Witness Name: David Semple
Statement No: 1
Exhibits: DS1
Dated: 6 June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DAVID SEMPLE

I, David Semple, will say as follows: -

Personal details

1. My full name is David Mark Semple.

Medical Career and employment at the Countess of Chester Hospital

2. My qualifications are MBChB which I was awarded by The University of Glasgow in 1988. I became a Member of the Royal College of Obstetricians and Gynaecologists (MRCOG) in 1994 and became a Fellow (FRCOG) in 2007. I am also a Member of the British Society for Colposcopy and Cervical Pathology (BSCCP) and a Member of the British Gynaecological Cancer Society (BGCS). I have an MA in Medical Law and Ethics from the University of Swansea (2006).

3. I have been working in Obstetrics & Gynaecology ("O&G") since 1991 and worked as a Locum Consultant in O&G from 2001 to 2003. I was employed as a Substantive Consultant in O&G at Leighton Hospital in Crewe from June 2003 to 2006. I have worked as a Substantive Consultant in O&G at The Countess of Chester Hospital NHS Foundation Trust ("the Hospital") from June 2006 to present.

4. In 2015 and 2016, I was working as a Consultant in O&G at the Hospital. At that time, I was also the Divisional Medical Director for Planned Care.

Divisional Medical Director (Urgent Care)

5. In 2015 and 2016, the Hospital was structured into two clinical divisions, Planned and Urgent Care. At that time, Planned Care included all the surgical specialities, the non-acute medical specialities as well as O&G. Urgent Care included all the acute medical specialities, the Accident and Emergency Department as well as Paediatrics and Neonates. The Neonatal Unit ("NNU") sat within Urgent Care and was managed by their management team.

6. I started as Divisional Medical Director for Planned Care in July 2012. The main objectives of the role, based on the job description, were as follows:-

   a) Overall medical leadership of the Division;

   b) Ensure the Trust's strategic vision was embedded in the Division;

   c) Drive service and quality improvements and innovation;

   d) Ensure a system was in place for effective appraisal for medical staff and to ensure medical productivity was maximised;

   e) Manage budgets effectively; and

   f) Ensure a system was in place for the investigation of serious incidents and appropriate governance structures were in place.

7. As Divisional Medical Director for Planned Care, I chaired the Divisional Governance Board and became the Associate Medical Director for Quality and Safety in March 2017. The Divisions co-operated with each other via discussions at Management and Quality Meetings, as well as informal meetings between the Divisions and meetings with the Divisional Medical Directors and the Medical Director.

8. During 2015 and 2016, I sat on the Quality, Safety and Patient Experience Committee ("QSPEC") which met monthly and had replaced the previous Quality, Performance and Compliance Board in 2013. I sat on the committee as the Divisional Medical Director for Planned Care (representing the Division).

9. The remit of the QSPEC was to monitor the Trust's quality strategy, monitor contract performance with regards to quality, monitor compliance with external standards set by the Care Quality Commission ("CQC"), monitor serious incidents, review the Trust's risk register, gain assurance from the Divisions on quality and monitor trends regarding patient experience as based on its Terms of Reference.

10. I attended a meeting of the QSPEC on 20 July 2015 (**INQ0003211**). The issue of the divisional structure across Planned and Urgent Care was discussed as it was felt to be a possible hindrance to the maternity/neonatal/paediatric services. At a further QSPEC meeting on 14 December 2015 (**INQ0003204**), I said that it was essential that Paediatrics and Neonates should be in the same structure as Obstetrics going forwards. I had always felt that O&G plus Paediatrics and Neonates should be together under the same management structure as they are intrinsically linked from an operational and strategic perspective.

11. In 2012, I spoke out against the move to two divisions from three, which effectively meant the end of a Women's & Children's Division ("W&C"). We were put under pressure to choose between keeping Obstetrics and Neonates together in Urgent Care with Paediatrics and Gynaecology going into Planned Care or putting O&G together in Planned Care and Paediatrics and Neonates into Urgent Care. As an O&G team, we felt that we must stay together as we needed to be managed by the same team from an operational and governance perspective. Despite O&G being split from neonates and paediatrics, the existing Women's & Children's Governance Board continued.

12. I do not consider the way in which Maternity and Neonatal services were structured across Planned and Urgent Care had any impact on the way in which the increased mortality rate in the Neonatal Unit and suspicions about Lucy Letby were dealt with. The initial concern over the increased mortality rate was discussed at the Women's & Children's Governance Board and QSPEC. Individual cases would have been discussed at the perinatal mortality meetings.

13. During 2015 and 2016, I also chaired the Planned Care Divisional Governance Board as well as the Planned Care Clinical Committee. In addition, I sat on the Planned Care Divisional Committee, the Corporate Directors Group, and the Finance & Integrated Governance Board as well as QSPEC.

14. An obstetric review of neonatal deaths and stillbirths from January to November 2015 was discussed at the QSPEC meeting in December 2015 (**INQ0003204/3222/3251**). The plan was for this to be reviewed at the W&C Governance Board and for monitoring of the action plan. A further thematic review of the cases from a neonatal perspective was completed by Dr Brearey in February 2016 and discussed at the W&C Governance Board in June 2016. Minutes from this meeting were received and noted at QSPEC in August 2016. At the August QSPEC meeting a Neonatal Unit Briefing paper was tabled by Alison Kelly. I did not attend the August QSPEC meeting, I presume due to annual leave.

15. The relationships between clinicians and managers during this period was reasonable but occasional tensions occurred. The relationships between medical professionals including doctors, nurses, midwives, and others at the Hospital were generally good. I do not consider that professional relationships affected the management and governance of the Hospital in 2015 and 2016.

16. Lessons learned about adverse incidents or deaths in the Hospital were identified through departmental mortality reviews and the Divisional Governance Boards through to the QSPEC. I was not involved in any discussions with local networks about adverse incidents or deaths of babies.

17. Cases involving deaths on the NNU would all have been discussed at the Women's & Children's Perinatal Mortality Meeting. Prior to that there would have been formal review of the cases by the paediatric and obstetric teams. Doctors participated and led the reviews.

18. I was aware of a rise in mortality in the NNU in 2015/2016. I was first made aware of concerns about a member of staff in May/June 2016 in a meeting, but I cannot remember the exact date this took place.

19. The mortality review process was discussed at the QSPEC meeting on 14 December 2015 **(INQ0003204)**. The discussion centred around the proposed new mortality review process. I was aware of the mortality review process introduced in 2013, which set out that all deaths were to be reviewed by teams comprising a Consultant and Senior Nurse and quarterly mortality review reports were to be received by the Board of Directors. I was aware of

significant slippage in the timelines of the reviews, hence the planned new mortality review process. It was agreed that the Medical Director would review all deaths and that the QSPEC were to receive a quarterly detailed report on mortality which was also to go to the Board of Directors, which did happen in practice.

20. I was aware of the "Neonatal and Still Birth Review" presented by Ms Fogarty at the QSPEC meeting held on 14 December 2015 **(INQ0003204)** and I read the review. I understood that this review of Neonatal deaths and still births at the Trust, during January to November 2015, would be taken through the correct governance structure within the W&C Governance Board.

21. I was aware that Dr Stephen Brearey was also conducting a Thematic Review of Neonatal Mortality in February 2016 and had brought in an external expert, Dr Nim Subhedar, a Consultant from Liverpool Women's Hospital, to aid with this review. As a Divisional Medical Director, I was aware and would have expected to have been made aware of a review of this nature involving an external Consultant. I saw a copy of the Thematic Review report. I did not discuss the issues arising with Dr Brearey as it would have been discussed and actioned via the W&C Governance Board which, at the time, I did not attend.

Concerns about Lucy Letby

22. I became aware of concerns about Lucy Letby at a meeting early one morning with some Consultant Paediatricians, some Consultant Obstetricians and Neonatal Nurses/Managers. I am unsure of the exact date of this meeting. I did not raise concerns with Senior Management at the Trust as I was aware that concerns had already been raised by the Paediatric Team and they had far more knowledge of the issues/concerns than I did.

23. I became aware of the unexpected deaths of Child O, on 23 June 2016, and Child P, on 24 June 2016, around the time they died or certainly within a few days. I was not aware at the time of Dr Stephen Brearey and/or Dr Ravi Jayaram expressing concerns that these deaths may have been caused by Lucy Letby.

24. I attended a meeting along with other Consultants, the Executive Team and Sir Duncan Nichol on 30 June 2016. I am aware that the handwritten record (**INQ0014258**) of the meeting suggests that Dr Jayaram raised a concern that there was "*potentially a member of staff*

causing concern. Recurring theme". There appeared to be a reluctance from the Executive Team to go to the police at that time. The plan was to undertake a review in the following 2 weeks whilst Lucy Letby would be on holiday, with a definitive plan to be made regarding possible exclusion or police involvement. I asked on 3 occasions for assurance that after a 2-week "deep dive" of Lucy Letby's work whilst she was on holiday, that if there were serious concerns, that appropriate action would be taken. In the meeting, I was assured that action would be taken after two weeks. I did not attend any further meetings and did not receive any response.

25. I have been asked for my view on approaching the police at this stage. I understood that Lucy Letby was on holiday for two weeks and plans were being developed on action to take following her return. I recall that the possibility of informing the police was an option being considered. I am not an expert in neonatal care. I felt that babies needed to be protected by removing her from the NNU whilst investigations took place. I recall feeling concerned that there didn't seem to be a proactive plan to address these concerns when Lucy Letby returned form holiday.

26. I was not at any follow-up meeting to check what actions had taken place. I did not provide any information to external agencies nor raise concerns as I did not have all the details of the concerns raised. I trusted my paediatric colleagues who had all the information and expertise and would raise their concerns as appropriate.

Downgrading of Neonatal Unit

27. On 7 July 2016, I was copied into an email regarding the downgrading of the NNU (**INQ0002691**). The reason to downgrade the Unit was due to concerns around the rise in mortality which was unexplained at that time, despite Obstetric and Neonatal reviews, including the external review. I agreed with this decision.

28. I was not involved in the decision to move Lucy Letby off the Unit to a clerical role on 18 July 2016. I cannot remember when I was made aware of this, but it would probably have been around that time. I agreed with the decision to move her to a clerical role, but not the decision to put her in the Safety and Quality Team. I was not involved in Lucy Letby's grievance process.

29. I recall the meeting at which Eirian Powell referred to an incident where Jim McCormack said to her that she was "*harbouring a murderess on the Neonatal unit*" (**INQ0002879**). This was factually incorrect. I recall him asking the question "*Are you telling us we are harbouring a murderer in our department?*". He did not, in my view, make any accusations but was asking a general question. It seemed the Executive Team/Management placed more credence on Lucy Letby's word and her nursing management team rather than the Paediatric Consultant body.

30. I think that Lucy Letby should have been taken off the NNU, with immediate effect, after suspicions were raised and discussed at the meeting chaired by Stephen Cross (**INQ0014258**) after she returned from holiday (the 2-week review time). The Executive/Management Team and/or Paediatric Team would then have time to work out how best to go forward regarding police involvement or other external reviews.

31. I was not involved in any meetings thereafter, that I can remember, (**INQ0014258**) where this was discussed. I trusted my Paediatrician colleagues to continue to raise their concerns as they were more aware of the evidence of concern against Lucy Letby.

Royal College of Paediatrics and Child Health (RCPCH) review

32. My understanding was that the purpose of the RCPCH review was to look at the service as a whole and to examine the deaths to look for themes or any issues that may have been missed on previous reviews. I was not involved in this review. The report was received at the QSPEC in February 2017. I was asked to help coordinate the resultant action plan, along with the paediatric/neonatal team, the draft of which was received at the QSPEC meetings in March and April 2017. I forwarded the completed action plan to the Executive Team on 1 December 2017. I attach to my statement marked **EXHIBIT DS1**, a copy of the action plan and my email to the Executive Team attaching it.

(INQ0101327)

Informed of Police Inquiry

33. I attended a briefing from Tony Chambers, on 16 May 2017, in the boardroom regarding the fact that police had been contacted and were helping to "*exclude any unnatural causes*" (**INQ0003079**). I was not involved in any decision to contact the police, but I felt a sense of relief that finally concerns had been listened to.

Risk Registers and Clinical Risk within the Trust

34. As Divisional Medical Director for Planned Care, I chaired the Planned Care Governance Board and sat on QSPEC. I would have been involved in the clinical risk/risk registers within Planned Care.

35. The evaluation/investigation of the rise in mortality in the NNU in 2015/16 was reviewed by clinicians (**INQ0003222** & **INQ0003251**). Individual cases would have been discussed at the combined Women's and Children's Perinatal Mortality Meetings although I do not have minutes from these meetings.

36. At the QSPEC meeting, on 15 May 2017 (**INQ0003206**), Julie Fogarty attended in her new role as Interim Director of Risk and Safety, and she was reviewing the Safety & Quality Team and the processes they had in place. Although I had knowledge of this, I was not actively involved in the review.

37. On 16 June 2017, as the Associate Medical Director with a remit for Quality and Safety, I sent an email to all the Consultants in Planned and Urgent Care (**INQ0006771**) stating; "*Please be assured that Julie Fogarty (Interim Associate Director of Risk and Safety), Mel Kynaston (Associate Director of Nursing) and I are acutely aware of on-going concerns around clinical risk within the Trust. To put it mildly we have inherited a mess*". In my opinion, this situation had arisen due to poor leadership within the Risk Team and poor oversight from the Executive Team.

38. The approach to risk within the Trust was to respond to issues raised by external agencies such as the CQC, but external agencies would not have actual input into the day-to-day risk work within the Trust.

39. Following my appointment I, along with the new Risk Team Leader, Julie Fogarty, attempted to change the approach to clinical risk and risk and safety management by taking the following steps:

    a) Tried to ensure members of the Risk Team were not on short-term secondments;
    b) Tried to ensure appropriate feedback on Datix/incidents was provided to frontline clinical staff in a timely manner;

c) I organised 3 rounds of externally led Root Cause Analysis (RCA) investigation training for approximately 80 members of staff (both clinical and managerial) to ensure no-one was asked to lead a serious incident review without appropriate training. The RCA training led to a better standard/level of Serious Incident report writing;
d) No-one was named in an incident review action plan without being informed beforehand;
e) Attempted to better disseminate learning from incidents;
f) Improved liaison with the Medical Education Team in relation to trainees involved in incidents to ensure appropriate support and learning;
g) The committee structure was already embedded, but I started to attend the Urgent Governance Board.

Safeguarding of babies in Hospitals

40. I attend safeguarding training as part of my annual mandatory training. I do not recall receiving any specific training regarding situations where a member of staff is suspected of harming babies or children in Hospital. I was aware of the Child Death Overview Panel process, but I have had no training in this and have never been involved in any such cases.

41. I was not aware of Appendix 6 of the Trust's Disciplinary Policy regarding "*Consideration of Referral to the Local Authority Designated Officer*". I did not contact the Local Authority Designated Officer and I am not aware if anyone else did.

Reflections

42. I do not think there are any steps that could have been taken to earlier identify that Lucy Letby was harming babies on the NNU. I think the Paediatricians raised concerns as early as they felt able to.

43. I consider that if the babies had been monitored by CCTV, the crimes of Lucy Letby could have been prevented. I am aware that CCTV was considered in the July 2016 Action Plan, but I am not aware if this was ever actioned.

44. I consider the Inquiry should make the following recommendations to keep babies in NNUs safe from any criminal actions of staff:
    a) Verify all staff members, for example, up to date DBS checks;

b) Ensure all mandatory training is completed;
c) Ensure the environment is in line with national requirements and that there are appropriate levels of staffing and equipment;
d) Ensure appropriate senior supervision at all times; and
e) CCTV for all cots.

Requests for documents

45. I do not have any documents or other information which are potentially relevant to the Inquiry's Terms of Reference.

Statement of Truth

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

Signed: PD

Dated: 6.6.2024.