Witness Name: Dr Lucy Beebe
Statement No.: 1
Exhibits: 0
Dated: 26th June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR LUCY BEEBE

I, DR LUCY BEEBE, will say as follows: -

Personal details

1) My full name is Dr Lucy Sian Beebe (nee Hunt). My qualifications are BSc (Hons) MBChB (Hons) MRCGP.

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

2) I completed my medical degree at the University of Leicester, graduating in 2009. I am a member of the Royal College of General Practitioners.

3) I undertook my foundation training (FY1 and FY2) at University Hospitals Leicester. I then commenced paediatric specialist training in the Midlands (ST1-3). I tried to move my training to the North West but was unable to get a deanery transfer. This led to me leaving paediatric training and working as a locum paediatric SHO in Wrexham. I&S I&S, I started General Practice training in 2014.

4) Prior to working at the hospital, I worked at four other neonatal units; Kettering (Paediatric ST1), Northampton (Paediatric ST2), Leicester Royal Infirmary (Paediatric ST3) and Wrexham Maelor (Paediatric Locum SHO)

5) I worked between August 2015 and February 2016 in the hospital's children's ward and neonatal unit as part of my first year of GP training (GPST1). I worked less than full time (60%). Between February 2016 and August 2016, I worked as a GPST1 in Obstetrics and Gynaecology and between August 2016 and March 2017, I was a GPST2 in Care of the Elderly. Both placements were at the hospital.

6) I left the hospital in March 2017. I obtained my certificate of completion of training in General Practice in November 2019. I currently work as a GP Partner in North Wales.

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

7) While working at the hospital, I was not directly employed by the hospital, and was instead employed by the then St Helens and Knowsley NHS Trust who were designated as lead employer for junior doctors at this time. Any HR/contract issues were dealt with by the lead employer. My clinical supervisor during my paediatric placement was Dr Gibbs (Consultant Paediatrician). If I had any clinical issues and needed support, I would have contacted the Paediatric Registrar initially and then the Consultant on call if needed. The Paediatric Consultants were always approachable and supportive to the Junior Doctors.

8) I have been asked how I would describe various categories of relationships at the hospital:

   a) I don't remember any personal interaction between myself and the nursing managers or senior hospital managers, so I am unable to give an opinion on relationships between managers and clinicians.

   b) I don't recall any issues. I felt that the relationships between clinicians appeared like that of the previous hospitals I had worked at.

9) I do not believe that the quality of relationships on the NNU affected the quality of the care being given to the babies on the NNU.

10) I found the general culture on the NNU from August 2015 to February 2016 to be very similar to the previous units I have worked on. The doctors and nurses worked well together with a mutual respect. Typically, I find that neonatal nurses can often be very protective of their patients, particularly with new, inexperienced junior doctors. It took some time for me to gain their trust and to understand that I was not a typical GP trainee, as I had some experience of working with neonates.

11) Following my time on the NNU, I moved to the Obstetrics and Gynaecology team at the hospital in February 2016. In my opinion, the two departments had good working relationships. I became aware that the NNU had been downgraded via an email sent to me from the Obstetric Consultants in July 2016. I have no knowledge of any changes to the working culture in 2016 as I was not working on the NNU.

12) I do not recall hearing any comments or reports relevant to the Inquiry about the quality of care, the quality of the management, supervision or support of doctors between 2015-2016.

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

13) I had examined Child I on a number of occasions. I was not present when Child I died on 23 October 2015. In my police statement [**INQ0000514**, page 3], I state that -

"I remember it being odd that she kept on getting unwell and as I have said previously I wondered whether we missed something that she had been born with, like a metabolic condition to explain why she kept on collapsing. I remember being quite frustrated that she would go out to other Hospitals and then in a few days she would come back better, but with no answers. I felt upset when she died because we hadn't got to the bottom of it".

14) During my evidence at the criminal trial, on 27 January 2023, I commented that my reaction to Child I's death was one of "shock and frustration" [**INQ0010297**]. Although I stated I was shocked at Child I's death, it was not because I thought somebody had intentionally harmed her. As a doctor, you spend your entire career trying to help and heal patients. It is almost unthinkable that a doctor or nurse could intentionally murder patients. I was not aware of the underlying concerns regarding Letby, so to me, I was more concerned that the baby had an unusual diagnosis that had not been found in time.

15) I remember being shocked about Child I's death because I was not expecting her to die. Despite her recurrent medical emergencies, I remember she had been doing well and I thought she had come to a stage where she was likely to be discharged home to her family in the future.

16) I do not now recall when or how I came to learn of Child I's death. I was not aware of any continuing discussions between members of staff about Child I's death. I did not attend the debrief meeting in respect of Child I on 9 November 2015.

17) In the final page of my police statement [**INQ0000514**] I state that:

"*[My] only memory of the person arrested is seeing her in a side room crying on an occasion, saying 'It's always me when it happens'. It wasn't the main ITU room, it was the*

first HDU room but I can't even say it was after [Child I] died or if it was in relation to another incident because there was a number. We all have times when we are involved in really awful diagnoses and we all have times like that, so I really didn't think anything of it then and to be perfectly honest it was a perfectly normal reaction looking back even now".

18) I do not remember any incidents on the unit. It is not uncommon for babies to need emergency care or resuscitation. My interpretation of the event at the time was that Letby had an unfortunate run of shifts, which has happened to most nurses and doctors during their careers.

19) I was not involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

20) I was not concerned about the neonatal death rate during my short time at the neonatal unit. I worked part time and was split between the children's ward, post natal wards and the NNU. I was not personally involved in any resuscitations or deaths. I did not know how deaths on the NNU were usually investigated. I appreciated that unexpected or unexplained deaths should be reported to the coroner for further action.

21) I did not have any suspicions about Letby during my time on the NNU and was not aware of any concerns being raised about her. It came as a surprise to me when I saw her named in the media after her first arrest. No one raised concerns about Letby directly with me.

22) I was not aware of any concerns about Letby being raised with management during my time at the hospital.

Safeguarding of babies in hospitals

23) I do not recall receiving safeguarding training, specifically in respect of what to do when abuse by a member of staff towards babies or children in the hospital is suspected.

24) I do not know whether the Royal College of GPs or GMC assist doctors with safeguarding guidance or advice in the context of suspicion or abuse by a member of staff towards babies. I am now the safeguarding lead at my GP practice. If I needed advice in this scenario again, I would seek advice from my local safeguarding team which has dedicated safeguarding nurses and doctors.

25) I do not recall receiving any training on the process used and organisations involved in reviewing a child death such as Child Death Review, Sudden Death in Infancy/Childhood (SUDI/C) and the Coroner's Office.

26) I have not been involved in raising concerns about paediatric deaths so cannot comment on what external scrutiny bodies with whom concerns could be raised.

Reflections

27) In my opinion, CCTV may have prevented the crimes of Letby.

28) Systems, including security systems relating to the monitoring of access to drugs and babies in NNUs, might possibly have prevented deliberate harm being caused to the babies named on the indictment.

29) I have been asked what recommendations I think the Inquiry should make to keep babies in NNUs safe from any criminal actions of staff. My view is that formal safeguarding training should address what to do where there is concern about intentional harm from staff, when to suspect and how to raise concerns. I also believe that steps should be taken to ensure that staff who are whistleblowing are listened to and protected from harm.

Any other matters

30) There is no other evidence I can give from my knowledge and experience which is of relevance to the work of the Inquiry.

31) My statements to the police remain accurate and I do not wish to amend them.

32) I have not given any interviews or made any public comments about the actions of Letby or the matters of investigation by the Inquiry.

Request for documents

33) I have no further documents or other information which are potentially relevant to the Inquiry's Terms of Reference which I can provide.

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: 3/7/24