Witness Name:
Dr David Harkness
Statement No.: 1
Exhibits: 0
Dated: 20.06.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR DAVID HARKNESS

I, Dr David Harkness, will say as follows: -

Personal Details

1. My name is Dr David Harkness, I have been asked by the Thirlwall Inquiry to provide a witness statement in response to questions asked of me by the Inquiry. I set out the information below.

Medical Career and employment at the Countess of Chester Hospital (the "Hospital")

2. I qualified as a doctor in 2009 at Cardiff University. My professional qualifications are MBBCH MRCPCH

3. I undertook my Foundation Training in North Wales from 2009-2011. I subsequently undertook my Paediatric training across North Wales, Cheshire and Merseyside. I undertook placements in Chester, Wrexham, Glan Clwyd and Whiston in General Paediatrics and neonates and Community Paediatrics, Tertiary Neonates in Arrowe Park and Liverpool Women's hospitals. I also undertook rotations in Oncology, Neurology and Emergency Medicine in Alder Hey Children's Hospital.

4. In 2014-2016 I was a Paediatric Registrar at the Hospital. My responsibilities at that time included covering the children's ward and the special care baby unit including out of hours on-call duties as well as clinics.

5. I have been a Consultant Paediatrician in Wrexham Maelor Hospital since 2020 and the Named Doctor for Safeguarding Children for Betsi Cadwaladr University Health Board ("BCUHB") since 2022

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

6. During my time at the Hospital I reported to Dr Jayaram as the Clinical Director. My first registrar post was at the Hospital and I felt very well supported by my consultant and nursing colleagues. The team worked well together and were easily approachable, accessible and open to support. There was a great relationship between clinicians, nurses and midwives and a friendly atmosphere. I cannot comment on the relationship with the operational team or higher management of the department because as a registrar I did not have much to do with them.

7. I felt that the relationships between staff on the unit had a positive impact on the care of the patients. Team members of all backgrounds were respectful and friendly to each other, and the care of the babies was always put first. The culture was friendly and pleasant with good working relationships between staff and a warm and supportive environment for families.

8. I was unaware of the professional relationships outside of the immediate team and if this had any bearing on the management of the unit.

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

9. I was involved in the care of a number of babies that featured in the criminal indictment against Letby. I made numerous witness statements to the police in the course of their investigation and gave evidence at the criminal trial. These babies' tragic deaths were also the subject of coronial investigations for one of which I again provided a statement and oral evidence at the inquest.

10. I have been asked a number of questions arising from my involvement in the care of these babies that I will address below. My recollection is based on my previous statements and evidence unless otherwise indicated.

Child A

11. Child A was born at 31 + 2 weeks gestation and was one of twins. He was born in good condition but needed CPAP. An Umbilical venous catheter was sited but its position was considered to be inappropriate (it was found on x-ray to have gone too far). It was left in to allow access until a more suitable line could be placed. When I first encountered Child A (at approximately 17:00 on 8 June 2015) I sited a percutaneous long line which, on review of the x-ray I also considered to have gone too far, however, on reflection I consider

this to have been ideally positioned. Child A later suffered an apnoeic event and then went into cardio-respiratory arrest and tragically died.

12. Child A's deterioration and death was certainly unexpected. He appeared to thrive and was making steady progress with his respiratory support and was breathing by himself. He was in a very stable condition, making very good progress along with his twin sister.

13. I described in my statement to the police (dated 5 July 2018 [**INQ0000056**]) that I recalled when reviewing Child A just prior to 20:26 on there to be "*unusual blotchy pattern of well-perfused pink skin over the whole of Child A's body coupled with patches of white and blue skin*". I also described this in my evidence at Letby's criminal trial as "*patches of kind of blue/purple colour, there were patches of bright red colour, there were white patches, and they didn't fit with something that you would find on a baby that's not pumping any blood around their body. That can look purple and can be pale, but it doesn't look anything like this patchy pattern that this baby had*" [**INQ0010266 p.24**]. I stated in my police statement [**INQ0000056 p.5**] that *"In my professional career, this spans over 10 years. I have never witnessed or seen that pattern of discolouration on the skin prior to the collapse of [Child A]… I have witnessed this on other neo natal collapses at the Countess of Chester during my time at the hospital (February 2014 – March 2016). I haven't witnessed this since".*

14. This observation was discussed in multiple conversations following Child A's death. Although strange, at no point did anyone consider this being caused by anything malicious or from my knowledge, feel that concerns should have been raised. I recall conversations which involved registrars and SHOs at the time, as well as possibly the consultants. I remember very little of these discussions, other than no one had seen these patches and marks before and could not think of a diagnosis. I do not think anyone would have considered malicious acts such as injecting air, as none of us had seen this as a consequence of air embolus and consequently suspect a colleague. I was personally very upset following the death.

15. Aside from the multiple conversations I have described above, I cannot remember if there were any specific debriefs concerning the death of Child A. The consultant body were very supportive of me as an individual. Dr Jayaram sat with me alone after Child A passed away, which was very thoughtful and very much appreciated. I do think that 'hot debriefs'; those immediately after the event and 'cold debriefs'; those held over the coming days or weeks are very beneficial for staff, as well as trauma counselling, which is now becoming common in practice.

Child E

16. Child E was born at 29 + 5 weeks gestation and was one of twins. This is a good gestation with fewer and fewer problems now seen at this gestation. He and his brother were of quite a good size and had a relatively uneventful start to life. One of the risk factors considered was absent diastolic flow, relating to the flow from the placenta which increases the risk of the baby having problems with their gut. Both twins were closely monitored and we were cautious with their feeds.

17. In my statement to the police (dated 17 October 2018 **[INQ0000222]**) I recalled being asked to review Child E by Letby on the evening of 3 August 2015. Child E had suffered a vomit which featured flecks of blood. This was considered to be caused by irritation from the feeding tube. Having reviewed and prescribed medication to settle the lining of the stomach, Child E looked relatively settled. Approximately half an hour later however, Child E developed sudden, substantial bleeding. I noted this to be unusual. This was then followed by a further episode of substantial bleeding which I commented to be "*out of nowhere*" and something I had not seen before or since.

18. Child E then suddenly deteriorated and I noted a strange discolouration over his body. I stated that "*This appeared as purple and pale patches and was quite unusual... The colour was not solid purple, it was patchy and I would expect his entire body to go purple or pale if due to poor perfusion. If the blood supply is really poor they go white, initially it is arms and legs and then it affects the rest of the body. But it does not appear as a patch on the chest and then a patch somewhere else. Child E's colouration appeared so quickly and was not reflected by the monitor, potentially it would disappear to the touch but with perfusion problems if you touch it would tend to go pale. There was no bruising or any sign of blood under the skin, it was just patchy.*".

19. As described above, I and at least one other registrar had seen this before in Child A. His death was still fresh in my memory when I documented this. I was still unable to think of any explanation. Again, as I have described above in relation to Child A, this observation was discussed with the colleagues on the unit and similarly, I discussed Child E's unusual discolouration with Dr ZA at some point following her arrival on the NNU. I do not remember if anyone else was present or if there were any further conversations. Again, at this time I did not have concerns of this being due to malicious activity and had no reason to raise it as a concern. As I explained in my police statement [**INQ0000222**], whilst the unusual discolouration was strange, Child E was on different medications and fluids to Child A and no link could be established from a medical point of view between the two.

20. I remember in my conversations with Dr ZA after her arrival on the unit, that baby E did have risk factors for necrotising enterocolitis ("NEC") given there was a history of reduced placental blood flow in utero. NEC was therefore our suspicion at the time, despite it being not confirmed on x-ray and Child E's very unusual presentation.

21. I would not have been present or party to conversations regarding the offer of a Post Mortem examination to Child E's family, which is normal. It was common for parents to not want a Post Mortem examination and at the time (and from my level of experience) I had thought that his cause of death could have been necrotising enterocolitis such that a Post Mortem examination would have been unnecessary. As I have outlined above, my observations in relation to bleeding and unusual discolouration were thought to have been related to NEC.

22. From the knowledge and experience I have now, in my position as Named Doctor for Safeguarding Children, I would initiate the PRUDIC process, the Welsh equivalent of SUDIC, due to this being a death that was not anticipated 24 hours earlier, this would have involved a Post Mortem examination. I am unsure of the full details of the PRUDIC and SUDIC policies in place at that time, but both were in use. I do not think that decisions to undertake these procedures in inpatient deaths was common at the time, although in light of the events at the Hospital it has affected the practice in my health board and I am sure it has affected practice elsewhere.

23. I have no independent recollection of any further conversations I had in relation to Child E in addition to those I have described above, in my police statements, evidence in Letby's trial and in the statement from Doctor ZA **[INQ0000220]**.

24. I also do not remember whether any (formal or informal) debriefs occurred in respect of Child E's death or if I was involved. If one was convened then my attendance at it would have been useful. Again, as I have described in relation to Child A (paragraph 15 above) I do consider debriefs to be useful.

25. I became aware of the police investigation into these deaths when the Consultants informed me that the findings of an initial review by the CQC in early 2016 had been referred to the police. There was a general level of awareness on the unit that the police were investigating these cases but I was not aware of any specific details other than this.

Child F

26. Child F was the twin brother of Child E. On the evening following Child E's death (4/5 August 2015) I reviewed Child F as a result of his heart rate increasing and him having milky aspirates. This prompted me to request a septic screen. I was again thinking about NEC but this was not simply a suspicion substantiated merely due to our view as to Child E's condition and based on the aspirates.

27. Child F's heart rate remained high which could be as a consequence of insufficient fluid intake, and his blood sugar was low. This was explainable as a consequence of frequent vomits which would interfere with baby's ability to keep their blood sugars up. My plan on review was to therefore for a Dextrose bolus to increase his blood sugar and a fluid bolus of normal saline to ensure he was receiving adequate fluids and to bring his heart rate down.

28. An ECG was requested as a further possible cause of Child F's high heart rate could have been a supraventricular tachycardia ("SVT") which is an abnormally fast heart rhythm caused by abnormal electrical activity in the upper part of the heart. Medication called Adenosine would have been available to bring the heart rate down if this was suspected.

29. Child F's ECG was fast with narrow complexes, which could be suggestive of a SVT. I was concerned about both Child F's increased heart rate and low blood sugars and I discussed these concerns on the phone with Dr Gibbs, the consultant on call, as well as with the nurse looking after him, **Nurse T**. Dr Gibbs' experience led him to suggest that Child F's heart rate was not high enough for an SVT premature baby which would be closer to 300 beats per minute.

30. I do not remember any further conversations I had with regard to Child F's high heart rate and low blood sugars either that night or at any other time after. I also do not remember any specific debriefs regarding this. Again, I do think debriefs are useful and if one was convened then my attendance at it would equally have been useful.

Child G

31. As I describe in my statement made to the police on 14 September 2018 **[INQ0000338]**, Child G had been born at Arrowe Park Hospital before being transferred to the NNU at the Hospital. I was involved in her care on 7 and 21 September 2015. She had suffered a few

episodes of deteriorations prior to the night of 6/7 September 2015 but had up until then been considered to be quite stable with the acknowledgment that this could (and with premature babies often can) change very rapidly.

32. Child G had chronic lung disease, which is common in premature babies, she was in receipt of low flow oxygen and was doing quite well on that. She was underweight and received a large volume of feeds with assistance for this through a nasal tube. She also had slightly large ventricles observed on cranial ultrasound scans which are fluid spaces in the brain. Overall, however her presentation was not concerning.

33. Child G had a deterioration on the evening of 6/7 September 2015 which required her to be intubated. She was in receipt of a very high level of oxygen flow and was considered to be very sick without an obvious cause. She was treated for suspected Sepsis or aspiration (which was a risk due to her large volume of feeds).

34. I do not remember the specifics of any conversations about Child G's deterioration that night or who those conversations were with. I cannot recall any discussion with regard to Child G having projectile vomited. At handover it is routine to go through an overview of events as well as the current situation; ventilation, observations, results and condition. All doctors on shift from the night and day would have been present. I am sure I would have been concerned about how unwell child G was and I would have had discussions with the nurses and doctors, including the consultant following the ward round. We would again summarise the situation and plan.

35. I was also involved in Child G's care on 21 September 2015. Again, as I describe in my statement made to the police **[INQ0000338]**, I have documented in the NNU line insertion and removal record chart that day. There had been several failed attempts to insert a permanent cannula and whilst I cannot remember, I presume that I was asked to attempt this myself. It appears that I had a few failed attempts before asking Dr Gibbs to attempt cannulation who successfully inserted a peripheral intravenous cannula into her left foot.

36. During the cannulation Child G would have been connected to a Massimo or a Phillips monitor, this would not have been disconnected or turned off by either Dr Gibbs or me during cannulation.

37. I cannot remember any further involvement in Child G's care that day or if I was present in any conversations at 10:20 relating to her deterioration. I did not have any specific

concerns that I would have raised from my recollection. I also cannot remember any debriefs. If one was convened, then my attendance at it would have been useful.

Child I

38. Child I was born at 27 weeks gestation at the Liverpool Women's hospital ("LWH"). She transferred to the Hospital on 18 August 2015 following which she experienced desaturations, bradycardia and suspected NEC. Child I was transferred back to LWH and treated conservatively for NEC (i.e. with antibiotic therapy and ceasing her feeds) whilst there.

39. Child I returned to the Hospital on 13 September 2015 having suffered recurrent episodes of a distended abdomen. As I recall in my statement to the police dated 17 October 2018 **[INQ0000517]**, she was breathing on her own and improved such that on examination signs of NEC were not present.

40. On 30 September 2015 (as described in my second statement to the police dated 5 November 2019 **[INQ0000516]**) Child I was doing well and gaining weight. There was no concern her blood test results. At 16:30 that day Child I vomited, her oxygen levels dropped, and she stopped breathing. This episode was resolved, and x-ray investigation indicated NEC which was treated by adding an extra antibiotic to her medications.

41. I undertook a routine review of Child I at 22:00. I do not recollect any specific conversations I had with anyone regarding her earlier deterioration at 16:30. I am however sure I would have discussed this with the nursing team. I do not remember having any specific concerns to raise based on the history and investigations but would have discussed Child I with the consultant routinely. Unfortunately, as I have previously stated, premature babies with a background such as Child I can and often do deteriorate rapidly.

42. On 13 October 2015 at 03:36, Child I was found by a nurse to be pale, lifeless and gasping for air. As I note in my statement **[INQ0000517]** there appeared to be no indication as to why this might have happened. I reviewed her at 16:00. I recorded that her blood gases and ventilation were all acceptable. Her blood pressure, which had dropped through the day, had improved with dopamine and her bowel sounds were present. X-rays had been sent to Alder Hey Hospital for review and I discussed the case with them, however I do not recollect any specifics of these conversations. The team's thoughts with regard to the collapse earlier in the morning was NEC. There was nothing definitive in relation to this as

a diagnosis, but her abdomen had become larger and firmer and she had not yet been seen by the surgeons (there had been no real indication for this previously).

43. Again, I would have discussed Child I's earlier deterioration with the nursing team and any doctors present during my review. I cannot recall any concerns that I needed to raise, but we would have discussed her during handover.

44. I am not aware of any conversations around the timing of deteriorations or relation to the staff on duty. NEC was a plausible explanation for her deteriorations.

45. Overnight on 13/14 October 2015 Child I's oxygen requirements had increased and there had possibly been some collapse of her lung. A new endotracheal tube had been inserted which improved things temporarily, but she deteriorated again and there was suspicion of a pneumothorax. She had deteriorated further and required cardiopulmonary resuscitation ("CPR") in the early hours of the morning.

46. I reviewed Child I at 11:00 on 14 October 2015 and noted that her two cardiac arrests the previous night had been notably long (approximately 20 minutes). Her oxygen level had come down quite quickly and I addressed this with a paralysing agent make it easier for the ventilator to breathe for her. Her blood gases were acceptable but not encouraging and her lactate level was quite high which indicated that she was unwell. On examination I noted some crackle on the left side of her lungs which was consistent with the suggestion of some collapse in the lung or infection causing the issues with her ventilation. She had opened her bowels and had good fluid output suggestive that her blood pressure was good. Blood cultures demonstrated a high white cell count which was indicative of an infection, inflammation and stress. There was a note from the Alder Hey surgical team after my entry in the notes which advised that Child I had a stricture (narrowing) of the gut which could have been caused by the medical treatment of the previous episode of NEC. Their advice was to continue with her current antibiotic regime, keeping her feeds via Total Parenteral Nutrition ("TPN") and suggested venting her abdomen via her rectum in the event of this becoming more distended. They requested daily x-rays and bloods to monitor for signs of NEC to enable them to reach a decision as to her suitability for surgery.

47. I would have discussed Child I's deteriorations over the course of the night during my review, but I cannot remember who was present. I did not have any specific concerns to raise due to the previous discussions and findings suggestive of NEC.

48. I cannot recollect any debriefs. I was not present at the debrief noted at **[INQ0000429 p.1543]** and I am sure that if I was working, I would have been invited. Whilst I had been involved in Child I's care it is not feasible for all staff to attend a debrief, although all efforts are made to release staff from other duties. In hindsight I do not think my presence there would have had an impact on the discussions as I did not have any additional concerns at the time.

49. I was present at the Neonatal Mortality Meeting on 26 November 2015 **[INQ0003288]** but I do not remember any specific reference to or discussion about Child I's collapses and her death on 26 October 2015. It is unlikely that these meetings would discuss in any detail the increase in deaths or trends and certainly not concerns of inflicted harm. These meetings tend to review the events in the notes and identify any learning. It is not a comprehensive review of the case.

Deaths of the NNU between 2015 and 2016

50. During this period, I was at ST3 level of my training. I was reasonably experienced but not at the level of seniority where it would be commonplace or appropriate for me to be aware of the exact annual number of deaths on the NNU. I am unsure as to my awareness at that time of the data prepared by MBRACE-UK, the Neonatal National Research Database ("NNRD"), NHS England or any other organisations about the mortality rate and number of serious incidents on the NNU. I am unsure of what data would have been available, but I do not feel that given my position within the team, there would be a need for me to have been made aware at the time. I was aware that there had been more deaths, from informal discussions over the period 0f 2015-2016 but I was not at that time of the view that these deaths were attributable to anything suspicious or feel that I needed to raise this as a concern.

51. Deaths on neonatal units are investigated differently depending on circumstances and local/national policy. Every death is reviewed by way of the Perinatal Mortality Review process which as I have explained above, involves an examination of the notes with relevant clinicians (usually obstetricians, neonatal doctors, nurses and midwives) and look to identify any issues and learning but this is not a comprehensive review. The SUDiC process enables deaths to be investigated where the mechanism of death is unclear and would involve a Post Mortem examination. These deaths are also routinely referred to the Coroner. Internally, should the circumstances of a death relate to an incident logged on a hospital incident reporting system there are numerous ways in which further investigation will follow depending on the severity of harm associated with the incident. For deaths

relating to a logged incident, the NNU or the divisional governance team will prepare a report that examines the circumstances of the episode of care looking to identify any care and service deficiencies with a view to making recommendations as to how any such deficiencies can be remediated and lessons learned.

52. Consultants are always involved in discussions in respect of babies who have died on the NNU. These discussions relate to the decision as to whether they are able to issue a death certificate or should discuss any issues with the local Coroner. Decisions about Post Mortem examinations are made during these conversations and any additional concerns would typically lead to the death being referred to the Coroner. Outside of these discussions and the perinatal mortality meetings I am not aware of what other meetings occurred during this time and the exact processes engaged in relation to learning lessons from these deaths.

53. I cannot remember any specific debriefs for deaths or clinical events. At that time, I was not aware of, and neither did I have any concerns about Letby. In hindsight I believe that there should have been debriefs around significant clinical events, however I do not think that the practice at the Hospital was significantly different to anywhere else I have worked in this respect. This is however something that is improving with time.

Safeguarding of babies in hospitals

54. I have not received any specific safeguarding training relating to suspected abuse of patients by staff towards babies or children in hospital. I have received safeguarding training up to level 5 and to my knowledge this is not commonly included in the level of safeguarding training required of any paediatrician (level 3).

55. When I worked at the Hospital I was not aware of if or how the General Medical Council ("GMC") could assist with concerns relating to suspected abuse by staff that led to harm of patients, but I am now aware of what processes and assistance can be provided. As I have described above however, I did not have any such concerns for this to be relevant. There are safeguarding teams in each Trust/health board that differ in structure, I am not aware of the structure in the Hospital at the time. In my current role at BCUHB I would expect staff to be able to contact one of the team, be it a safeguarding specialist, Named or Designated Doctors for Safeguarding Children or Child Death or Head of Safeguarding Children with any concerns. I would expect for those concerns to be listened to, respected and escalated within the relevant team. Within BCUHB if concerns were raised to or by

me, I would discuss them with the Director of Safeguarding and Public Protection, Head of Safeguarding Children and the Executive Directors of Medicine and Nursing.

Speaking up

56. When I worked at the Hospital and during 2015-2016, I was not familiar with the processes by which someone could raise concerns such as whistleblowing or freedom to speak up guardians as I did not need to utilise such processes. However, I was aware of their existence.

57. I do not remember there being any in depth training regarding CDOPs, SUDiC or coronial procedures during my training, as such, I would certainly not describe it as comprehensive. I would not have expected this to form a core part of our training other than a brief overview as part of wider safeguarding training. I do recall a lecture regarding SUDiC later in my training.

58. I was aware of the various external bodies (e.g. NHS England, the local commissioners, Monitor, NHS Improvement, the Care Quality Commission, Child Death Overview Panels, the police or the GMC) whose function was to scrutinise the care and service delivery to patients at any hospital (amongst other functions). As I did not have any concerns at the material time (in 2015-2016) I did not consider it to be necessary to utilise or make contact with them.

59. I was involved in the Coronial investigation relating to the death of Child A, who was subsequently named on the Letby criminal indictment. I provided a witness statement and oral evidence in the inquest. I feel that all information that I provided was accurate and sufficient. As was that provided by the other witnesses and the Hospital.

The responses to concerns raised about Letby from Trust management

60. I left the Hospital in 2016 and was not working on the NNU when the concerns with regard to Letby had been raised. I cannot therefore comment as to the Trust Management's response to those concerns. I was working in the hospital when the CQC had become involved which created a feeling amongst the team that we had in some way failed. The morale was impacted by this, but I have no first-hand experience as to how the team perceived the Trust management's response to concerns raised about Letby.

Reflections

61. I have often thought about what if anything could have been done to prevent these incidents and continue to consider what measures could be put in place to prevent something similar happening. I have been asked as to whether CCTV monitoring of the babies on NNU would have prevented Letby's crimes and I think it is very difficult to answer this question. From the evidence I have seen I would expect that Letby would have taken any CCTV equipment into account when harming the babies and tried to obscure her actions. I do not think CCTV would be enough of a deterrent to have stopped her making any attempts on their lives. CCTV over the patient spaces however, would also invade the privacy of breast feeding mothers which would need to be considered.

62. I have also been asked by the Inquiry as to whether systems, including security systems relating to the monitoring of access to drugs and babies in NNUs would have prevented deliberate harm being caused to Letby's victims. There are reasonable restrictions to drugs within hospitals where in most cases drugs are locked away with only one or two sets of keys to allow access held by the nurses on shift. I believe this was the case at the Hospital at the time. Stock count is closely monitored for some groups of medication, however I do not believe Insulin to be one of these. Insulin has been used by health professionals in other cases of murder and attempted murder, so there is perhaps a need to review how access and monitoring could be/ should be changed.

63. Access to the NNUs is restricted, but I think further restriction to individual babies could be more problematic than beneficial. I cannot even begin to think how access could be restricted to specific staff members on a shift-by-shift basis, but even if implemented this would also run the risk of denying access to non-designated staff in the case of an emergency.

64. From my experience neonatal deaths are often far too easily attributed to prematurity and sepsis as well as NEC, amongst other common mechanisms of death. The evidence for cause of death is often poor, but this is often not considered in great detail. Understandably we as health professionals do not instantly consider malicious harm by our colleagues but there are also other medical conditions to consider. Additionally, Coroners are also not extensively trained and experienced in neonatal death to challenge the information given.

65. Moving forward I feel strongly that where there is no clear evidence of cause of death and/or death was not anticipated 24 hours previously, these deaths should be managed

following SUDIC/PRUDIC protocols with wider discussions with Named Doctor's for Safeguarding and/or child death alongside coroners and the Police where appropriate. Named Doctors for Child Death must encourage and actively take part in discussions when children die on the NNUs and must be involved in perinatal morbidity and mortality discussions (In Wales there is only one Named Doctor for Child Death Nationally, so this would fall to Named Doctors for Safeguarding Children for the Health board). The experience and background of the Named Doctors will vary, with some having very little neonatal experience and it is essential that they consider and respect the opinions of colleagues with neonatal experience, and consider seeking guidance from other Named Doctors, especially those with neonatal experience.

66. I have no other evidence to support the Inquiry. I have reviewed the various statements and documents provided to me by the Inquiry and consider my prior evidence to be accurate and have not made any public comment concerning the actions of Letby or the Inquiry.

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: 20/06/2024_____