Witness Name: Dr Sudeshna Bhowmik
Statement No.: 1
Exhibits: None
Dated: 4 June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR SUDESHNA BHOWMIK

I, Dr Sudeshna Bhowmik, will say as follows: -

Personal details

1. My full name is Dr Sudeshna Bhowmik.

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

2. I gained my primary medical qualification as a doctor (MBBS) in 2002 from University of Delhi, India. I gained my MRCPCH (Member of Royal College of Paediatrics and Child Health) qualification in 2007. I gained my Certificate of Completion of Training (CCT) at the end of my specialist training in September 2016, when I was added to the Specialist register of the GMC (General Medical Council) as a paediatrician. I am currently a Fellow of the Royal College of Paediatrics and Child Health.

3. I have been in paediatric training in the UK since August 2004. I worked as Senior House Officer (SHO) in Paediatrics in Southend Hospital for one year and did a two=year SHO training programme in West Midlands consisting of 6 month posts at George Eliot Hospital, Nuneaton (general paediatrics), Birmingham Women's Hospital (tertiary neonatology), Burton General Hospital (general paediatrics) and Birmingham Children's Hospital (paediatric cardiology). I then moved to North West deanery in August 2007 and had postings in Tameside Hospital (ST3 general paediatrics), Royal Manchester Children's Hospital (ST3 paediatric metabolic and paediatric neurology), Wythenshawe Hospital (ST4 general paediatrics and tertiary neonatology), Rochdale Infirmary (ST5 general paediatrics and community paediatrics), Royal Manchester Children's Hospital (ST6 paediatric oncology, ST6 paediatric allergy/immunology, ST6 – 7 paediatric respiratory), Wrexham Maelor Hospital (ST7-8 general paediatrics) and Countess of Chester Hospital (ST8 general paediatrics) over subsequent years.

4. I was posted in Countess of Chester Hospital ('the hospital') in an ST8 post (speciality trainee year 8) from March 2016 to September 2016. This was my final training post before I gained my CCT. I worked on the registrar (middle grade) rota, working on a part-time

basis, which typically consisted of Wednesday to Friday. Primarily, I spent the majority of my time on the Children's ward, only working on the neonatal unit (NNU) when there was a operational need for me to do so, or when on call.

5. I&S I started working as a locum paediatric consultant in November 2016 (Alder Hey Children's Hospital, then Arrowe Park Hospital). I have been a substantive full-time consultant at Arrowe Park Hospital since 2017.

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

Child L

6. I have been asked about my involvement in the care of Child L following his birth on PD April 2016. I have already given a statement to the police regarding his admission to the NNU which is reproduced at **[INQ0001223]**. Unfortunately, as set out in that witness statement, I have no specific memories of Child L. As such, the detail of my involvement that was provided to police was taken purely from my clinical notes. I had noted that Child L's observations were normal other than a slightly high respiratory rate and low weight. He was clinically well and there were no risk factors for sepsis. There was nothing remarkable about Child L's observations (they were in keeping with him being born pre-term) and I confirm that having re-read his notes, I do not find anything in his presentation at the time which would have given me any cause for concern.

7. I have been asked about the episode of hypoglycaemic collapse suffered by Child L on the morning of 9 April 2016 where he had to be resuscitated. I was not present on NNU when this happened (this was a Saturday so only on-call staff would have been present). I do not remember when I learnt about Child L's collapse and have no recollection about any discussions regarding this. I had been working part-time Wednesday to Friday during that post. Hence after my shift on Friday 8 April, I would likely only have been back at work on the following Wednesday 13 April and most likely been based on the children's ward rather than NNU.

Child N

8. I have also been asked about my involvement in the case of Child N. I provided a further witness statement in relation to Child N to police **[INQ0000626]**. Unfortunately, I do not have any personal recollection of Child N and my input was once again based on my clinical notes. I attended his delivery at 13:42 hours and he had a low birth weight, but he cried immediately and had good APGAR scores of 9 at one min and 9 at 5 mins (APGAR

scores are a scoring system out of 10 to evaluate how well a baby is adjusting to life outside the womb – anything over 7 is reassuring). He was brought to the NNU. His initial observations were satisfactory and his care was handed over to a colleague. I next saw Child N on the ward round the following morning of PD June 2016 at 11am. He was on antibiotics and breathing unsupported in room air, with oxygen saturations of 100%. I learnt that Child N had had an episode overnight, at around 01.10 hours, when his oxygen saturations had dropped to 40% along with colour change and duskiness, but had settled thereafter and did not need supplemental oxygen for very long. As this was a long time ago, I do not have any actual recollection of the ward round on PD June 2016 and am basing my response on the clinical notes. I cannot remember what my thoughts were about the incident of collapse. I also do not remember having any discussions about it with colleagues.

Child O

9. I had also been involved in the care of Child O (born PD June 2016) on 23 June 2016. As detailed in my witness statement to police **[INQ0001396]**, I had been on a long day on-call shift and had been on the children's ward in the daytime. I went to NNU for afternoon handover between 16:30 – 17:00. On arrival at NNU, I found that Child O was being resuscitated in the intensive care room (Nursery 1) and helped with doing cardiac compressions. Sadly, his death was pronounced whilst I was present as resuscitation attempts proved ineffective. I remember discussing with Dr Gibbs (on-call consultant) about the sudden collapse of Child O and his death and the need to check his triplet siblings (Child P and other surviving sibling). As sepsis is the first differential diagnosis for any deterioration in a neonate, we agreed that his siblings should be screened and covered with antibiotics as a precautionary measure. We examined both the siblings and did not have any concerns about them.

10. I recollect that I was not back at work until the next week when I learnt that Child P had also died, whilst the third triplet (who was transferred to a different hospital) survived. I remember being very surprised to hear this and had discussions with fellow trainees, who were all surprised as well. I do not recall specifics of those discussions but the general feeling was that of surprise, along with speculations about cause of death such as infection, metabolic or genetic conditions etc. At some point after this, I was informed by the consultants about the previous mortality concerns on the unit (which I was not aware of before) and the decision to invite the RCPCH to conduct an inquiry into this. I cannot recall exactly when or who had informed me of this.

<u>Raising concerns about deaths and critical events</u>

11. I have been asked about the number of deaths which occurred on NNU between 2015 and 2016. I do not know the answer to this. I first became aware of the increased mortality on the unit following the deaths of Child O and Child P. As far as I remember, all of us trainees had been informed collectively by our consultants about the mortality concerns and decision to invite an RCPCH inquiry into this. I did not have any concerns up until then.

12. I do not have any access to any data collected by MBRACE or any other organisation regarding these deaths. I cannot recall having access to any of this data whilst employed at the hospital.

13. I completed my posting at Countess of Chester Hospital in the first week of September and moved onto Wrexham Maelor Hospital on 7 September 2016. I therefore did not get to hear of the formal outcome of the RCPCH inquiry or lessons learnt. I only heard through word of mouth (informally from other trainees and consultants) that no conclusive reasons had been found for the increased mortality and subsequently heard of the decision to commence a police inquiry.

14. Most hospitals conduct perinatal mortality and morbidity meetings (jointly with obstetric and paediatric teams) a few times a year to discuss cases of death or severe illness/ complications in the newborn period. I cannot remember if Countess of Chester Hospital had a similar system. I am unable to comment on how deaths were usually investigated on NNU in this hospital.

15. I do not remember being part of any formal discussions about the deaths or clinical events of any of the babies named in the indictments, apart from the RCPCH inquiry and later the police statements. It is possible that discussions may have taken place in morbidity mortality meetings that I was not present for (especially with me being a part-time worker at the time).

16. I subsequently became aware following the police investigation and subsequent court proceedings that Lucy Letby had been arrested and charged with crimes in relation to a number of babies on the NNU. Personally, I did not know Lucy Letby very well; I only have vague memories of having worked with her. I did not have any concerns about her at the time whilst I was working at the Countess of Chester. I only became aware of concerns and suspicions about Letby when the police investigations were underway and she was arrested. I did not report any concerns about either Letby or about the safety of babies on the unit, because I did not have any concerns at the time I was working there. It is only in retrospect, when reviewing cases for police statements, that I became aware of the bigger picture and noted the events that occurred before or after my own shifts.

Safeguarding of babies in hospital

17. I have had regular Level 3 Safeguarding training during my career and am aware of processes to report concerns of abuse by staff members in hospital. In the first instance we are encouraged to report to our line managers and discuss referral to social services and/or police. As doctors, we would seek support or advice from peers (eg. safeguarding leads in hospital) or professional bodies such as defence unions (Medical Defence Union, Medical Protection Society etc) or British Medical Association.

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

18. I cannot recall what the exact processes were for raising concerns within the hospital in 2015-16. As previously stated, I have worked for a number of organisations over many years and therefore due to the length of time elapsed, I cannot be sure as to which processes related to each respective organisation. Current recommendations in most hospitals now would be to escalate concerns through departmental channels (e.g. clinical director, clinical governance and safety leads) and speaking to the Freedom to Speak Up Guardians if concerns remained unaddressed.

19. I have had training on processes such as Child Death Review, Sudden Unexpected Death in Infancy or Childhood (SUDIC). I think my training was comprehensive enough to understand when to raise concerns or suspicions; however as already stated I did not have concerns at the time I was working at the hospital. It is only in retrospect, when reviewing cases for police statements, that I became aware of the bigger picture and noted the events that occurred before or after my own shifts.

20. I have not communicated with any other external agency (e.g. Care Quality Commission, NHS England, Coroner's Office etc.) in relation to my involvement with the babies that are the subject of this Inquiry.

The culture and atmosphere of the NNU at the hospital in 2015-2016

21. I spent relatively little time on NNU during my posting in the hospital, compared to time spent on Children's Ward, Paediatric Assessment Unit or Children's A&E. I was a less than full-time trainee (I&S) and mainly worked Wednesday – Friday with 60% on-calls compared to a full-time trainee (i.e. 60% of long-day on-calls or night shifts, including 60% of weekend on-call shifts). I was rarely on NNU during routine 9 – 5 shifts as usually one of my colleagues who had started the working week from Monday was already very familiar with what was going on in NNU and would carry on for the rest

of the week. Therefore, most of my time working on NNU used to be mainly during on-call shifts i.e. evenings (5pm – 9pm) or night shifts (8:30 pm – 9am) but I would also be covering other areas such as Children's Ward and Paediatric Assessment Unit as well. Hence overall, my time on NNU was probably around 20% of my working hours.

22. My immediate line manager in the hospital during my posting would have been my educational supervisor, Dr Murthy. I would have reported any concerns – had I had any - to any of the consultants e.g. whoever was on-call during a shift or else to my supervisor or the clinical lead of the department.

23. I was not aware of any tension or issues between staff members at the time I was working there. I would not be able to comment on relationships of clinicians or nurses with managers as I did not have any dealings with managers. I did not observe anything during my work on NNU which made we worry about the quality of care given to the babies there. I spent limited time on NNU, but did not have any concerns about the culture there – it did not seem any different from other neonatal units I had worked in across the country. The only noticeable change was after June 2016 when the RCPCH inquiry was called and the NNU was downgraded to a Level 1 unit – all staff in general appeared worried and ill at ease. Prior to this, I found all staff professional, approachable, and pleasant to work with.

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

24. I did not raise any concerns about Letby with those in management because I did not have any concerns at the time I was working there.

Reflections

25. It is difficult to say if CCTV monitoring of babies could have prevented Letby's crimes. More obvious acts such as dislodging of an endotracheal tube etc. would be easier to detect (especially in retrospect), whilst administration of wrong/extra drugs may still be difficult to detect or prove. The existence of CCTV monitoring may act as a deterrent and may be helpful to look back at unexplained events. Security systems monitoring access to drugs or babies may also be of some benefit though not fool-proof. Both of these ideas could be included in recommendations this inquiry should make; however it would also be an invasion of privacy of parents spending time with their babies, some of whom are incredibly poorly, as well as mothers trying to breast-feed or to express breast-milk. There is therefore a difficult balance to be struck.

Any other matters

26. I do not have any other evidence to present to this Inquiry. I confirm that my statements are accurate to the best of my knowledge and do not need any amendments.

27. I have not given any interviews nor made any public comments about Letby or this inquiry.

Request for documents

28. I do not have any other documents or information relevant to this 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: 20/6/24