Witness Name:
Simon Hedley Greaves
Statement No: 1
Exhibits: 0
Dated: 11th June 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR SIMON HEDLEY GREAVES

I, Dr Simon Hedley Greaves, will say as follows: -

Personal

1. My full name is Simon Hedley Greaves

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

2. I have been asked to provide a short summary of my career as a doctor. These are:

    a. MBBS 2012 University of London
    b. Member of The Royal College of General Practitioners
    c. GP Register since 07 November 2017

3. My GMC reference number is I&S .

4. I completed a graduate-entry course at St George's Medical School, in London, from 2008 to 2012. I then did my foundation training in London, working in Kingston Hospital and Epsom & St Helier Hospitals.

5. In 2014, I moved up to Cheshire, where I started my GP training. My initial placement was six months in general practice in Birkenhead, followed by a six-month placement at the Royal Liverpool Hospital in geriatrics.

6. I then moved to the Countess of Chester Hospital for a year where I worked in paediatrics, orthopaedics and obstetrics and gynaecology.

7. I finished my GP training with a fifteen-month placement at Lache Health Centre in Chester.

8. On finishing my training, I moved to City Walls Medical Centre in Chester, where I am now a GP partner.

9. I started at the Countess of Chester hospital in paediatrics on 5th August 2015. I then moved to orthopaedics on 2nd December. My third placement was obstetrics and gynaecology which started on 6th April. I finished working at the Countess of Chester in August 2016 and have not been employed there since.

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

10. My supervisor was Dr Saladi, Consultant Paediatrician, during my paediatrics placement. During the working, day, we would report to the on-call registrar or consultant.

11. I was the subject of a police audio interview on 5th February 2021. The transcript of the interview is at **[INQ0101310]**. From page 14 onwards, I am asked some general questions about the NNU. I stated that while undertaking my GP training on the NNU I did not:

    "find it a very pleasant working environment…and [I] didn't feel particularly welcome on there…".

12. I had not worked with children in hospital before and I found the staff on the paediatric ward welcoming and easy to work with. This was in stark contrast to the neonatal unit, where it felt that the new doctors seemed to be something that had to be tolerated. Some of the staff were helpful, but others could be critical and unhelpful and did not seem willing to take the time to teach.

13. At page 15 of the interview transcript, I say:

"...the nurses seem to be quite domineering in what they wanted…and didn't seem to respect the doctors…I didn't find some of them overly helpful either…I also, sometimes, got the impression that some of the senior consultants felt like it was run more by the nurses than by the doctors...[and that there was] an unpleasant atmosphere and not a particularly collaborative one between doctors and nurses on the NNU"

14. I had no contact with hospital managers and experience of their relationships with clinicians.

15. The relationship between doctors and nurses was unlike any ward I had worked on before. The nurses appeared disinterested in working with the doctors and the senior doctors appeared frustrated at the lack of cooperation from their nursing colleagues.

16. I have been asked if the quality of relationships and/or culture on the NNU affected the quality of the care being given to the babies on the NNU. I think it probably did. I think there was some resistance from the staff on the neonatal unit to consultants providing clinical oversight and leadership and this may have allowed an environment to exist where poor clinical care might go unnoticed and criminal acts might be easier to hide.

17. I cannot comment on the wider management and governance of the hospital.

18. I was based on the NNU from August to December 2015 while I undertook my training. I had not worked in another neonatal or paediatric unit. It is difficult to compare a neonatal unit to an adult ward, however, adult wards I have worked on and the paediatric ward at the hospital had a far more inclusive and collaborative working environment than the neonatal unit.

19. There was more respect and better communication between doctors and nurses on the adult ward I worked on.

20. I do not remember hearing any comments or reports about the neonatal unit at the Countess of Chester prior to my arrival in 2015.

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

21. I was not involved in developing lessons learned about adverse incidents or deaths in the hospital.

22. My paediatric placement was only for four months. When I arrived, I became aware that there were concerns about an unusual number of deaths. When I returned in April 2016 to work in obstetrics and gynaecology I heard of further deaths.

23. I do not know how deaths on the NNU were usually investigated. I was not involved.

24. I was not aware of the suspicions or concerns of others about the conduct of Letby.

Safeguarding of babies in hospitals

25. I have had safeguarding training for both adults and children, which I am required to update regularly. I am not aware of having had training specifically relating to abuse on the part of a member of staff towards babies or children.

26. I have not sought assistance from any professional body regarding a member of staff suspected of harming patients. When I worked at the hospital, I was a Senior House Officer and therefore would have sought advice from the on-call registrar or consultant if I had immediate safeguarding concerns.

Reflections

27. Had the babies been monitored by CCTV, the crimes of Letby could possibly have been prevented. It might have acted as a deterrent and might have enabled her to have been caught sooner.

28. I have been asked if I think systems, including security systems relating to the monitoring of access to drugs and babies in NNUs, would have prevented deliberate harm being caused to the babies named on the indictment. This is possible. I do not know how practical this would be on a neonatal ward as I did not administer drugs on

the ward. Additionally, it is my understanding that Lucy Letby used large volumes of air in her attacks which I believe would not be prevented by such systems.

29. I have also been asked what recommendations I think the Inquiry should make to keep babies in NNUs safe from any criminal actions of staff. I make the following recommendations based on my experience on the unit only and not with any information that has subsequently become available. I feel that there should be:

    a. Clear consultant-led clinical management structure.
    b. Integrated, collaborative working between all clinicians and healthcare workers on the ward and a ward-based consultant or registrar.
    c. Openness and respect between colleagues at all levels.

Any other matters

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

31. The transcript of my audio interview appears to be accurate, and I do not wish to make any changes.

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

Request for documents

33. I do not have any documents or other information which 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.

Signed: Signed by: Personal Data

Dated: 11.07.2024 | 16:17:00 BST