Witness Name: Dr Astha Vasudeva Soni
Statement No.: 1
Exhibits: AVS1-3
Dated: 12 June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ASTHA VASUVEDA SONI

I, Dr Astha Vasudeva Soni, will say as follows: -

Medical career and employment

1. I am a Registered Medical Practitioner, GMC number PD I was awarded my primary medical degree, MBBS in March 2003 from the Government Medical College, Patiala, Punjab, India. I undertook my medical studies at the Baba Farid University of Health Sciences, Patiala, Punjab, India. I enrolled on the degree course in 1997 and completed it in 2002 with my degree being awarded in March 2003. I also undertook internship between January and December 2002 at the Rajindra Hospital, Patiala and then a House Officer placement for 6 months at the General Hospital, Chandigarh from 1 January 2003 to 30 June 2003. I obtained my membership from the Royal College of Paediatricians and Child Health (MRCPH) Part 1 January in 2006, I completed the written Part 2 in January 2007 and the clinical Part 2 examination in October 2008.
2. I have undertaken my paediatric training in the UK and set out details of the posts and hospitals I have worked in below:

   February 2005-August 2005 Senior House Officer (Trust Grade) Paediatrics, Barnet General Hospital (Hertfordshire)

   August 2005-August 2006 Senior House Officer (Trust Grade) Paediatrics, Scunthorpe General Hospital (Lincolnshire)

   August 2006-February 2007 Senior House Officer Neonates, St Helier Hospital and Queen Mary's Hospital for Children (Surrey)

   February 2007-August 2007 Senior House Officer Paediatrics, Queen Mary's Hospital for Children (Surrey)

   August 2007-February 2008 ST2 Paediatrics, Heartlands Hospital (Birmingham)

   February 2008-August 2008 FTSTA2 Paediatrics SSHO, Stafford General Hospital (Staffordshire)

   August 2008-February 2009 FTSTA3 Paediatrics, Birmingham Children's Hospital

   February 2009-June 2009 FTSTA3 Paediatrics, Alexandra Hospital (Worcestershire)

March 2010-February 2011 ST4 Neonates (WTE 0.66), Queen's Medical Centre, Nottingham

August 2011-August 2012 ST4 General Paediatrics (WTE 0.6), Countess of Chester Hospital (the "hospital")

August 2012-February 2013 ST5 Community Paediatrics, Ormskirk General Hospital (Lancashire)

February 2013-February 2014 ST6 Paediatric Endocrinology and Diabetes, Alder Hey Children's Hospital, Liverpool

February 2014-September 2014 ST7 Paediatrics, Ormskirk General Hospital (Lancashire)

September 2014-March 2015 ST7 Paediatric Diabetes, Ormskirk General Hospital (Lancashire)

March 2015-September 2015 ST8 Paediatrics, Whiston Hospital (Merseyside)

September 2015-March 2016 ST8 Paediatrics, Countess of Chester Hospital (the "hospital")

3. Since March 2016 I have been employed at the Sheffield Children's Hospital as a Consultant General Paediatrician with a specialist interest in diabetes. I undertook training as a speciality trainee in diabetes and endocrinology but my work as a consultant general paediatrician has been in diabetes and therefore, I no longer consider myself to have a specialist interest in endocrinology, only diabetes.
4. I was a speciality trainee (ST8) at the hospital from September 2015- February 2016. I have worked at the hospital previously from August 2011 to August 2012 as a part time (0.6 whole time equivalent) ST4 specialty trainee. I had no management or additional responsibilities in either role.
5. I completed my posting at the hospital in March 2016 and joined my current job at Sheffield Children's Hospital NHS Foundation Trust. I joined as a consultant paediatrician in general paediatrics with specialist interest in diabetes. I am currently employed at Sheffield Children's Hospital NHS Foundation Trust in the same role.

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

6. Between September 2015 and March 2016, my managers would be paediatric consultants working within the unit at that time. My direct line of reporting would be to the on-call consultant or consultant covering NNU.
7. In terms of the relationships between clinicians/nurses and managers and between medical professionals, there was nothing out of ordinary and I did not note anything. The seniors (consultants) were all very supportive. As trainees we felt that supervision was adequate and we could ask for help and advice when needed.

8. I do not believe the quality of relationships on the NNU affected the quality of care being given to babies on the NNU. I was not aware of issues with the quality of relationships on the NNU at the hospital.
9. I did not find the culture in the hospital was different to any other unit I had worked in before. I found the culture similar to other hospitals I had worked in as a trainee.
10. I had no concerns about working relationships at the hospital and I was not aware of any problems. The hospital's paediatric department was a popular place to work. We as trainees had a lot of respect for the consultants and they were all very supportive.

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

Child F

11. I have provided a number of witness statements as part of the police investigation in relation to babies whose care I had been involved with. As far as I am aware, I was not asked to provide any statement in relation to Child F as I was not involved in his care.

12. I have reviewed an email from Doctor ZA to Dr Brearey dated 6 June 2017 (INQ0005890), the extract of the records dated 13 August 2015 (INQ0000859_0039) and the report of the test results dated 12 August 2015 (INQ0000859_0334). I started my posting at the hospital in September 2015 after this result was reported. I do not remember seeing this particular report subsequently or having any knowledge of this child.

13. During my posting, I did manage a few neonates with hypoglycaemia and as per my normal practice, I would have sent a hypoglycaemia screen for a child with low glucose and unexplained hypoglycaemia when clinically indicated at the time of a hypoglycaemic event. A hypoglycaemia screen requires a number of blood tests to be requested but I would not request more than one hypoglycaemia screen for the same baby if one screen has already been sent. I have provided a statement to the police in the case of baby I&S who had recurrent hypoglycaemia and high glucose requirements and where I did request a hypoglycaemia screen. I exhibit that witness statement as Exhibit AVS1. In I&S's case, I do not recall receiving the C-peptide results as these took some time to be reported. Referring back to the statements I had provided, there were two other babies I&S and I&S who had hypoglycaemic episodes. I have provided these witness statements as Exhibits AVS2 and AVS3. In these cases also, I do not recall receiving c-peptide results. I am not able to remember any other babies where I requested hypoglycaemia screens but my entries in their notes would have indicated my involvement at that time.

[INQ0102022, p1-7]

[INQ0102022, p8-20]

14. The email sent to Dr Brearey is from June 2017 almost 2 years later so I am not sure if the doctor writing has misremembered. I do not recall seeing any high insulin results or c peptide results that suggested the presence of exogenous insulin where none was prescribed or having discussion about them. I think if I had discussed it I would remember as it would have been of significance or concern and I would have discussed with the consultant and also with Alder Hey endocrine department as almost all cases of persistent hyperinsulinaemia were managed by them as the tertiary centre.

15. As said above, I did send hypoglycaemia screens for the babies with hypoglycaemia at the time of a hypoglycaemic events but I do not recall being told of any high insulin results or c-peptide results.

16. As c-peptide was low with high insulin levels in Child F when tested in August 2015, that would indicate that insulin found in the blood was not endogenous insulin that had been produced by the baby. If high insulin is because baby had been making insulin, c-peptide and insulin levels both should be raised. Raised insulin levels with low c-peptides are suggestive of exogenous (administered from outside) insulin.

17. I am not able to identify the baby Doctor ZA is referring to in her email to Dr Brearey. I was not working at the hospital at the time Child F's results were reported. I do not remember discussing this report subsequently with anyone including Doctor ZA.

18. I do not recall being aware of any concerns and/or suspicions being raised due to blood results showing high levels of insulin or c-peptide results indicating exogenous insulin whilst I was posted to the hospital between September 2015 and March 2016.

Child G

19. I have reviewed the extracts of Child G's case notes (INQ0000272_3153-3158), nursing records (INQ0000272_3225-3235) and the witness statement of Dr Gibbs dated 7 December 2018 (INQ0000339_0001-0019). I have not previously been asked to provide a statement in relation to my involvement in Child G's care.

20. I do not have any recollection of my involvement in Child G's care and am reliant on the entries I made at the time and my usual practice.

21. In the case notes, I have made an entry on 25/09/15 at 2030. It says ATRP which means that I was asked to review the baby (patient) because they were having desaturations. That means that baby was dropping their oxygen levels. This is usually picked up on saturations monitor. Some of the desaturations were self-correcting i.e the oxygen levels were dropping but coming up without any interventions. As per my notes, one of the

thoughts were that baby had possible gastroesophageal reflux. I have also mentioned that baby had some temperature instability. Their temperature fluctuated between 36.6-36.9 degrees and the Baby needed 5 blankets to warm them up. Bloods were sent earlier in the day due to baby needing 5 blankets to maintain their temperature and results have been written by Dr Fielding in the entry above mine at 2020.

22. I examined the baby and have written that baby was pink, well perfused and they were handling appropriately. Baby was already on antibiotics (cefotaxime). So, in my clinical impression, the desaturations were likely to be due to reflux. My plan was if they were to deteriorate clinically, to reculture and change their antibiotics. I have also written in plan about repeating their CRP (C reactive protein) in the morning.

23. The next entry by me is from 26/09/15 at 9.45am when I have seen the baby on my morning ward round. I have listed the main problems as extreme prematurity, PDA (patent ductus arteriosus), ROP stage 2 zone1 (retinopathy of prematurity), CLD- off oxygen now (chronic lung disease-), Reflux. I note baby had Recently had sepsis concerns- on cefotaxime (antibiotic) Day -5 (of the course of antibiotics). Their observations were V-SVIA, sats 97-98% in air, HR 130-140, Temp 36.3-36.6 and Feeds150mlskg/day, 3 hourly feeds, alternate bottle and NG. In relation to sepsis I noted "*Sepsis-on cefotaxime, completed 4 days of cefotaxime last CRP is 2, no access*". My findings on examinations noted baby was alert, pink and well perfused and all systemic examination was normal. So my impression was that baby was clinically stable.

24. The nursing notes from 25/09/15 record that I have reviewed the baby at 2030 and spoken to dad and explained to him that baby was handling well. Their Hb (haemoglobin) was stable and they were not for transfusion at that time. She has then recorded that dad was attending to evening feeds and handles the baby well.

25. I made a plan to discuss with Dr. Saladi (Consultant) regarding antibiotics because there was no IV access in situ. The options were to complete the 5 days course of antibiotics by giving one day worth of doses intramuscularly or recannulate the baby to give a longer course of IV antibiotics. I have made an instruction to the nursing staff to encourage bottles as long as they were tolerated and to inform me/medical team if there were concerns.

26. I was not aware of any concerns or discussion at that time regarding the care of Child G.

27. I do not remember attending any discussion or debrief regarding Child G. We used to discuss cases with consultants at handovers. As a junior doctor, I would also discuss patients directly with consultants at or after a ward round and if I had concerns I would

contact the consultant to discuss them. It is difficult to involve juniors who have a pattern of shift working in each debrief if it is not happening on their shift.

Child H

28. I was involved in Child H's care and gave a statement to the police dated 26 October 2018 (INQ0001022). I set out my involvement in her care at paragraphs 24-37. I stand by the contents of my statement. I have no recollection of the events.

29. I was not aware of any concerns or discussion at that time regarding the care of Child H.

30. I do not remember attending any discussion or debrief regarding Child H.

Child J

31. I was involved in Child J's care and gave a statement to the police dated 11 September 2018 (INQ0001130). I set out my involvement in her care at paragraphs 21-39. I stand by the contents of my statement. I have no recollection of the events.

32. I was not aware of any concerns or discussion at that time regarding the care of Child J.

33. I do not remember attending any discussion or debrief regarding Child J. I think there should be a process within the neonatal unit to discuss all collapses/arrests in a structured way and all the members involved in baby's care should be informed about the outcome.

34. The notes of the Neonatal Perinatal Morbidity and Mortality Meeting on 10 December 2015 (INQ0005446) list me as attending. I do not recall this meeting or how often they were held. I do not remember how many I attended. The minutes record the discussion but I do not have any recall of what discussion took place. The one page minutes I have been provided with record discussion of two perinatal cases not the babies referred to in this statement.

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

36. I did not have access to the MBRRACE-UK, Nation Neonatal Research Database (NNRD), NHS England or any other organisations data about the mortality rate and the number of serious adverse incidents on NNU.

37. I was not aware of the process at the hospital for learning lessons about adverse incidents or deaths. I was not involved in any local network discussions.

38. I was not particularly worried about the number of deaths but I thought it was strange. A lot of collapses/ arrests (more than expected) occurred during my 6 month posting at the

hospital. During handover, we might have mentioned amongst the junior doctors whilst handing over to the next shift that it was strange but we were not concerned.

39. I do not recall the procedure at the hospital for the investigation of deaths on NNU in 2015/2016.

40. I do not remember clearly but think there was a debriefing process. I remember attending at least one debrief but do not recall the details. I do not know if I attended any discussions or debriefs for the babies named on the indictment.

41. I was not aware and had no idea of the suspicions and concerns of others about the conduct of Letby.

42. I did not report any suspicions or concerns about Letby or any concerns for the safety of babies on the NNU. I had never considered the possibility that someone was harming the babies.

Safeguarding of babies in hospitals

43. I have had safeguarding training but it was more geared towards identifying abuse in children from carers and how to investigate and safeguard them. I do not remember receiving training specifically where abuse on the part of a member of staff is suspected.

44. I have not located from my professional body the GMC any specific guidance on safeguarding if concerns involve staff in contrast to parents/carers. I do update my safeguarding training regularly as part of my mandatory training and revalidation but there is no training about abuse or harm from member of staff to the children and babies. If I had safeguarding concerns in the context of suspicion or abuse by a member of staff towards babies or any patient, I would escalate via their manager. I would seek advice from my trust's safeguarding team, will then share information accordingly and escalate.

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

45. I do not know what processes and procedures for raising concerns within the hospital were in place in 2015-2016.

46. I had training on the processes used and organisations involved in reviewing a child death as part of my speciality training but I do not recall any specific training in the hospital. The training I received covered the process and what to do if there is a child death. I do not remember if it covers when to raise concerns or suspicions.

47. I did not provide any information about Letby to any external bodies as I had no concerns.

48. I do not recall providing information to the Coroner about any of the deaths of the babies named on the indictment. If I had, there should be reference to informing the Coroner in the notes.

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

49. I did not raise any concerns about Letby as I did not have any.

Reflections

50. CCTV monitoring may have detected the crimes of Letby but usually people with criminal intent are clever. I am sure they will find a loop hole so CCTV could be counterproductive and would have given false sense of security.

51. Security systems relating to the monitoring of access to drugs and babies would prevent deliberate harm and a system may have prevented an insulin overdose being given.

52. In relation to the Inquiry's recommendations, I believe they should include that if staff have concerns, they should be listened to and that everyone should keep an open mind.

Any other matters

53. I do not believe I have any other evidence. I have given a total of 7 statements to the police about my involvement in the care of babies on NNU. I have exhibited additional police statements relating to babies I&S, I&S and I&S who had hypoglycaemia. The other statements are:

PD-05-18 Baby I&S

PD-10-19 Baby I&S

54. I have not given any interviews or made any public comments.

Statement of Truth

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

Signed: Personal Data

Dated: 12/06/24