Witness Name:
Statement No.: 1
Exhibits: 0
Dated: 22 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JIAN MIN HOR

I, Jian Min Hor, will say as follows: -

1. My full name is Jian Min Hor.

2. I provide this statement in response to a request dated 7 June 2024 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request").

3. To assist the Inquiry to the best of my ability, I have addressed each question set out in the Rule 9 Request insofar as I am able to do so at this stage of the process.

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

4. I graduated from University of Liverpool, with a Bachelor of Medicine and Surgery (MBChB) in 2012.

5. I attained membership to the Royal College of General Practitioners (MRCGP) in 2018.

6. I received fellowship to the Royal Australian College of General Practitioners (FRACGP) in 2018.

7. My medical career to date is as follows:

    a. March 2022 – ongoing. Medical student mentor and teaching at Monash University, General Practice, Guardian Medical Clinic, Box Hill and Monash University Health Services, Australia.

b. 18 October 2021 – ongoing. General Practitioner in General Practice at Guardian Medical Clinic Burwood / Box Hill, Australia.

c. 4 January 2023 - 20 June 2023. General Practitioner in Urgent Care at Glen Waverley PPCC, Australia.

d. 14 May 2018 – 27 September 2021. General Practitioner in General Practice at Our Medical Home Cranbourne, Australia.

e. 3 August 2016 - 1 August 2017. GPST 3 Doctor in General Practice at Bunbury Medical Practice, UK.

f. 6 April 2016 - 2 August 2016. GPST 2 Doctor in Obstetrics & Gynaecology at Countess of Chester Hospital, UK.

g. 2 December 2015 - 5 April 2016. GPST 2 Doctor in Geriatric Medicine at Countess of Chester Hospital, UK.

h. 5 August 2015 - 1 December 2015. GPST 2 Doctor in Orthopaedics at Countess of Chester Hospital, UK.

i. 4 February 2015 - 4 August 2015. GPST 1 Doctor in Paediatrics at Countess of Chester Hospital, UK.

j. 6 August 2014 - 3 February 2015. GPST 1 Doctor in General Practice at Great Sutton Medical Centre, UK.

k. 2 April 2014 - 5 August 2014. Foundation 2 Doctor in Histopathology / Haematology at Warrington Hospital, UK.

l. 4 December 2013 - 1st April 2014. Foundation 2 Doctor in Gastroenterology at Warrington Hospital, UK.

m. 7 August 2013 – 3 December 2013. Foundation 2 Doctor in Psychiatry at Hollins Park Hospital, UK.

n. 4 April 2013 - 6 August 2013. Foundation 1 Doctor in Vascular Surgery at Warrington Hospital, UK.

o. 5 December 2012 - 3 April 2013. Foundation 1 Doctor in Acute Medicine Unit at Warrington Hospital, UK.

p. 1 August 2012 - 4 December 2012. Foundation 1 Doctor in Upper Gastrointestinal Surgery at Warrington Hospital, UK.

8. In 2015 – 2016, I was a General Practice Specialty Trainee, at the hospital.

9. I left the hospital on 2 August 2016. I currently work in Victoria, Australia, as a General Practitioner.

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

10. Between June 2015 and June 2016, I did not work under any managers. I reported to the paediatric specialist registrar or consultant paediatrician.

11. I have been asked to describe the relationships between: (i) clinicians and managers; (ii) nurses, midwives and managers; and (iii) medical professionals (doctors, nurses, midwives and others) at the hospital.

    a. I cannot comment on relationships between clinicians and managers as I did not witness any communications between consultants and managers.

    b. I cannot comment on relationships between nurses, midwives and managers as I did not witness any communications between nurses / midwives and managers.

    c. With regards to relationships between medical professionals, I felt there was very good camaraderie and working relationship between consultants, registrars, senior house officers, paediatric nurses and NICU nurses.

12. I do not think the quality of relationships on the NNU affected the quality of the care being given to the babies on the NNU.

13. There was a safe and supportive work culture on the NNU between June 2015 and June 2016. I always had someone more senior to turn to in the event of any uncertainty or queries. Consultants were welcoming of any queries, if registrars were not available.

14. I cannot comment on whether the professional relationships affected the management and governance of the hospital in 2015 and 2016 as I had no interactions with management and governance.

15. I cannot comment on whether the quality of relationships, or the culture on the NNU, changed in any way after June 2016 as I no longer worked on the unit at this time.

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

16. I was present during part of the attempt to resuscitate Child A on the evening of 8 June 2015. I provided a statement to the coroner dated 4 March 2016 **[INQ0008892].**

    a. I left the resuscitation of Child A to attend the Paediatric Ward to update the handover list and clerk new admissions, as there were adequate members of staff present during the resuscitation. Given my brief involvement, I cannot comment on whether there was any discussion regarding Child A's deterioration or his presentation (in particular, any unusual discolouration) during his resuscitation.

    b. I was not involved in any discussions regarding Child A's collapse and death.

    c. I cannot recall whether there were any discussions or debriefs (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of Child A. I do not think I should have been involved in a debrief or discussion about this incident.

17. I cannot recall how many deaths occurred on the NNU between 2015 and 2016.

18. I am unable to recall whether I had access to data prepared by MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other organisations about the mortality rate and number of serious adverse incidents on the NNU.

19. Due to the passage of time, I am unable to recall how lessons were learned about adverse incidents or deaths in the hospital. I cannot recall whether I was involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

20. I was not worried about the number of deaths on the NNU. However, it felt unusual to have a number of sudden deterioration of neonates during my time there. Due to my limited experience in neonates, I did not bring this to anyone's attention at the hospital or elsewhere.

21. I am unable to recall the specific pathways used to investigate deaths on the NNU.

22. Due to the passage of time, I cannot recall whether I attended any discussions or debriefs (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of the deaths of the babies named on the indictment shortly after their deaths. I do not think I should have been involved in any debrief or discussion about any particular baby death.

23. I did not attend any discussions or debriefs following clinical events for the babies named on the indictment and in respect of which charges for attempted murder against Letby were ultimately brought. I do not think there should have been a discussion which I was part in relation to any specific event which I now know was an attack by Letby.

24. I was not aware of the suspicions or concerns of others about the conduct of Letby. No one discussed any concerns about Letby directly with me.

25. I did not use any formal or informal process to report any suspicions or concerns about Letby, or any concerns for the safety of babies on the NNU as I did not have any concerns to report.

Safeguarding of babies in hospitals

26. I have received safeguarding training. Unfortunately, I am unable to recall specifically what the training encouraged in respect of what to do where abuse on the part of a member of staff towards babies or children in hospital is suspected, but I unable to recall when and by whom. Safeguarding minors and mandatory reporting as practice is of the utmost importance.

27. I cannot recall local guidelines from my professional body and whether they assist with safeguarding guidance or advice in the context of suspicion or abuse by a member of staff towards babies. I did not turn to any professional body for advice in respect of events at the hospital. In this situation, I would have turned for help or advice from my supervisor.

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

28. Due to the passage of time, I am unable to recall the processes and procedures for raising concerns within the hospital that were in place in 2015-2016.

29. In my position at the time, we were trained in what deaths were reportable to the coroner when completing death certification, mainly for adults. On the paediatric rotation any child deaths processes were handled by more senior staff i.e. the consultants and registrars.

30. At the time, I did not consider what were the external scrutiny bodies with whom concerns could be raised. I did not provide any information about Letby, or express concerns or suspicions about the deaths or injuries to the babies named on the indictment, to any external bodies.

31. Aside from the statement I provided to the coroner dated 4 March 2016, regarding Child A **[INQ0008892],** I did not voluntarily provide any information to the coroner (in writing or by telephone) about any of the deaths of the babies named on the indictment.

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

32. I did not raise any concerns about Letby with those with management responsibilities at the Trust.

Reflections

33. If the babies had been monitored by CCTV the crimes of Letby possibly could have been prevented, as movement of staff and timeline of events could have been monitored.

34. I am not certain on 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 the babies named on the indictment.

35. I have been asked to comment on any recommendations I think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff.

    a. CCTV monitoring would provide invaluable information to review cases. Unfortunately, there is no absolute way to keep babies in NNUs safe from criminal actions of staff. The main way is to take any reporting of concerns seriously and make sure investigations are done by an independent party to avoid any bias.

Any other matters

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

37. I have reviewed the statement I provided to the coroner dated 4 March 2016, regarding Child A **[INQ0008892].** I consider this is accurate.

38. 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

39. 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 to the best of my knowledge and belief. 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 of its truth.

Signed: Personal Data

22.07.2024 | 09:38:25 PDT

Dated: ____________________________________