Witness Name: Dr Rhiannon Siân Austin
Statement No.: [XXXX]
Exhibits: [N/A]
Dated: 14/06/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Dr RHIANNON SIAN

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1. I, Dr Rhiannon Siân Austin, will say as follows:
2. I qualified from the University of Liverpool medical school in 2011 with an MBChB and BSc(hons) and after my foundation training, I entered into paediatric speciality training in Merseyside in 2013. I have worked at tertiary children's and neonatal units as well as in district general hospitals, including Alder Hey Children's Hospital, Liverpool Women's Hospital, Arrowe Park Hospital, Countess of Chester Hospital and Ysbyty Glan Clwyd. I have worked on tertiary neonatal units and within tertiary paediatric intensive care, renal, respiratory, and rheumatology teams. I gained my membership of the Royal College of Paediatrics and Child Health in 2015 (MRCPCH). I qualified as a paediatric consultant in January 2024 and entered on to the General Medical Council's (GMC) specialist register in February 2024. I am currently working as a paediatric consultant in Ysbyty Glan Clwyd, in north Wales.
3. When working at the Countess of Chester Hospital in 2015-2016 I was working as a specialist paediatric trainee (ST) year 3 and 4 (first years as a registrar). I had no management responsibilities other than assisting with organising the registrar rota when I worked there as an ST4. Following this I was placed at the Countess of Chester for a total of 16 months as part of training rotations again between March 2021 and September 2023.
4. I finished working at the Countess of Chester at the start of September 2023, and completed my final 5 months of paediatric training at Arrowe Park Hospital. I have been working as a paediatric consultant at Ysbyty Glan Clwyd in north Wales since February 2024.

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

5. We, as paediatric doctors cover both the paediatric ward and the neonatal unit whilst working at the hospital. Our line manager when we rota to different hospitals is therefore usually our educational and clinical supervisor and the clinical lead of the department. Our line of reporting would usually be first to the paediatric consultant or clinical lead. Dr Gibbs and Dr Brearey were my supervisors (ST3 and ST4

respectively), and from memory Eirian Powell was the senior nurse in charge of the NNU.

6. I was not personally aware of the relationship between clinicians, nurses, midwives and their managers and I did not personally have any communication with the high levels of management. Whilst working at the hospital in 2015/2016 I felt that there was generally a good relationship between medical professionals (doctors, nurses, midwives and others) at the hospital. I felt that the consultants were always supportive and available for advice and support. The nursing staff on the NNU were approachable when I had concerns about a patient and were receptive to my concerns. Nurses of varying different experiences were always comfortable and happy to contact one of the doctors to review patients when they or the family were concerned about them. We would have a post-ward round huddle with the nurse in charge to update them with the plans from the ward round.
7. I do not feel that the relationships between staff on the NNU effected patient care during the timeframe stated. As with all healthcare settings I have worked in there are sometimes discussions between doctors and nurses around the care of a patient, and generally I recall that when there were discussions around how to best manage a patient the nursing staff were always comfortable to question and discuss with the medical staff (of all levels) if they were unsure about a plan or felt that something could maybe be done differently.
8. Whilst working at the Countess of Chester Hospital during 2015-2016, I felt that my consultants were always supportive and available for advice and support. The nursing staff on the NNU were approachable when I had concerns about a patient and were receptive to my concerns. Nurses of varying different experiences were always comfortable and happy to contact one of the doctors to review patients when they or the family were concerned about them.
9. As a junior member of the medical team at the time I am unable to say one way or the other whether professional relationships affected the management and governance of the hospital in 2015/2016.
10. I also worked at another hospital during 2015/2016 and I would describe the culture to be the same. Whilst working at another hospital I did not personally have much communication with non-clinical managers and I was unaware of the specific relationships between nurses, midwives and managers and the relationship between medical professionals was much the same, and I would say that my consultant colleagues at the Countess were more approachable and supportive than at other hospitals I have worked at. Whilst working at other hospitals during that time I had personally only ever heard positive comments from other colleagues regarding the

quality of care that patients received at Chester, particularly when sick patients required transfer to either Liverpool Women's or Alder Hey Children's hospital for more specialist care. More over, as a junior doctor in training the paediatric department at the Countess of Chester was known to be a lovely place to work at and trainees enjoyed being placed there due to the supportive and approachable consultant body, but I am unable to comment on any comments specifically on management.

11. I worked at the Countess of Chester Hospital between September 2015 and March 2016 as an ST3 and then again between September 2016 to March 2017. I do not recall from memory any specific changes in culture between these times.

Child G & Child H

12. I was aware that between junior colleagues there were informal discussions about how sad it was that there had been a number of sick babies and that it must be difficult for the nursing staff on the NNU and the doctors involved with those patients, as well as their families. I cannot specifically recall suspicions or concerns around Child G and Child H.
13. As far as I recall I did not attend any discussions or debriefs with regards to Child G and Child H. On review of my involvement at the time, and comparing the incidents to others I have experienced in other departments and roles, I do not feel a debrief or discussion would be necessary specifically in relation to me, but that I would expect following a cardiac arrest for a debrief to be held for the team members involved in this.

Child I

14. Following the return of Child I from Arrowe Park hospital I clerked the patient into the unit and took handover from the transport team, and assessed and examined them. As the notes state [INQ0000429 p. 1524-1526] Child I was stable and required no change of management at this time, and the management plan from Arrowe Park Hospital was continued.
15. I know that following Child I's death I was aware they had passed away, but I do not specifically recall when I was informed or by whom. I do not specifically remember if I thought the death was unexpected or concerning.
16. I do not remember any specific conversations between medical staff regarding concerns and/or suspicions over the care of Child I.
17. As far as I recall I did not attend any discussions or debriefs with regards to Child I's care. On review of my involvement at the time and comparing the incident to others I have experienced in other departments and roles, I do not feel a debrief or discussion

would be necessary specifically in relation to me, but that I would expect a debrief to be held for the team members involved.

Child J

18. I was the registrar covering the paediatric and neonatal units during the nightshift 26 – 27 November 2015. Dr Verghese was my senior house officer. I recall Dr Verghese discussing Child J with me [INQ0001065 p 319] and concerns that baby was having new desaturations. Following the discussion, we decided we should start antibiotic treatment to cover for possible infection, given the baby's gestation and their background history. As detailed in my police statement [INQ0001118] later in the night I was called to attend to two new admissions (unplanned birth of premature twins born at home) to the NNU and as I felt this could potentially become a clinically unsafe situation, I therefore called Dr Gibbs and asked for his attendance on the NNU. Nursing staff had concerns about Child J in the early morning of 27 November 2015 and as Dr Gibbs was in attendance on the NNU, he reviewed and attended to Child J whilst myself and Dr Verghese were attending to stabilising the new admissions. After Dr Gibbs reviewed Child J, I recall being informed that their condition had changed and that as well as treating as possible infection they had suspected seizures which were now being treated with medication.
19. I do not recall having any specific concerns regarding the care of Child J, or being aware of concerns of other colleagues, other than wondering if Child J had developed further complications associated with their already known conditions which would need further management or investigation.
20. As far as I recall I did not attend any discussions or debriefs. On review of my involvement at the time, and comparing the incidents to others I have experienced in other departments and roles, I do not feel a debrief or discussion would be necessary specifically in relation to my involvement.
21. I am not aware of the exact number deaths that occurred on the NNU during 2015 and 2016.
22. Access to MBRRACE-UK data is freely accessible on their website. I did not have access to data from the National Neonatal Research Database or NHS England. I was aware of these but I cannot recall whether I accessed it specifically at the time, other than for furthering my knowledge about epidemiological monitoring of mortality and morbidity, as part of my paediatric training.
23. I was not involved in discussions with local networks about the morbidity and mortality of babies on the NNU. I recall attending joint paediatric and obstetric mortality and morbidity meetings at the hospital itself, but not attending external meetings.

24. I was worried about the number of deaths on the unit. During the first few months as an ST3 at the hospital I was aware of colleagues who had very difficult shifts on the NNU, but as I was a relatively junior doctor and I wasn't sure if this was a natural fluctuation in mortality, as can sometimes happen, or if it was something to be concerned about. I recall having informal conversations with consultant colleagues and that they were reviewing the situation.
25. As far as I was aware more senior doctors would be involved with investigating deaths on the NNU. As a junior member of the medical team, I was not involved in this at the time. If the medical practitioner, usually the consultant in charge of the patients care in paediatrics, felt that the death could be explained and there was a cause then a death certificate could be issued. If not, then the coroner would be consulted and a decision about a post-mortem would be made. In recent years all deaths are now discussed with the medical examiner as well. I recall Dr Brearey being unsure as to why a patient on the NNU had died. He discussed this case with the coroner due to this uncertainty and to decide whether a post-mortem would be needed. However, I cannot recall the exact date of this discussion.
26. I was not involved in any discussions or debriefs in respect of the deaths of the babies named on the indictment shortly after their deaths. Again, as stated above, when I compare my involvement in their care to other cases I have been involved with in other hospitals I do not feel that I would need to attend a debrief, but attending morbidity and mortality meetings which all staff can attend is usual for reflection and learning, and these meetings were held at the Countess at this time, but these would be held at set times and therefore not directly after a death.
27. I do not recall attending discussions or debriefs in relation to clinical events for the babies named on the indictment and in respect of which charges for attempted murder against Letby were ultimately brought. One event that I gave a police witness statement about, but I have not specifically been asked about in this statement, was a baby who collapsed whilst intubated and required resuscitation. I recall having an informal debrief with Dr Neary, the consultant present during the event, but I do not recall having a discussion or debrief with other members of staff. In reflection now, I think this would have been useful.
28. I was aware during my second period working there in 2016 that Letby was no longer on patient facing clinical duties. At the time I presumed this was due to her performance as a nurse as opposed to her purposefully harming patients. I cannot recall exact dates when I became aware of this.
29. I did not use any formal processes to report concerns about Letby as I personally did not have any concerns specifically about her. As mentioned above, we as juniors had

Irrelevant & Sensitive

open discussions with consultants during handovers and ward rounds about the increased in morbidity and mortality and that they as a consultant body were reviewing this. I was aware that a review by the Royal College had been carried out in 2016.

Safeguarding of babies in hospitals

30. As part of our training as paediatric doctors we are expected to undertake nationally approved safeguarding training and attend departmental and local peer-reviewed safeguarding meetings. I do not recall that any of the previous safeguarding training used to specifically deal with what to do if a staff member is suspected of causing intentional harm to a child or young person, but would more generally deal with when to be concerned about different types of abuse, including non-accidental injury and how you would escalate concerns surrounding this.
31. The GMC has guidance on safeguarding children as does the Royal College of Paediatrics and Child Health, but again there is no specific guidance on suspicion of abuse by a member of staff as far as I am aware. If I had a suspicion I would turn to a consultant colleague for advice, particularly the clinical lead of the department and/or the safeguarding lead in the first instance, followed by the medical director and then chief executive of the hospital. If I had a serious concern that a crime was being committed as opposed to poor practice or negligence, I would have to consider approaching the police as an individual if I did not think my concerns were being taken seriously. I did not seek advice from any professional body with regards to the events at the Countess of Chester.

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

32. I recall that the process for raising concerns during 2015/2016 would follow a hierarchy, first of which for myself at the time would have been raising concerns with the consultants including the clinical lead for the department, followed by the medical director and then the chief executive of the hospital. Since 2016 I noted that freedom to speak up is 'advertised' and encouraged a lot more at the trust than it was previously. I am unable to comment specifically on the processes for whistleblowing.
33. As part of our mandatory safeguarding training as paediatric doctors we review and become familiar with the process of dealing with a Sudden Unexplained/Unexpected Deaths in Infancy and Childhood (SUDI/Cs) and when and how to use the Coroner's office. Paediatric trainees have awareness of Child Death Reviews and attend these for learning purposes when other clinical duties allow. This training would be expected of us as trainees. It would be arranged by ourselves and annual assessments by the

deanery would ensure we were up to date with relevant training. Local employers, such as Countess of Chester, would check that as we rota to them that we are up to date with what they require. I felt at the time the training I received was sufficient and I had senior colleagues who were supportive to turn to in situations where I was unsure.

34. As a junior registrar at the time I was aware that my first place to report to with concerns with be the clinical lead or senior nursing staff. I was also aware that externally I could raise concerns with the Care Quality Commission (CQC), but I had only ever been in communication with them when they came to do a CQC review and wouldn't have been aware of how to report to them at another time. If I had a concern about a medical practitioner I would report to the GMC and the NMC for a concern about a nurse. I did not raise concerns to any external bodies. I did not have a specific concern about Letby at the time.
35. I do not recall personally providing any information to the Coroner regarding any of the deaths of the babies named in indictment.

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

36. I did not raise any concerns about Letby with those in management at the Trust.

Reflections

37. I am unable to say either way whether CCTV could have prevented Letby's crimes.
38. With regards to the use of security systems such as monitoring of access to drugs and babies I would need to review data and studies on how security systems reduce harm in patients. I am unable to say conclusively that having stricter security in place would have prevented deliberate harm to these babies.
39. With regards to ensuring the safety of babies on NNUs from criminal actions of staff I feel that continuing double checking of medications and possibly using intelligent drugs cupboards with finger print access which are used in many hospitals now is important as well as full transparent investigations of any incident forms completed, especially around collapses and deaths, and to comply with Duty of Candour guidance.

Any other matters

40. I do not have any further specific evidence or knowledge which is specific to the inquiry.
41. I have not given any interview or otherwise made any public comments about the actions of Letby or the matters of investigation by the inquiry.

Request for documents

42. I have no documents that are potentially relevant to the Inquiry's Terms of Reference.

Statement of Truth

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

14/06/2024

X Personal Data

Dr Rhiannon S Austin
Paediatric Consultant
Signed by: Rhiannon Austin I&S

Signed: _____

Dated: _14/06/2024_____