clinicians providing chest compressions to Child P.

67. I remember and from my statement [**INQ0001471_0006**] that I was asked to prepare equipment for inserting an intravenous line and that I had one attempt myself to put an IV cannula into Child P's left hand but was not successful, so I then prepared equipment for my seniors who were also trying to get an IV access.

68. In my statement [**INQ0001471_0006**], I have said that I thought that several team members were trying to gain IV access. I do not have specific memories of who and how many people were trying but now would agree that gaining IV access is often a key part of resuscitating a baby so that emergency medications can be delivered, so it may well be that if available several team members attempt this simultaneously.

69. In my police statement [**INQ0001471_0006**], I have stated that either as or soon after my arrival on the NNU I remember it became necessary to deliver chest compressions to Child P which would mean that either his heartbeat was absent (his heart had stopped) or that his heart was beating so slowly that it would not support adequate circulation of blood to his body organs. I do not have a specific memory of exactly when his chest compressions were started or when and who identified that this was needed. However, I do remember that there was a rotating team of healthcare staff providing chest compressions for Child P and that I was one of the doctors allocated to do this.

70. It is usual that the role of the clinician delivering chest compressions is rotated between several people as if one becomes physically tired when delivering chest compressions then the efficacy of the compressions can be negatively impacted, so it is usual to rotate that role.

71. From my statement [**INQ0001471_0006**], I remembered at that time that Dr V was predominantly in a leader role for the resuscitation and that I remembered Dr U assisting Dr Ukoh with airway at one stage. From my statement [**INQ0001471_0007**] and from my memory, the nurse Lucy (who I can now confirm from memory is me referring to Letby) was also involved in care for Child P during the resuscitation.

72. Nursing roles during a resuscitation often include preparing and administering medications but I do not remember now and did not remember when I provided my police statement who prepared and delivered medications to Child P. I remember and said in my statement [**INQ0001471_0007**] that initially our resuscitative efforts seemed successful in that Child P's heart started beating effectively again (this is called return of spontaneous circulation and means that the heart is pumping at sufficient rate and efficiency to perfuse the vital body organs).

73. I remember that on at least a further two occasions over the next few hours, Child P's heart stopped beating again and he required resuscitation including chest compressions again on these occasions. These episodes of the heart stopping are called cardiac arrest. When I provided my statement [**INQ0001471_0008**], I said that I had judged the team response to these arrests to be swift as Child P was on a cardiac monitor which should alarm and alert staff of a falling heart rate and that from my memory there were doctors on the NNU all day so there would have quickly been a doctor in the room. However, this statement assumed that any fall in the heart rate should therefore have been picked up promptly by staff in the room and doctors alerted immediately. This was based on the assumption that all staff present on NNU that day were acting in the patient's best interests.

74. At the time I provided my statement, I did not have any knowledge that Letby was under suspicion of murdering Child P and others. Therefore, I would now reflect that the consistent staff presence in and around room 2 that I mention in my statement [**INQ0001471_0008**] would have counted Letby as a staff member who I thought at that time was working to keep the patient safe but is now known not to be the case.

75. I would now judge with the benefit of what has been made public since, that Letby cannot be assumed to have been reliably counted on to alert nearby doctors at the earliest sign of a clinical deterioration in Child P.

76. I have also stated in my statement [**INQ0001471_0008**] that I was not in room 2 myself all day particularly as one of my roles was to collect and assemble equipment for my senior colleagues which would have required me to leave room 2. On reflecting extensively since providing my police statement, I remember at least one of the subsequent deteriorations in Child P occurred when I was outside of room 2 as I have a memory of being called into room 2 having been outside by the NNU nursing station when I was alerted by staff that Child P had again gone into cardiac arrest. My memory is that Letby was in the room when I entered room 2.

77. I cannot remember who if anyone else was in the room, who called me in and what events immediately followed. I just remember that at least this one of Child P's collapses must have started whilst I was not in room 2 and that when I was called in to help as part of the team response to this, that Letby was in room 2.

78. With the benefit of hindsight, these repeated cardiac arrests with limited clues as to what the cause was, despite the senior doctors considering and addressing potential reversible causes, were unusual in their frequency, rapidity of onset and from what I remember, the initial relative stability in Child P in between the arrests.

79. At this time on 24th June 2016, I was a relatively junior doctor who had been to only a few neonatal arrests (I think two prior to Child P). In the years since, I have been part of a resuscitation team for more paediatric and neonatal cardiac arrests. In the monitored environment of an NNU I have never again since Child P attended a neonatal cardiac arrest where the cause was entirely unknown.

80. In addition, the subsequent neonatal arrests I have attended that occurred within the hospital setting either occurred immediately at the time of delivery due to factors around the pregnancy and delivery, or if they occurred on the neonatal unit they occurred after a prolonged period of clinical deterioration (in my experience usually over at least hours if not longer) despite optimal neonatal care with trends pointing towards the possibility of a cardiac arrest, such as falling blood pressure despite escalation and optimisation of inotropes (blood pressure boosting medications).

81. The rapidity of Child P's deterioration and his continued cardiac arrests despite initial successful resuscitation, but from what I remember, without gradual trends and indicators to suggest an imminent cardiac arrest were unusual to the point of being entirely unique for me now with my subsequent 8 years of experience.

82. Child P is the only patient I have seen in my career who in the immediate hours after his initial deterioration continued to have multiple sudden and repeated cardiac arrests despite successful resuscitation to the initial arrest and now with hindsight, I would say that this is unusual.

83. I remember that during the day on 24th June 2016 that the senior doctors at Chester were arranging the transfer of Child P to a tertiary neonatal unit and from my statement [**INQ0001471_0007**], I felt at the time that these arrangements had started mid-morning around 11.00.

84. In my statement [**INQ0001471_0007**], I had understood that my senior colleagues were liaising with the appropriate services to arrange transfer of Child P to an NNU that could provide intensive care level support, which would be deemed necessary in a baby who had suffered a cardiac arrest and was requiring ongoing intensive care support (including invasive respiratory support) as Child P was.

85. In my statement [**INQ0001471_0007**], I said that I believed that my seniors were liaising with the neonatal tertiary team at Arrowe Park Hospital. I now know from experience that they were likely liaising with the neonatal transport team which I believe would have included a neonatal consultant who both provide the transport service for the baby, and I think also help find the appropriate bed space on a neonatal intensive care unit which at that time could have been either Arrowe Park Hospital or the Liverpool Women's Hospital within the region.

86. At the time I provided my statement [**INQ0001471_0007**], I understood that Child P was being transferred out because he had suffered a cardiac arrest of unknown cause and because he was requiring intensive care support because of this, so therefore he would be most appropriately cared for in a tertiary neonatal unit.

87. In my statement [**INQ0001471_0008**], I have said that I remembered Dr V speaking on the phone to the tertiary neonatal team. I do have a memory at some point during the day of 24th June 2016 that Dr V was on the phone at the NNU nurses' station which was just outside and set to the side from room 2 and that my understanding is that she was co-ordinating the transfer of Child P to a tertiary NNU. In my statement [**INQ0001471_0007**], I said that I remembered Dr V primarily functioning as a leader in the resuscitative efforts but that at one point she had helped in gaining IV access on Child P.

88. This is not something I have a clear memory of but is something in my subsequent experience I would say is sometimes required during a resuscitation. Having secure IV access to administer emergency medications is a crucial part of the resuscitation so if there is any difficulty gaining this then not uncommonly the most senior doctor present will assist in the efforts to secure it even if they are the leader.

89. I cannot remember which other nursing staff were involved in Child P's care and resuscitation efforts apart from Letby.

90. In my statement [**INQ0001471_0008**], I said that at some point during the morning there was a discussion about how the team would allocate roles and that the ward round on NNU needed to continue to ensure the other patients on the unit were all reviewed and received appropriate care. I do remember that Dr Kath Cooke was there as I said in my statement [**INQ0001471_0008**] and I think she was the allocated SHO to NNU that day.

91. I remember offering to stay and help with the resuscitation of Child P so that Dr Cooke could continue with the ward round on NNU. My memory was that I think Dr Cooke looked particularly upset as she had been involved in the resuscitative efforts of Child O the day before. I remember thinking that doing two neonatal resuscitations on siblings on subsequent days would be very upsetting and emotionally exhausting for any doctor. I thought it was appropriate for me to offer to stay and be the junior member of the resuscitation team instead and in my memory, this was agreed.

92. In my statement [**INQ0001471_0009**], I remembered that a chest x-ray was done to check Child P's endotracheal tube position i.e. ensure his breathing "tube was in a good position" to adequately inflate both lungs but that this chest x-ray also revealed that baby P had a pneumothorax which is a collection of air between the edge of the lung and the chest wall which can negatively impact a baby's ventilation. I do not have specific memories of this now so would rely on the information provided in my statement to the police.

93. In my statement [**INQ0001471_0009**], I describe remembering helping Dr U to set up equipment for inserting a chest drain and that from review of the patient notes at that time, a colleague inserted a small needle to decompress the pneumothorax (let the air out) until the chest drain was inserted. I do not have specific memories of this, but I remember I did not insert the needle or chest drain myself. Although I had previously inserted chest drains on a few occasions, in the situation of a baby who has become so acutely unwell that they have suffered a cardiac arrest, it would absolutely be more appropriate that a more senior experienced colleague in the room perform that procedure.

94. In my statement [**INQ0001471_0009**], I state that I remember Dr Brearey performing a cardiac ECHO on Child P at a time during the day when he had spontaneous circulation and that my understanding was that this was part of the team's efforts to find a cause for Child P's cardiac arrests. I do not now have specific memories of Dr Brearey performing the ECHO on baby P, but I do have a memory of Dr Brearey joining the resuscitation team at one point during the day and Dr Brearey was the consultant qualified to perform neonatal cardiac ECHOs at the Trust.

95. I also remember and have mentioned in my statement to police [**INQ0001471_0009**] that during the afternoon I was asked to review Child P's brother, Child R who at that time remained in nursery 2 on the left-hand side of the room. From memory, this was a repeat review as Child R had already been reviewed by one of my colleagues on their ward round earlier in the morning.

96. My memory was that at that time my senior colleagues' efforts to stabilise and identify the cause for the cardiac arrest (s) in Child P were ongoing and that because they were siblings and both Child O and Child P having suffered collapses of unknown cause, my seniors asked me to review Child R to check for any signs of deterioration in him.

97. I do not have specific memories of my assessment on Child R but my overall memory was that he appeared well, continued on his antibiotics that had been started after Child O's deterioration and that I came away from the review feeling relieved that Child R looked well but also perplexed as to what could have caused the sudden cardiac arrests in his triplet brothers.

98. From my memory and from my police statement [**INQ0001471_0009**], I remember the triplet's parents being on the NNU soon after Child P's first collapse (i.e. not long after I arrived on the NNU). In my junior position, I believe my communication with them was fairly limited from what I remember. Whilst I do not remember the precise wording, I do remember and included in my police statement [**INQ0001471_0009**] that on one occasion I spoke to Child P's parents to update them that Child P's heart was now beating spontaneously and that we were preparing to move him to a hospital with a tertiary level neonatal unit. In my statement [**INQ0001471_0009**], I have included that we had not yet confirmed which hospital had a cot space on their NNU, but I do not remember this part of the conversation now.

99. I have included in my statement [**INQ0001471_0009**] that in the late afternoon, Child P suffered his final cardiac arrest and that at the time of my police statement, I reviewed the patient notes to see that this was at 15:15 and that at this time I assisted the team by delivering chest compressions. I included in my statement [**INQ0001471_0009**] and can remember that there was an area of red inflamed skin overlying his sternum (breast bone) which I thought at the time was due to the repeated periods of chest compressions he had required that day.

100. I remember this was noted by the team and that efforts were made to ensure optimal chest compression delivery in the correct position (which is compressing over the lower third of the sternum just below an imaginary line joining the nipples and going to the depth of about one third of the depth of the chest) but if possible, not to aggravate this area of skin. I remember remaining in the recommended location for chest compression with the thumb encircling technique but taking extra care to ensure that the pads of my thumbs were in contact with Child P' chest but not any part of my thumb nails in case this aggravated his skin any further.

101. I had performed chest compressions in two neonatal cardiac arrests that I had attended previously in my career and on another two previous occasions in cardiac arrests in young children / infants brought into A&E. I had completed my neonatal life support (NLS) course including training in chest compressions in 2015 and was compliant in my advanced paediatric life support (APLS) training. Therefore, chest compressions were something that as a technique, I felt competent to perform and had been assessed as such in my NLS and APLS courses.

102. I remember and included in my statement to the police that at some point during the afternoon the transport team and the transport consultant Dr Rackham arrived on the NNU at the Trust and from my statement [**INQ0001471_0010**], I had stated that I thought Dr Rackham arrived sometime between 1430 and 1500, although I could not now remember that time range specifically. I remember he joined Dr V in a leadership role suggesting potential interventions. I think since providing my police statement I remember Dr Rackham suggested trialling administering atropine to aim to stimulate Child P's heart rate.

103. I remember and included in my police statement [**INQ0001471_0010**] that after a prolonged period of resuscitation and chest compressions following Child P's final cardiac arrest, that Dr V and Dr Rackham started to discuss whether the interventions were now demonstrating to be futile which means that despite ongoing efforts it did not appear that we were going to be successful in bringing Child P's heart rate back on this occasion. As the most junior member of the team, I do not remember being involved in these discussions and I do not remember details of what was discussed.

104. I have included in my statement provided to the police [**INQ0001471_0010**] that at that time I remembered Child P's parents being brought into room 2 to join the discussions and that there was a request made for Child O to be brought into the room, who at that time was in a cooling cot. A cooling cot is a special cot with a cooling function that can contain the body of a baby for a time after they have passed, usually with the intention that a family can spend some time with the body of their baby. I remember that at the point that Child O was brought into room 2 with the plan that the team would then stop chest compressions on Child P, that I was not required as part of the team actively resuscitating Child P or discussing with his family, so I was in the room but standing observing from a few metres away from Child P. From my memory the parents were in the room at that time with Child O in his cooling cot, Child P receiving chest compressions and Child R remaining in his cot or incubator.

105. From, my memory the staff present were Dr V, Dr Rackham and Dr U. I think there were other members of staff present but I cannot remember them specifically and I cannot remember if Letby was in the room. I recall that at the moment my seniors decided the team would now stop chest compressions of Child P, I became very upset and started to cry visibly. I remember not wanting my show of emotion to detract from support for the family at that time, so I left room 2. I went to the back stairwell connecting NNU to the postnatal ward and I remember spending some time there sat on the stairs crying but I cannot remember how long.

106. I cannot remember being present when a decision was made to transfer Child R to a tertiary unit and that may have occurred between my seniors whilst I was out of the room. When I had composed myself, I remember returning to the NNU and being asked by someone (possibly Dr V) to prepare transfer documentation for Child R in preparation for him to move to a tertiary neonatal unit. I cannot remember the conversation precisely but I have the overall memory that I was given the impression that Child R should be moved to a tertiary neonatal unit because his triplet brothers had suffered unexplained and catastrophic collapses which had led to their deaths and if there was any chance this could happen in Child R then it was appropriate he be moved to a tertiary neonatal unit that could offer the maximum level of intensive care support.

107. At that stage in 2016 from my experience, my memory is that I presumed my senior colleagues were concerned about a potentially inherited cause for the collapses i.e. a condition that could run in families so could affect multiple siblings. I do not remember any specific conduct or comments from Letby during the resuscitation of Child P on the 24th June, except that at some stage during either the later stages of Child P's resuscitation or after his death she said something like "*I can't believe this is happening / has happened again*" or "*I can't believe I have been on for this again*".

108. I remember following the resuscitation, the staff moved for a brief meeting to the handover and coffee room on NNU which was opposite the kitchen and near the NNU entrance door. I cannot remember if staff moved there whilst I was still in the stairwell composing myself or if they moved there sometime after I had come back onto the NNU. I do remember and included in my statement [**INQ0001471_0011**] that Dr Rackham, Dr U and Lucy (Letby) the nurse were present in the meeting.

109. My memory of the conversations that occurred whilst I was in that meeting were that the intention of the meeting was to make sure the team knew what our next tasks were.

110. Reflecting back, I think I may not have been in the room for all the discussions that were had in this meeting- I believe I either joined the team after it had started or returned to clinical tasks whilst other colleagues remained in the meeting.

111. I think that it may have been in this meeting in the handover room that Letby said something *like "I can't believe this is happening / has happened again*" or "*I can't believe I have been on for this again*".

112. I also from memory believe I became aware during this team discussion that Letby had sustained a needle stick injury at some point during the resuscitation. I do not remember who I heard or overheard this from in that meeting, or the details of what was said, and I do not have any memory of the moment or situation the actual needle stick occurred. I just have a

memory of becoming aware the needle stick injury had happened during the team discussion in the handover room.

113. My memory of the atmosphere in this room was one of exhaustion and almost disbelief at what a devastating thing had just come to pass with a family losing a second child in as many days. I cannot remember precise conversations but just the general feeling of the low mood in the room.

114. From my memory following Child P's death, I was assigned the role of completing the transfer letter for Child R to move to a tertiary NNU. I cannot remember or was not present when roles were allocated to the other members of staff present.

115. I have reviewed the statement provided by Dr Huw Mayberry [**INQ0001392_0001-0007]**. From my memory, I can remember one discussion I had with Dr Mayberry about the death of the siblings Child O and Child P. This discussion, I think happened at least several days later as mentioned in my police statement [**INQ0001471_0012**].

116. The reason for this is that my memory of the discussion with Dr Mayberry was that I was driving home from a shift at the Trust in the daylight and noticed that I had a call coming through to my mobile. I pulled over in the retail park near the Birkenhead tunnel to answer the call and it was Dr Mayberry.

117. In my memory, I was driving home either from a night shift or from a standard day shift as it was bright daylight hours when I pulled over and took this call. From my memory of my rota duties, I was on long days at the hospital until at least 2100 each night on 24th, 25th and possibly also 26th June 2016 so this telephone conversation I can remember with Dr Mayberry I believe must have been on or after the date of 26th June 2016.

118. I remember Dr Mayberry was, I think, an ST3 doctor which would have made him 1 year ahead of me in the training programme. I remember I felt he was very competent and also very approachable so we had got on well and I had felt during that rotation that he was a trusted colleague that I could ask for advice as well as having an understanding of how I might feel as an SHO approaching my next job as a middle grade.

119. From my memory, we had done a number of on-call shifts together and I felt from our work together that he was organised and showed good attention to clinical detail. My memory of the phone call I took from Dr Mayberry a few days after Child P's death was that he said during one of his night shifts earlier in the week that Child P and Child O had passed away, he had been asked to review one of the triplet's abdomen's overnight due to it looking full (i.e. swollen).

120. I cannot remember from memory whether Dr Mayberry told me he had been asked to review Child P or Child O's abdomen but from my statement it appears I thought at that time that Dr Mayberry was referring to Child P. I think from my memory going back 8 years, whilst I cannot remember specific details of the conversation, that Dr Mayberry was upset in that phone conversation that the baby had later become unwell and died, and he was reflecting as to whether there were any earlier clues that the babies were going to deteriorate.

121. Again, I cannot remember specifics but from my memory of the conversation I think I was keen to reassure him that the whole team were perplexed as there had not been clear signs that Child P was about to deteriorate and that several hours after Dr Mayberry had reviewed

Child P and in the hour before he collapsed, Dr Ukoh who was a senior middle grade with a lot of experience had also reviewed Child P as part of his morning ward round and had also assessed that at that time Child P looked stable.

122. I do not recall discussing either Child O or Child P with Dr Mayberry at nighttime handovers as he started his night shifts. If Dr Mayberry was the incoming night registrar on 24th June 2016, as I was on a long day shift that day so would have been at the night handover, it is entirely possible that I may have been the doctor to tell Dr Mayberry at nighttime handover on 24th June 2016 about the passing of Child P and that I just cannot remember this conversation.

123. From my memory, I really do not think I can have been the person who told Dr Mayberry about Child O's passing at handover on the evening of 23rd June 2016. From my memory and as in my statement to the police [**INQ0001471_0003**], I returned to work at the Countess of Chester after at least a week of annual leave and non-working days on 24th June 2016 and had no knowledge of or involvement with the care of the triplets until that day.

124. From my memory, I was not in the hospital at all on 23rd June 2016 and the first time I heard about Child O's birth and also his death was in the morning handover on 24th June 2016. Therefore, I do not believe that I could have been the colleague who told Dr Mayberry about baby O on the evening of the 23rd June 2016.

125. I remember as I said in my police statement [**INQ0001471_0012**] that sometime after Child P's death, I believe at least a week if not more, I had a discussion with Dr U about whether he knew of any results from the post mortem of Child P. I believe from memory, I instigated this discussion with Dr U, as at some point during that morning during a conversation with other junior trainees, another junior trainee (I am afraid I cannot remember who) said they had heard information that one of the triplets had been found to have a liver injury.

126. Whilst I cannot remember the details of this conversation, I think it consisted of the junior trainees (SHOs) present reflecting on how the triplets had collapsed unexpectedly with no apparent warning and wondering what could possibly cause this to occur. I remember that when someone mentioned they had heard that one of the triplets had been found to have a liver injury, another junior trainee present asked if that could have been caused by chest compressions. At this stage, the trainees did not know which triplet had been found to have the liver injury, and as I had been one of a number of clinicians performing chest compressions on Child P and I did not at that time know whether chest compressions could cause a liver injury, I decided to seek out Dr U and ask his advice since he was a senior trainee and had been present during the resuscitation of Child P.

127. I do not know where the information about a liver injury had come from to one of the junior trainees and now as a more senior trainee, I would still be uncertain as to how this information was known as I now understand that post mortem results should take many weeks if not months to be fed back to the clinical team. I do not think from memory that Dr U told me any information about the post mortem or causes of the collapse in either Child O or Child P.

128. I remember being initially upset and tearful asking him whether a liver injury could be caused by chest compressions. From my memory, Dr U and I talked in one of the cubicles on the paediatric ward and he reassured me that he did not think a liver injury could be caused by chest compressions and that having been there, he was content that my technique was competent in delivering chest compressions when it was my role during Child P's resuscitation.

129. I do not remember Dr U or anybody else at any other time during my placements at Chester telling me what the cause or causes were of Child P's clinical deterioration and subsequent death.

130. Sometime much later (it may have been years later) but I cannot remember who or how I was told the information, I was told that the liver injury had been found in Child O, the sibling who I did not meet until after he had passed away and therefore, I was not involved in the chest compressions or resuscitation at any stage for.

131. Subsequently in my years since 2016, the only time I have encountered liver injury as a clinician has been in the context of major catastrophic trauma to the abdomen, but I did not have that level of experience in 2016 hence I sought out the advice of my senior colleague Dr U.

132. I also remember feeling upset that I had cried and therefore needed to leave the room when Child P's chest compressions were stopped, and his brother Child O had been brought into the room. I was worried that I had been overwhelmed by the devastating situation by crying in at a time when the priority in that moment needed to shift to caring for the family members of Child P and Child O. I remember thinking that Dr U remained collected in this situation and that I had witnessed him on this occasion and on other occasions demonstrate that he was able to continue supporting and communicating with patient's families despite stressful or very upsetting situations and I think from memory I asked him how he developed this.

133. I cannot remember the exact words of the conversation but I think Dr U answered with something to the effect of one would never stop feeling the emotion, but you learn when to keep it pent up and when to let it out. I do not remember Dr U telling me any information about the cause for Child P or Child O's deteriorations and I cannot remember knowing whether he knew about the liver injury information before our conversation or whether he was hearing this for the first time from me.

134. I do not remember being told by anyone at the Countess of Chester of a cause for Child P's deterioration and death and whilst I cannot remember if there were further informal discussions with other colleagues over time, my impression was that no further information was shared for the rest of my time at the Countess of Chester and that the cause for Child P's collapse and death was still unexplained at the point that I was contacted regarding the police investigation several years later.

135. I do not have any memories of discussing Child P's death with Letby at any stage and I do not have any memory of the events described in the Facebook Messenger exchange between Letby and Dr U on 30th June and 1st July 2016 [**INQ0000569_24-25**] other than my discussion with Dr U described in paragraphs 125-133.

136. The only conversation I remember having with Dr Mayberry about the death of Child P is that which I have described in paragraphs 115-121 of this statement. From my memory I found Dr Mayberry a supportive colleague at that time and came to consider him a friend, so it is possible that there was another conversation between myself and Dr Mayberry about how I was coping following Child P's death but that I do not have any memory of it now.

137. I remember that at the end of one of my long day shifts either on the day that Child P died, or one of the immediate days following his passing, that Dr V was the consultant on-call and

was present at the nighttime handover at the hospital which used to occur at 2030-2100 most nights. From memory, after that nighttime handover Dr V asked if I could come to her office so we could talk about Child P, and whilst I cannot remember her exact invitation to start the conversation, I think she invited me because I was very upset about it and my overall memory was that she was asking me how I was coping.

138. This is the conversation with Dr V that I have remembered when providing my police statement in [**INQ0001471_0012**]. I do not remember any details of Child P's clinical deterioration or death being discussed in this conversation. From memory, Dr V allowed the conversation to be led by what I wanted to ask and whilst I cannot remember exact wording, I think she asked me if there was anything I wanted to talk about.

139. From memory, I wanted to express that I had found being the junior member of the team helping with Child P's resuscitation and seeing him pass away incredibly distressing and I was worried about how I was to mature and develop as a doctor so that I could remain composed and task focused during such an upsetting situation. I think from memory this was again me reflecting at the time how I had become overwhelmed crying when Child P's chest compressions were stopped and had needed to excuse myself from room 2 on NNU. I do not remember specifics but I think Dr V spent the rest of the conversation reassuring me that I had a lot of training ahead of me before I would be expected to deal with anything like I had seen on 24th June 2016 and that the middle grade colleagues I had seen deal with it seemingly calmly and in a composed manner were many years ahead of me in terms of experience and seniority.

140. I do not remember whether Dr V asked me any further questions and I do not remember Dr V discussing any details of Child P's clinical deterioration or death with me. With the benefit of hindsight and what I have learnt through the course of the police trial of Letby, I now wonder whether Dr V was starting to have concerns at that stage about either the nature of Child P' s collapse or the frequency of the neonatal deaths on the NNU and whether this conversation I had interpreted as a check in of my well-being after a devastating event was also actually Dr V creating an open ended environment for me to share in case I had any suspicions myself or anything unusual I has seen that I wanted to raise at that time.

141. At that stage however, as a relatively junior doctor who had limited experience of neonatal collapse and cardiac arrests and who had only been at Countess of Chester since March 2016 so Child P' s collapse and death was the only significant collapse and resuscitation I had attended on the NNU, I did not have any suspicions to raise and it had not even entered my mind that someone on the NNU could be harming babies.

142. Apart from those described above, I do not remember attending any other discussions or debriefs (formal or otherwise) between doctors on the NNU and / or between doctors and other medical staff in respect of the death of Child P. As time went on and my experience increased, I did reflect initially that it was unusual not to be invited to attend a formal debrief relating to such a devastating event, but I had presumed that the debrief may have happened after I left the Trust to join my next placement at the start of September 2016 so thought I maybe had just not been included.

143. I cannot remember if I discussed Child P's clinical deterioration and death with my clinical supervisor at Countess of Chester or with any other colleagues informally other than those conversations that I have described above.

144. I do not remember being present when or know if without me present any discussions of concerns were raised about the similarity of the circumstances between Child O and Child P's deaths.

145. I cannot remember noticing a change in the way nurses and doctors on the NNU interacted with each other following the deaths of Child O and Child P. I was not aware until the media published details of the court trial that a member of staff was removed from clinical duties on the NNU soon after the 24th June 2016.

146. My impression and memory of that time in 2016 was that for the next approximately 2 months until I left the Countess of Chester at the start of September 2016, is that I myself felt more anxious and apprehensive when I was allocated to cover the NNU but that I put this down to me having been upset by such a devastating unexpected death of Child P despite resuscitation efforts and being apprehensive when in this same location, rather any noted change in the behaviour or interactions of other staff on the NNU.

Royal College of Paediatrics and Child Health ("RCPCH") Invited Review

147. I am afraid I do not have any memory at this time of being told about the nature or purpose of the review conducted by the RCPCH at Countess of Chester in 2016.

148. I am also sorry but I cannot remember any information about my interview with the RCPCH. I can see from the dates in the review [**INQ0010260_0029**] that it is stated that the review and therefore the interviews including mine were carried out on 1st and 2nd September 2016 which were my penultimate day and final day at Countess of Chester in 2016 before I moved to a new placement at Whiston.

149. I am afraid I have no memories of this interview with the RCPCH team. The only information I can offer is that in my memory, I only became aware that the Countess of Chester had a higher than expected rate of neonatal mortality towards the end of my placement there in 2016.

150. The only unexpected neonatal collapse and the only cardiac arrest I had been called to and therefore been involved with was Child P, so I only had experience of his one case plus my awareness that his brother Child O had passed away the day before Child P.

151. It is possible due to the timing of the RCPCH review that the process of being asked to be interviewed for this RCPCH review may have been the first time I became aware that there was a higher than expected rate of neonatal mortality on the NNU at Countess of Chester. I am afraid from my memory I cannot provide any further information with regard to the RCPCH invited review.

Response to Neonatal Deaths

152. As I mention in paragraphs 149-151, from my memory throughout most of my 2016 placement at the Trust, I was not aware that the NNU had a higher than expected rate of neonatal mortality.

153. I was deeply upset by the death of Child P and with the knowledge that his brother had passed away the day before him. At my ST2 level of training at the time, I understood that a post

mortem should find the cause and that senior colleagues would rely on this to find the causes of the boys' deaths.

154. My experience at that stage was that the consultants at Chester were thorough and I believe I would have known there was a regular perinatal M&M (morbidity and mortality) meeting covering the neonatal unit. Therefore, at my junior position then I would have thought the deaths of Child P and Child O would be explored through post mortem results and M&M review. I do not remember being aware until the end of my rotation at the Trust in 2016 of previous unexpected deaths on the NNU before Child P and Child O or that there had been an increased rate of neonatal deaths on NNU in the year before I had joined the trust.

155. At the time I was placed at Countess of Chester in 2016, I did not know that that there was available data on mortality rates and number of serious incidents on the NNU from data prepared by MBRACE-UK. At that time my only experience of using MBRACE-UK was the data collected and statistics published to provide guidance on prognosis in terms of survival and long term outcome for babies born prematurely. This guidance was something I had used as a resource when speaking to families with pending premature delivery of their babies, but I did not know that there was also data available on perinatal and neonatal mortality by Trust / Health Board at that time. This was likely due to me being relatively junior at that time.

Reviews of Deaths and Adverse Events

156. From my memory in 2016, the Countess of Chester had a DATIX incident reporting system accessible on the Trust intranet by which adverse incidents were reported and reviewed. I do not remember if I had used this DATIX reporting system myself during my placement in the Trust in 2016 but I do have memory of experience with it during at least one of my 3 placements in the Trust in 2016, 2017 or 2018.

157. I do not believe that I submitted any DATIX incident relating to the unexpected collapse or death of Child P. My memory is that at the time in 2016, I understood neonatal deaths in the Trust were investigated through the perinatal M&M meeting process. I was not from memory ever involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

158. As in paragraph 154 my memory is that at the time in 2016, I understood deaths on the NNU in the Trust were investigated through the perinatal M&M meeting process. Child P was the only neonate who I had contact with who died on the NNU during my time at the Trust in 2016 and I do not remember being involved in any investigation held by the Trust into his death or that of any other neonatal death on the NNU. I may have presumed at the time that a doctor at my ST2 level of training would not be invited to participate in such an investigation, but I believe I understood that senior middle grade trainees and consultants would contribute to investigations.

159. I believe at the time I would have thought that a post mortem would be carried out for all cases of death in babies, children and young people under the age of 18 years where there was an unknown cause of death.

160. I did not from memory attend any discussions or debriefs (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of the deaths on NNU other than the discussions referred to in paragraphs 115-142.

161. The only information I have in addition to that already provided in paragraphs 115-142, is that I have since found by going back through my educational portfolio, that some days after the death of Child P, I submitted a case-based discussion in my RCPCH eportfolio (included at **Exhibit JB1**) in which I provided my own interpretation in a brief summary of Child P's case. This was from my own junior understanding at the time and was submitted to Dr U who made feedback comments for my own further development. I do not remember writing or submitting this case-based discussion but it appears to be my own reflections and understanding of the background and what I had seen on 24th June 2016 made a few days afterwards and with feedback from Dr U. I must clarify that the case description itself was not made with access to the notes or with senior oversight but rather is my reflection and interpretation as I was then an ST2 doctor following the event.

162. My RCPCH eportfolio summary of the case (at **Exhibit JB1**) made at that time is transcribed as follows:

> "*MCTA triplets were born by semi-elective caesarian section at 33 weeks in good condition. They were transferred to the neonatal unit, screened for sepsis, established on non-invasive ventilation and IV fluids. They all remained stable for the first 48 hours, weaning down their ventilatory support, completing 36 hours of antibiotics with negative cultures and starting to establish feeds with EBM. Suddenly at* **PD** *of age one triplet deteriorated rapidly with abdominal distension, desaturation and bradycardia followed swiftly by cardiac arrest. Unfortunately he did not survive. At this point the other 2 triplets were re-screened for sepsis, put nil by mouth and commenced on IV fluids. Approximately 18 hours later on day* **PD** *of life another of the triplets had a sudden deterioration with bradycardia, desaturation and loss of cardiac output. Myself and the senior paediatric team (ST8 registrar and 2 paediatric consultants) attended the infant who was swiftly intubated, ventilated and received full resuscitation (CPR, inotropes, alkalysing agents, anti-seizure medications, multiple fluid boluses, surfactant etc). We achieved a return of spontaneous circulation on 4 occasions over the course of approximately 7 hours with periods of relative stability in between the collapses. During this time the infant was normoglycaemic, had an appropriate cortisol stress response, was relatively easy to ventilate, gained a chest drain for a small right sided pneumothorax with subsequent good expansion of right lung on CXR, had a normal ECHO and had no microbiological or inflammatory evidence of infection. Sadly after his 4th cardiac arrest despite full, prolonged resuscitation we were unable to achieve a spontaneous cardiac output and CPR was ceased, the baby then allowed to go to parents for cuddles. The remaining triplet whist clinically well at this point was transferred for tertiary level neonatal care in case of a similar episode. The two deceased triplets are awaiting post mortem for unexplained cause of death. Learning points; - Full cardiopulmonary resuscitation in an infant – Causes of sudden collapse in a premature infant – Psychological impact of an unexpected death on family and staff*". My colleague Dr U then added the following comments under the headings of "Areas of strength and suggestions for development: Comments *NLS based CPR performed perfectly. Assisted with procedures and ongoing management during resuscitation*" and "Agreed learning objectives: *Consider the impact of unexplained sibling deaths on remaining triplet*".

163. From memory I was not in the hospital at the time of any of the other unexpected neonatal deaths and would not have expected to be part of any discussions or debriefs following these other cases.

164. I did not from memory attend any discussions or debriefs following the clinical events for the babies named on the indictment and in respect of which charges for attempted murder against Letby were ultimately brought. From memory I was only in the hospital at the time of one other unexpected neonatal collapse and on that occasion I was not called to assist or be involved with the baby's care or stabilisation and I continued providing clinical care to other patients in a different area. This was Child Q as mentioned in my police statement [**INQ0001563_0001**] to [**INQ0001563_0003**].

165. From memory and from my police statement [**INQ0001563_0001**] to [**INQ0001563_0003**], I was in the hospital on the 26th June 2016, the day that Child Q suffered an unexpected collapse but I was not involved in his care at that time and didn't meet him to be involved in his care until 28th June 2016. I do not remember attending any discussions or debriefs relating to Child Q.

Awareness of Suspicions

166. I was not aware of the suspicions or concerns of others about the conduct of Letby during my time at the Trust in 2016.

167. From my memory, in Autumn 2017 I was contacted by the police team from Operation Hummingbird to inform me that there was a police investigation into the NNU at the Countess of Chester and that I would be asked to provide a statement. This was the first time from memory I had any knowledge that there was any police involvement and I believe I still did not know at that point that there was interest in any particular individual or that concerns had been raised about Letby by other staff members.

168. I cannot remember if at any point during the process of providing or signing statements to the police whether or not I learnt from them that the police investigation had been instigated due to concerns about a particular individual working on the NNU. I believe from memory that the first time I learnt that there were suspicions or concerns about specifically Letby's conduct was when the media announced that she had been arrested for the first time in 2018.

169. I did not from memory ever use any formal or informal process to report any suspicions about Letby or concerns for the safety of babies on the NNU because I did not have any concerns during my time at the Trust in 2016.

Safeguarding of babies in hospitals

170. I had been given safeguarding training and had completed the ALSG (Advanced Life Support Group) Child Protection Recognition and Response (CPRR) course for healthcare professionals in 2015. This did not from memory include any specific training of what to do where abuse is suspected on the part of a member of staff towards babies or children in hospital.

171. The (CPRR) course did from memory direct attendees to the Royal College of Paediatrics and Child Health Child Protection Companion as an ongoing resource to access for guidance in matter of safeguarding. This RCPCH companion is an extensive document, with the current edition's chapter 14 covering "Abuse in Special Circumstances", within which subchapter 14.2.6 provides general guidance on safeguarding children in hospital and subchapter 14.6.2 provides general guidance on allegations of abuse made against a person who works with

children. I have transcribed each of these subchapters in their current form in 2024 into the text boxes below.

172. Whilst I do not believe I had received specific training in this areas, I had been trained to access the RCPCH Child Protection Companion if I required guidance in areas of safe guarding and if I had experienced any suspicions myself that a child was being harmed by a member of staff (which I did not), then I could have accessed this resource for general guidance. The RCPCH Child Protection Companion is accessible online via the RCPCH website. The current edition accessible in 2024 contains the following guidance in the next 2 text boxes relating to suspected abuse of a child in hospital or suspected abuse of a child by an individual who works with children. I cannot be sure whether this same or similar advice was present in the RCPCH Child Protection Companion edition available in 2016. From referring to the current edition of the RCPCH Child Protection Companion, I can see that it was last updated in 2017 and was due for review in 2020 so I do not know if the guidance now available in 2024 was present and/or any different in 2016. Within the guidance transcribed below, I would understand the abbreviation LSCBs to refer to Local Safeguarding Children Boards. I have transcribed the guidance as it is stated in the RCPCH Child Protection Companion available in 2024;

Subchapter 14.2.6 of the RCPCH Child Protection Companion provides the following guidance;

"14.2.6. ***Children in hospital***

14.2.6.1. Children in hospital can be abused by other patients (including other children), health professionals, non-clinical staff, the child's parent/carer or family, visitors or strangers. The abuse can take various forms but incidents of physical and sexual abuse are more likely, as are other forms of maltreatment; including overmedication and inappropriate restraint and disciplinary techniques.

14.2.6.2.
Key issues
- It is essential that children are listened to and that mechanisms exist to make it easy for children to make abuse and potential abuse known
- Any suspicions must be reported to the consultant in charge of the child, senior nurse manager for the unit and the Named/Designated professional without delay
- The highest standards of privacy and dignity must be maintained and care should be provided in a location and environment that is safe, healthy, child-friendly and suitable to the age and stage of development of the child or young person
- Children should not be cared for in an adult ward
- Where there is no adolescent unit available hospitals should take the additional needs of adolescents into account and provide appropriate facilities and risk assessment of safeguarding needs
- There is a duty to inform the local authority when a child has been or will be accommodated in a healthcare setting for three months or more
- Facilities should be secure
- Policies relating to breaches of security involving the police and local safeguarding procedures should be in place
- The local authority is responsible for the welfare of children in its hospitals. Commissioners and providers are responsible for ensuring children are safeguarded."

Subchapter 14.6.2 of the RCPCH Child Protection Companion provides the following guidance;

> *"14.6.2.* ***Allegations of abuse made against a person who works with children***
>
> *14.6.2.1. Children can be subjected to abuse by those who work with them in any setting. All allegations of abuse or maltreatment of children by a professional, staff member, foster carer or volunteer must be taken seriously and treated in accordance with consistent procedures. LSCBs have responsibility for ensuring there are effective interagency procedures in place for dealing with allegations against people who work with children.*
>
> *14.6.2.2. Those undertaking investigations should be alert to any sign or pattern which suggests that the abuse is more widespread or organised than it appears at first sight, or that it involves other perpetrators or institutions. It is important not to assume that initial signs will necessarily be related directly to abuse, and to consider occasions where boundaries have been blurred, inappropriate behaviour has taken place, and matters such as fraud, deception or pornography have been involved.*
>
> *14.6.2.3. Key issues*
> *- See section 14.2.5.* (link to section on looked after children)
> *- A senior paediatrician should be involved in the paediatric assessment when professional abuse is being considered. The implications of the allegation are highly significant; both for the child, the professional and their employing body.*
> *- There is a specific procedure for investigation of professional abuse which runs alongside the child protection investigation.*
> *- Named and designated professionals will be involved in the process when a health employee is being investigated.*
> *- All organisations which provide services for children, or provide staff or volunteers to work with or care for children, should operate a procedure for handling such allegations which is consistent with the guidance.*
> *- If an allegation is substantiated, the managers or commissioners of the relevant service should think widely about the lessons of the case and how they should be acted upon.*
> *- Suspected criminal activities should be reported to the police."*

173. As mentioned above, the Royal College of Paediatrics Child Health Child Protection Companion contains the sections of general advice transcribed in the text boxes following paragraph 172 on investigating where professional abuse is suspected under the category of "abuse in special circumstances". The professional body for doctors to which I belong, the GMC (general medical council) provides guidance to healthcare professional on how to report a doctor to the GMC if there are any fitness to practice or significant conduct concerns.

174. I do not have experience of this, having never had suspicions or concerns on the part of a member of staff towards babies or children in hospital. I did not have concerns about any member of staff during my time at the Trust in 2016 or up until Letby's arrest in 2018.

175. If I had been in the situation of having concerns about safeguarding a child or baby from suspicions about abuse from a healthcare professional, I would have several potential sources of advice and help in addition to the general advice provided by the RCPCH quoted above. Who I would contact for advice and support would depend on the exact situation and the urgency.

176. Local support would include the on-call paediatric consultant at that time or the lead consultant for a named patient, the named paediatric consultant for safeguarding in the department and the named safeguarding paediatric nurse and/ or midwife in the department. Advice at this stage as a paediatric trainee could also be gained from my educational and clinical supervisor at the trust in question, or potentially a supervisor from another Trust.

177. In terms of seeking advice and help from clinicians outside the Trust in question, I would consider enlisting advice from the safeguarding team at the regional tertiary safeguarding centre and / or in the case of a neonate, the safeguarding or clinical lead for the regional / network tertiary neonatal unit.

178. In relation to child deaths, whilst I would not have had the experience to known this at the time in 2016, I now know at my current stage of training in 2024 that in addition to the Child Death Review (CDR) and Child Death Overview Panel (CDOP) that should take place after the death of anyone under the age of 18 years, there is also the potential to request a Joint Agency Review (JAR) as a co-ordinated multi-agency response involving police and social services and that deaths of sudden or unknown cause can meet criteria for a JAR. This would be another line of potential investigation if one had concerns about the neonatal deaths being due to the actions of a healthcare professional, but I would not have had this knowledge at my stage of training in 2016 and did not have any suspicions myself in 2016 whilst working at the Trust.

179. Finally, I would also be likely to seek advice from my medical indemnity provider to advise me on my duties and responsibilities with regard to raising my concerns. I did not have concerns during my time at the Trust in 2016 so did not turn to any professional body at that time. However, in 2018 once I had been made aware of the police investigation and requested to provide police with a witness statement, I did then ask the medical indemnity provider Medical Protection Society for advice in providing the statements to the police and then more recently for advice with providing a statement for the Thirlwall inquiry.

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

180. I am afraid I cannot remember whether I knew what the processes and procedures were for raising concerns within the Hospital in place in 2016, including whistle blowing and freedom to speak up guardians.

181. As mentioned in paragraph 156, I was aware of the DATIX reporting system which as I understand it can be used to report serious incidents and also to raise concerns within the hospital. As a junior trainee, my memory of the consultant team at the Trust is that they were very approachable, and I would have trusted that if I had raised a concern with any one of the paediatric consultants in the team that I would have been listened to and consideration given to my concerns.

182. I believe from memory, that at my level of ST2 in 2016, I would not have yet received training on the process used and organisations involved in reviewing a child death such as Child Death Review or Sudden Death in Infancy / Childhood (SUDI/C). I would have had some training in the completion of the Medical Cause of Death Certificate (MCCD) for adult patients and on the role the Coroner's Office could play in advising around MCCD completion for adults. I do not believe at ST2 I had yet received training or had any experience of the Coroner's Office in relation to child deaths and I believe that any training I received on this

and the other processes used and organisations involved started several years later in my training.

183. In 2016, during my time at the Countess of Chester, I believe from memory that I would have understood that concerns regarding fitness to practice or malpractice by doctors could be raised with the General Medical Council (GMC) and that concerns regarding the care delivered by a department or hospital could be raised with the Care Quality Commission (CQC). At my stage of training at ST2, I do not think I would have been aware of the process called Child Death Review, that it involved a Child Death Overview Panel (CDOP) and I would not have known the process to raise concerns to the CDOP.

184. I would have been aware that any suspected criminal activity should be reported to the police but had no experience of this directly. As I did not have any suspicions or concerns prior to being contacted the police investigation, I did not provide any information on Letby or express any concerns or suspicions to any external scrutiny bodies.

185. Once I had been contacted by the police investigation team, I provided witness statements to the police in 2018.

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

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

187. I did not raise any concerns about Letby with those with management responsibilities at the Trust as I did not have any concerns about Letby until hearing that she had been arrested in 2018.

Reflections

188. I think that if babies had been monitored by CCTV the crimes of Letby could possibly have been prevented, or at least her actions could have been stopped earlier if her earlier crimes had been captured on camera.

189. I reflect that as a healthcare professional, I would be content to work in a healthcare setting with CCTV provided that the intention of the monitoring is to ensure the safety of the patients. I understand that CCTV would be filming not just the healthcare professionals but also patients, parents and families in an NNU setting and that some families might have concerns around certain or all aspects of their time with their baby being captured by CCTV on NNU.

190. My opinion is that the potential of CCTV to prevent anything like this ever happening again justifies its consideration for inclusion on NNUs.

191. From what I have read about the police investigation and trial of Letby in the media, there are some security systems that might have prevented some of the deliberate harm that Letby caused. Security systems relating to access to drugs might have prevented or limited deliberate harm it appears was caused by administering medical drugs. For example, an automated dispensing cabinet that could only dispense drugs prescribed by a doctor, or one which required a traceable and recorded sign in for dual healthcare professionals requesting

medication at each event so that who removed what medication at what time and how much was removed could be recorded and checked, might have limited Letby's access to medications that caused harm.

192. As above, there could be safeguarding brought into the NNU process of dispensing medications by way of automated dispensing cabinets for medications that require and record staff sign in for each medication requested and / or a 2 nursing staff requirement for dispensing, drawing up, preparing and administering medications which would reduce the potential harm an individual could inflict by way of medication administration.

193. I recognise that these suggestions would entail significant resource requirements for such equipment and in view of the extra word load to have a 2 person check for each stage of drug dispensing, preparation, and administration, would require a significant increase in the number of nursing staff on NNUs. The suggestion of CCTV already made above I would personally be in support of.

194. I reflect as to whether a standardised pathway of escalation, high alert and monitoring could be designed which could be instigated if any member of staff raises concerns that a member of staff may harming patients. The pathway could for example specify that the lead clinician for the area and the safeguarding lead for the department be notified of the concern, along with a management representative for that area and an urgent meeting between the parties be completed within a set time frame.

195. Such a pathway could trigger the process by which for a specified length of time all results of certain specific blood tests completed in that department need dual sign off by 2 senior level clinicians / scientists in separate departments such as the lead paediatrician for the clinical area and a clinical biochemist (such bloods might include hypoglycaemia screen results, drug toxicology levels and/or a rise in serum creatinine enough to qualify as an Acute Kidney Injury level 3). This pathway could also necessitate that the Child Death Overview Panel (CDOP) and Medical Examiner (ME) be alerted that a concern has been raised so that it is considered in their review of all deaths in that department.

196. I would also say that the potential for healthcare staff inflicted harm on patients needs to be covered by medical and nursing education programmes. I appreciate that there will be no standard "likely presentation" or "common sign" for harm inflicted on a patient by a healthcare professional, but the possibility of it occurring and the teaching of such cases as this should form part of the training of all doctors, nurses and allied healthcare professionals who will have contact with patients and also for those with system decision making and management roles within healthcare systems.

Any other matters

Is there any other evidence which you are able to give from your knowledge and experience which is of relevance to the work of the Thirlwall Inquiry?

197. I have a further memory of performing a ward round review, transcribing blood test results, and asking a senior colleague for advice on blood test results in April 2016 for another baby named on the indictment but one for whom I was not asked to give a police statement, but feel it could be of relevance to the work of the inquiry.

198. At the time in 2016 I did not understand the results or what they could indicate, and I did not have any suspicions myself about the conduct of Letby or anyone else on the NNU. I was not aware of the concerns that others had. I was asked to review the notes for this baby as part of the police investigation in 2019 (possibly May or June 2019 from memory) and then at that time with my greater clinical experience in addition to now the awareness that there were concerns of criminal actions by a member of staff to influence how I interpreted the results, I then in 2019 realised the significance of those results.

199. When I had the opportunity in 2019 to review the notes of this baby, I was able to refresh my memory of the day in 2016. However, I have not had the opportunity to review the notes again since May/June 2019 and what follows in paragraphs 200-224 is my best recollection now of events in 2016, and my best recollection now of what I read in the baby's notes in 2019. I would be happy to provide a further statement with access to the relevant medical records if this was able to provide any more detail.

200. With the hindsight of what I learnt from the media publications during the court trial, namely that there were concerns Letby could have harmed babies by administering inappropriate medications, I now realise that I may have transcribed and asked a senior colleague for advice on a blood result that suggested someone had administered insulin to the baby.

201. I remember having contact with a mum of twins in the days before her twins were born during my early weeks at the Trust in 2016, when I provided counselling as to what care she might expect her babies to need on the NNU after they were born. I remember meeting this mum of twins whilst she was in an antenatal room on the antenatal/postnatal ward at Chester and giving her verbal information about what to expect when her twins were planned to be delivered at, I think, from memory around 33 weeks gestation. I do not have specific memories of the details of what we discussed so I would rely on my usual practice of antenatal counselling as I remember it at the time.

202. From my memory, being that mum was on the ward rather than on delivery suite, I would now interpret that memory to mean that she was not in active labour at that time but that the plan was to deliver her babies in the coming days, but I cannot remember the details of the planned delivery.

203. I do not believe from memory that I was involved with the twins' care on the day they were born, nor in their first few days of life. From memory, I had a period of annual leave around that time and my next memory is hearing from the team that that one of the twins (Twin 1) had suffered an unexpected episode where he stopped breathing whilst he was on the NNU.

204. I cannot remember the details of how I found out that Twin 1 had suffered a collapse. I cannot remember any further details and I was not from memory on shift or involved when Twin 1's collapse occurred. I have a memory of being involved with Twin 2's care some days after his twin brother had suffered the unexpected collapse. I think this date would have been in April 2016 but I cannot remember the exact date.

205. I think I remember that the day I met and became involved with Twin 2's care was a day that started with a power cut to the Women's and Children's building. I have a memory of a power cut that started during a morning handover where there was a delay in the generator providing back up power. I believe from memory that this was the day I met Twin 2, because I have a memory of when I first arrived on NNU after handover that morning, the power cut was still ongoing, so in room one of NNU the team were still using torches and my memory is that this

is when I first met Twin 2. I have not had the opportunity to refer to hospital records to confirm this memory of the power cut on that day.

206. Usually the ward round on NNU would be shared between the more senior doctor (consultant and / or a registrar) and more junior doctor (SHO), the latter being myself that day. I think from memory Dr U was the senior doctor with me on NNU that day, but this is from my memory of 2016 and I have not had the opportunity to corroborate this with any medical or hospital records. As the NNU SHO, one would expect to be carrying the delivery suite neonatal SHO bleep which means if any deliveries required a paediatric doctor to be present (such as caesarean sections, instrumental deliveries etc), then I would be contacted to attend those.

207. I remember reviewing Twin 2 as part of my ward round. I think I remember that the registrar Dr U wanted to review the other twin, his brother Twin 1 himself being the more senior doctor, as he had been the twin who had suffered the collapse at a PD of age. I remember that the twin boys were in room one of the NNU.

208. I cannot remember any specific details of my examination of Twin 2, but I also cannot remember any acute clinical concerns from my ward round review of him. From my memory of reviewing Twin 2's medical notes in 2019, I could see that in 2016 I had included a section in my ward round documentation for blood results from a hypoglycaemia screen because this baby had been affected by hypoglycaemia in his early days on the neonatal unit. I do believe from my memory of 2016, that I remember thinking I should include previous blood tests results in my ward round documentation so copied blood results from the computer into his paper notes.

209. I do not think from memory that I understood at this stage that this baby's hypoglycaemia episode had been anything particularly unexpected for a baby of his gestation. My memory is also that I believed at this time I was copying blood results that would have been already previously reviewed by a senior colleague and therefore known to the wider team into his paper medical notes for completeness.

210. My experience at that point in my training was that abnormal blood results were usually called through by telephone from the laboratory to the clinical team, so I was not expecting to be transcribing any abnormal results for Twin 2. I remember that as I copied his available hypoglycaemia blood results from the computer, I noticed that the computer displayed what the expected ranges were for the results and that the insulin reading was flagged by the computer system as being high and out of range. I cannot remember for certain at this time now in 2024 whether I noticed any computer system suggested range or flag with regard to the C-peptide result on that day in 2016. However, from memory of when I was able to view Twin 2's notes in 2019, I believe I remember seeing that on that day in 2016, I had written both the insulin and C-peptide results into the paper medical notes. I would not have been familiar in 2016 with the units or ranges used for these values and I did not know myself at that time what the normal ranges were for these results.

211. At that time as an ST2, my experience of hypoglycaemia screens was rather limited. I had not from memory been involved in interpreting the results of hypoglycaemia screens at my ST2 level. From memory, my only prior experience at that time would have been helping to take samples and request blood labels on a small number of previous cases in other Trusts when senior colleagues had requested a hypoglycaemia screen.

212. I believe from memory, I knew at that time that a hypoglycaemia screen consisted of usually a multitude of blood tests taken in the event that a patient was hypoglycaemic and that many of these blood results took a number of days to weeks to yield results. I do not remember understanding the significance or interpretation of the insulin and C-peptide results on Twin 2 at that time.

213. I do remember noticing that the insulin result was out of range on the computer programme on which they were displayed and not understanding what this meant. As stated in paragraph 210, I cannot now remember whether I noticed or documented anything with regard to the C peptide on that day in 2016. I only remember noticing when I was asked to review Twin 2's notes subsequently in 2019 for the police investigation, that the C-peptide result in relation to the insulin result suggested exogenous insulin had been given to the baby.

214. I do remember that after viewing Twin 2's results on that day in 2016, I then approached the middle grade (registrar) that day on the NNU who I think from memory was Dr U to ask him about the results. My recollection is that he was sat at the computer in room one of the NNU as I told him these results. I cannot remember if I read the results aloud to the registrar, or if I showed him the results on the computer or in the paper medical notes, but I do remember flagging these results to him and that this was the reason I went to speak to him at that time. I cannot remember what my words were.

215. I remember that as part of that discussion either he or I noticed that there was no glucose result as part of the hypoglycaemia screen. I cannot remember the exact words that the registrar used, but I remember his advice being something to the effect of; the results we had so far could not be interpreted without the glucose results and therefore the rest of the hypoglycaemia screen needed to be resulted before they could be interpreted.

216. I did not at that time understand the significance of these results and it did not enter my mind that someone could be trying to deliberately harm babies on the NNU. I had no knowledge that there was any concern from senior colleagues about unexpected collapses in babies on the NNU. No part of me considered or understood at that time that the results could indicate someone intentionally administering insulin to the baby.

217. From my memory of reviewing the notes in 2019, on that day in 2016 I had flagged in my written documentation in Twin 2's ward round note that the insulin blood results were out of the normal range and that I had also written in the C-peptide result. From memory in 2016, my understanding of hypoglycaemia screens at that time would have been that complete results took some time to come back and that it could be a number of days or weeks before we had complete results. At that stage and level of my training and experience, I did not know that it would be highly unusual for the insulin and C-peptide to result before the blood glucose result and therefore that the blood glucose result should have been back by that stage.

218. I did not understand or have any suspicion at that time that the blood glucose result could be missing rather than just not yet available or that the results suggested someone on the NNU had administered exogenous insulin to a baby.

219. If I am correct in my memory that same day described in paragraphs 205-217 was also the same day that the Trust experienced a power cut, then at this time now in 2024 my only other memory of that day is that I was then re-deployed away from the NNU for some time, due to the delay in back up power necessitating the move of the Elective Caesarean section theatre list over to the hospital's main theatres.

220. From memory, due to the long distance between these main theatres and the paediatric teams on the NNU, I was asked to remain in the main hospital theatres for the elective C-section list that day in case paediatric support was needed. I have not had the opportunity to review medical or hospital records to confirm this memory of the power cut happening on the same day, but it is the recollection that I have.

221. I cannot remember details of any other babies I reviewed on NNU ward round that day, and I am afraid I cannot remember whether we as the neonatal doctor team handed over verbally or on the written handover that the rest of the hypoglycaemia screen needed chasing for Twin 2. I do not have any further memory relating to my involvement with the Twins 1 or 2.

222. On review of the notes in 2019 at the time of the police investigation, I remember seeing in the notes that I reviewed Twin 2 when he was being prepared for discharge and I believe I remember from the notes that I finished his discharge letter. A discharge letter is populated by nurses and doctors throughout a baby's stay on the neonatal unit and is then finished by a doctor at the time they are discharged. From my memory, I believe in 2019 I saw in the 2016 medical notes that colleagues had documented that the hypoglycaemia screen was normal after I had written the hypoglycaemia results into Twin 2's notes as described above.

223. Whilst I do not now have any specific memories of seeing these documentations when I finished his discharge letter, or of completing his discharge letter, at that stage in my training I would have accepted a senior paediatric colleague's interpretation of the hypoglycaemia screen results.

224. I now understand with the benefit of hindsight from the trial and also from my greater experience with hypoglycaemia screens that it was highly unusual for the blood glucose result to not yet be available when the insulin and C peptide were resulted and that actually the blood glucose result may have been missing rather than not yet available. I also now understand, with the years of experience I have gained since both clinically and through the police investigation and trial, that a high insulin and a low C peptide result indicate exogenous insulin administration and that in the context of an NNU patient who has never been home and is not prescribed insulin for any reason, that deliberate harm on the part of a healthcare professional is a possible cause.

225. As stated above, I have not had the opportunity since 2019 to review Twin 2's medical notes so paragraphs 201-223 are provided from my best recollection now in 2024 of the day in question in 2016 and my memory of what I read in Twin 2's notes having been requested to do so by the police investigation in 2019. I would be happy to provide a further statement with access to the relevant medical records if this was able to provide any more detail.

226. I have reviewed my statements and do consider these accurate but wish to provide the following clarifications:

    a. With regard to the audio recording of my witness interview with Cheshire Police on Child P, Child R and Child Q on the 11th June 2018 **[INQ0007509_0001** to **INQ0007509_0048].** I would say that the written statements provided to Cheshire Police on Child P and Child R [**INQ0001471_0001** to **INQ0001471_0012**] and on Child Q [**INQ0001563_0001** to **INQ0001563_0003**] constitute the clarified documents of the audio recorded interview and therefore the written police

statements themselves and this statement for the Thirlwall inquiry constitute the clarification of the audio record interview [**INQ0007509_0001** to **INQ0007509_0048**]. The only additional clarifications I would wish to highlight are that firstly, in some places for my previous hospital placements [**INQ0007509_0044-0048**], the Trusts in question have been redacted as "sensitive and irrelevant" but in other places their names have been left visible. This information should either be fully redacted as "sensitive and irrelevant" or included. It needs to be consistent. I note that at the start of this Thirlwall inquiry I have been asked to list my previous placements including location. Secondly on page [**INQ0007509_0025**] of my audio interview, I would reiterate the clarification made in my written police statement that whilst in my memory the healthcare team had not left the NNU during the afternoon, that I was not in room 2 at all times myself so I could not say whether or not a doctor was present at all times in room 2. Also, that at the time I provided my audio interview in 2018 I did not know there were any suspicions or concerns regarding Letby and therefore at that time I would have considered her as part of the healthcare team providing consistent care to Child P which I now understand she cannot be reliably considered to have done (as previously clarified in paragraphs 73-77 of this statement). Finally, I would also like to clarify in my audio statement [**INQ0007509_0007**] lines 4 and 6 of that page I am trying to describe that routinely every baby on a neonatal unit would have a clinical review including in almost all circumstance, an examination by a clinician every day. Otherwise, I would say that my written police statement and this statement for the Thirlwall inquiry already contain any necessary clarifications to my original police audio interview.

b. With regard to the written statement provided to Cheshire Police on Child P and Child R **[INQ0001471_0001** to **INQ0001471_0012].**

    i. On page [**INQ0001471_0003**] in the penultimate paragraph I wish to clarify the wording of my statement "*in the position of junior we are generally paying attention to the side we are covering*". I would clarify that from my memory of handover at the Trust at that time, the different incoming junior day team members covering each different area of the department (paediatric ward, NNU, children's observation bay and postnatal wards) are all present and quiet allowing the night team to handover each area to the relevant team members.

    ii. My phrase "*paying attention*" was meant to reflect that the junior trainee doctors present would usually only have in front of them the written handover sheet and patient list for the area they were expecting to cover that day and therefore would usually only make their own notes of jobs, important clinical or safeguarding points on the patients of the area they are expecting to cover that day.

    iii. The day team are quiet and listening to the night team and consultant throughout the handover so I would still have had the opportunity to listen to the verbal handover for the NNU even if I would not have expected to have the written list of NNU patients or be taking notes, as I was not expecting to cover the NNU area that day.

iv. Next to clarify is on page [**INQ0001471_0004**] when I have included in my statement "*it is a standard procedure if a twin or triplet had become unwell then precautionary measures would be taken with their sibling*". In this statement I am referring to patients in the newborn period where factors such as genetics, conditions inside the uterus (womb) and the situation of the delivery might be expected to affect babies from the same multiple pregnancy (twins, triplets etc) in the same or similar way in early life.

v. It would mean in my experience at that point in 2016 and now, that it is standard practice if particular concerns such as infection are felt for one sibling of a multiple pregnancy in the first few weeks of life, then precautionary investigations and treatment are often instigated in other babies born from the same pregnancy even if those other babies appear well.

vi. With regard to any further clarifications, I wish to make for my police statements on Child P and Child R, these are all described in paragraphs 42-146 of this statement for the Thirlwall Inquiry.

c. With regard to my written statement provided to Cheshire Police on Child Q **[INQ0001563_0001** to **INQ0001563_0003].**

i. I would clarify that in paragraph 5 on page 1 of this statement [**INQ0001563**] when I state "*would see him to ask him for advice*" with "him" referring to Dr U, my memory was that this was to ask Dr U for advice regarding other patients that I was involved with that day, not Child Q as from memory I was not involved with the care of Child Q that day. I would clarify that in paragraph 7 of this statement [**INQ0001563_0002**] when I state that I have seen from review of the notes that Child Q was being reviewed on ward round by my consultant that day Dr Saladi and that I was documenting notes for Dr Saladi, this would mean that Dr Saladi as the senior clinician was performing the review, examination and formulating the daily plan for Child Q and that I was in the role of documenting his review and plan in Child Q's notes.

ii. In paragraph 14 on page 3 of my police statement [**INQ0001563_0003**] I have stated that I believe I reviewed or was part of the reviewing team for baby Q on average once a week over the 3 subsequent weeks he was on the NNU at the Trust. I would clarify that this was an attempt to give a broad picture of the frequency with which I interacted with Child Q on NNU but not intended to describe a specific number of times I was involved in his care.

iii. I cannot remember without referring to Child Q's medical notes how many times specifically I interacted with or was involved in his care in his time on the NNU. I have no amendments or further clarifications to mention.

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

Request for documents

228. With regard to any documents or other information which are potentially relevant to the Inquiry's Terms of Reference, as described in paragraphs 161 and 162, some days after the death of Child P, I submitted a case-based discussion in my RCPCH eportfolio in which I provided my own interpretation in a brief summary of Child P's case. This was from my own junior understanding at the time and was submitted to Dr U who made feedback comments for my own further development.

229. I have found this documentation in preparing for this Inquiry and have appended it to this statement as **Exhibit JB1.**

230. As stated in paragraph 161, the case description itself was not made with access to the notes or with senior doctor oversight but rather is my reflection and interpretation as I was then an ST2 doctor following the event.

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 and honest belief in its truth.

Signed: PD **Dr Jessica Burke**

Dated: 29.5.2024