Witness Name: Anthony Ukoh

Statement No: 1

Exhibits: 0

Dated: 20 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF ANTHONY UKOH

I, Dr Anthony Ukoh, will say as follows: -

Personal details

1. My full name is Dr Anthony Ukoh.

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

2. I am currently working as a Paediatric Consultant. I have been practising Paediatric medicine in the UK for 28 years. I obtained my primary medical degree (MBBS) in Nigeria in 1992 after completion of my medical undergraduate training there. I passed the PLAB exam in the UK in September 1995 and secured my first Paediatric post as a Senior House Officer in February 1996. After I passed the Paediatric membership exam, I went on to complete my postgraduate Paediatric training in the London Deanery and subsequently was awarded Certificate of Completion of Training (CCT) in Paediatrics in 2010.

3. I have held numerous Paediatric posts and worked in various hospitals in the UK as a Paediatrician. I commenced as a Senior House Officer in Paediatrics, progressed on to Paediatric Registrar and finally to, Paediatric Consultant, the position I currently hold.

4. I have listed below my awarding bodies and memberships with professional organisations.

    a. MBBS (Nigeria)
    b. PLAB (GMC)
    c. MRCPCH (RCPCH)
    d. CCT (GMC)
    e. MDU
    f. BMA

5. When I left the hospital in August 2016, I was working as a Locum Paediatric Registrar. I did not have any management or additional responsibilities.

6. I left the hospital on 5 August 2016. I currently work at Altnagelvin Hospital, Londonderry, Northern Ireland as a Locum Paediatric Consultant.

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

7. My managers between April and August 2016 were Dr John Gibbs & Dr Stephen Brearey.

8. I feel unable 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. I was not there long enough to be able to truly give an accurate description of the relationships.

9. I did not know the nature and quality of the relationships on the NNU to comment on whether those working relationships affected the quality of care given to the babies on the NNU.

10. As far as I can remember, I would describe the culture on the NNU as cordial in August 2016.

11. I did not know much about the nature of professional relationships and so I feel unable to comment on whether those relationships affected the management and governance in the hospital in 2016. In that regard, I am not able to comment on how the culture of the hospital compared to other hospitals I worked at between 2015 – 2016 or how the working relationships compare to the equivalent relationships at the other hospitals in 2015 - 2016.

12. I had not heard any comments or reports on (i) the quality of care; (ii) the quality of the management, supervision and/or support of doctors; or (iii) the nature of the relationships on the NNU in 2015 - 2016.

Whether suspicions should have been raised earlier and whether Letby should have been suspended earlier

Child L

13. I was involved in the care of twins Child L and Child M on Saturday 9 April 2016 when working a long day shift (0800/0830 to 2100) covering the NNU and paediatric wards in my role as a locum Registrar. I gave a statement to the police dated 6 November 2018 in relation to Child L and Child M **[INQ0000639]** and there is a transcript of my oral evidence to the Crown Court in Letby's criminal trial **[INQ0010303 p. 33-40]**. Letby was convicted of the attempted murder of Child L and Child M on 9 April 2016.

14. In terms of my involvement, I was the Paediatric Registrar on-call on 09/04/16. I was carrying out routine morning ward round of all patients on the NNU. Child L was one of the in-patients. There were no clinical signs or symptoms that caused me concern after my examination on my ward round at 1020hrs.

15. I requested a blood sample from Child L in line with the Neonatal Unit Policy as blood sugar levels were running persistently low in a condition called Hypoglycaemia. When Hypoglycaemia occurs, part of the management plan is usually to investigate with blood tests to detect if there are any possible underlying medical condition. Blood samples would have been taken to the Biochemistry Lab at the hospital.

16. I note that the pathology report for Child L appear at **[INQ0001177 p. 7-8]** and **[INQ0001175]**. I was shown the blood test results that I ordered in respect of Child L by the police when they took a statement from me. This was the first time I saw those blood results. The results showed that the blood insulin levels in Child L appear disproportionately high compared to low C-peptide levels. If these results were shown to me at the time, I would have wondered if Child L had received exogenous insulin from an outside source. In terms of further investigations, I would have repeated the blood tests, discussed it with the Consultant on duty, other team members and possibly escalated the case to the Paediatric Endocrinology team for further advice.

17. I do not recall attending any discussions or debriefs (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of Child L. If the blood results were picked up at the time, then a discussion ideally should have been arranged to look further into this potentially serious issue.

Child M

18. I was involved in the care of Child M on 9 April 2016. In terms of my involvement, I was the Paediatric Registrar on-call on 9 April 2016. I was carrying out routine morning ward round of all patients on the NNU. Child M was one of the in-patients. I did not note any clinical signs or symptoms that caused me concern after examination on my ward round at 1025hrs.

19. I recall that at 1600 hours I responded to a call for help in respect of Child M **[INQ0001226]**. Child M looked pale with no spontaneous body movements and appeared lifeless. Two other neonatal nurses were also present. I gathered over time from police interviews and court proceedings that Letby was one of the nurses. I do not recall who the other nurse was.

20. I described Child M's collapse as *"completely unexplained"* **[INQ0001226]**. I thought the collapse was unexplained because Child M appeared relatively stable prior to the collapse with no red flags, breathing nicely on his own with no prior respiratory support. His collapse came suddenly and even after resuscitation, various investigations carried out (chest and abdominal x rays and blood tests), did not confirm any obvious detectable cause like sepsis, infection or any respiratory condition. I do not you recall discussing Child M's collapse with Dr Ravi Jayaram or anyone else at the end of my shift.

21. As far as I can remember, I personally did not attend any formal debriefs or discussions in relation to Child M's collapse since Child M was successfully resuscitated and fortunately survived. If Child M had tragically died, there would have been debriefing and formal discussions and I would have expected to be involved.

Child N

22. I was involved in the care of Child N on 15 June 2016 when working a long day shift covering the paediatric ward and the NNU. There is a copy of the transcript of my interview with the police on 12 September 2018 in relation to Child N **[INQ0007389].**

23. I note that Letby was charged with 3 counts of attempted murder of Child N. One count on 3 June 2016 for which she was found guilty and two counts on 15 June 2016 (at about 0715-0730 hours and 1500 hours) for which the jury failed to reach a verdict.

24. I have considered the extracts from Child N's medical records (including the shift before and the shift after) **[INQ0000579 p. 33-47 and p. 96-103]**. Unfortunately, I do not recall the specifics of the morning handover on due to the lapse of time since the event occurred.

25. I examined Child N on 15 June 2016 at 0945 hours as part of my routine ward round examination. I recorded my examination and assessment in the extract of the clinical notes for Child N (including the shift before and the shift after) **[INQ0000579 p. 37-38]**. In terms of any clinical signs or symptoms which caused me concern, Child N appeared quiet with mottled skin. There was dried blood around the lips and inside the oral cavity. I observed intermittent episodes of abnormal extension of upper limbs with back arching.

26. I contacted a Consultant Haematologist by the name of Dr Caswell at Alder Hey Children's Hospital to seek advice about Child N's care **[INQ0007389 p.15-16]**. I was worried that Child N had deteriorated the night before with increased episodes of apnoeas (stopping breathing) There were unsuccessful intubation attempts with increased bleeding into the oral cavity. With this deterioration, his history of haemophilia, poor clinical appearance and abnormal body movements, I was very concerned he may have had a large bleed into his brain called intraventricular haemorrhage. I sought advice involving obtaining and administration Factor 8 (ADVATE) very urgently. ADVATE is a recombinant antihemophilic factor indicated for use in children and adults with haemophilia, used to control and prevent bleeding episodes.

27. I do not recall personally attending any discussions or debriefs, (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of the collapses of Child N on 15 June 2016. If one was held, I would have expected to have been involved in a debrief or discussion about Child N.

Child O

28. I worked the day shift on 23 June 2016 **[INQ0007389 p. 34].** Child O, a triplet, died on 23 June 2016. Letby was convicted of his murder.

29. I do not recall any discussions about Child O's death at the evening handover on 23 June 2016 and/or the morning handover on 24 June 2016.

30. I do not recall attending any discussions or debriefs, (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of the death of Child O on 23 June 2016. However, with every neonatal, child death or in fact

with death of any patient, I believe some form of debrief or discussion should be offered to all parties involved. If one was held, I would have expected to have been involved in a debrief or discussion about Child O.

Child P

31. I was involved in the care of Child O's siblings, Child P and Child R on 24 June 2016 when working a day shift covering the paediatric ward and the NNU. I gave a statement to the police dated 6 November 2018 **[INQ0001470]** and made a statement on 4 August 2016 at Dr Stephen Brearey's request **[INQ0005248]**. Child P died on 24 June 2016. Letby was convicted of his murder.

32. I do not recall what was discussed at the handover on the morning of 24 June 2016 about Child P and Child R's care.

33. I started the ward round examination on 24 June 2016 by seeing Child P first in Nursery 2 at 0935 hours **[INQ0005248]**. Child P appeared generally stable when I examined him. He looked slightly pale with a moderately distended abdomen and slightly mottled skin. I decided to rescreen his bloods to cover for possible infection **[INQ0001470]**.

34. Shortly after my examination of Child P, I recall being alerted to the fact that Child P had become unwell. As far as I was concerned, Child P's deterioration was unexpected given he did not look that unwell prior to deterioration. However, given the sudden deterioration and death of his sibling the day before, in my view as a clinician, this would always be a possibility.

35. I have reviewed the clinical note of Dr V at **[INQ0001453 p. 18]** stating:

"Called to Nursery 2 as [Child P] unwell. Dr Ukoh and SN Lucy present. Dropping sats and heart rate. Just a few mins earlier had briefly seen [Child P]…Shortly after this [Child P] deteriorated. Dr Ukoh started to bag…Dr U arrived and took over airway from Dr Ukoh…"

36. In my interview with the police and in my oral evidence to the Crown Court I stated that during the resuscitation of Child P a nurse requested that Dr U attend. I did not note anything suspicious about the conduct of Letby or any other individual at the time, however, I must point out that I was unaware there had been concerns and suspicions regarding Letby in the first place during the whole of my short period as a locum doctor at the hospital.

37. I do not recall attending any discussions or debriefs, (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of the collapse and/or death of Child P. However, with any neonatal, child death or in fact with death of any patient, I believe some form of debrief or discussion should be offered to all parties involved. If one was held, I would have expected to have been involved in a debrief or discussion about Child P.

38. I remember vaguely discussions about the similarity of circumstances between the siblings, Child O and Child P, but this was about the possibility of infection or some undetected rare inborn error of metabolism being possible cause for these sudden explained deaths. I do not recall who was present during those discussions.

39. I did not pick up on any changes in the way nurses and doctors on the NNU interacted with each other (e.g. paediatricians and nurses etc.) following the deaths of Child O and Child P.

40. A copy of a Facebook Messenger exchange between Letby and Dr U on 8 August 2016 between 0935 and 0940 hours appears at **[INQ0000569, p. 32]**. With reference to this exchange, I never had any discussion whatsoever with Letby.

Response to Neonatal Deaths

41. I was concerned about the number of deaths on the NNU, but I remember the Neonatal lead Consultant, Dr Brearey, had already informed me about this at the beginning of my placement at the hospital. They had taken note of the increase and were very closely monitoring events and were on a heightened level of alert.

42. I did not have 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. However, as mentioned above, I had been informed by Neonatal Consultant Lead at beginning of my placement, that the NNU had more than the national average mortality rate.

Reviews of Deaths and Adverse Events

43. There were firm protocols already in place at the hospital to review adverse incidents or deaths. I personally was not formally involved as a locum middle grade doctor in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

44. In terms of how deaths on the NNU were usually investigated, usually it would be through the coroner. There would also be mortality meetings held within the hospital. Doctors directly involved would usually start submitting their own statements as a first step.

45. I do not recall attending 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.

46. I do not recall attending any discussions or debriefs following clinical events for the babies named on the indictment. In hindsight, I think there should have been a discussion in relation to the specific events which I now know was an attack by Letby.

Awareness of suspicions

47. I was never made aware of the suspicions or concerns of others about the conduct of Letby throughout the short 4-month period I worked as a locum doctor at the hospital.

48. I did not use any formal or informal processes to report any suspicions or concerns about Letby, or any concerns for the safety of babies on the NNU as I was not aware of any concerns or suspicions in the first place.

Safeguarding of babies in hospitals

49. I received informal safeguarding training online through personal CPD learning via the Royal College of Paediatrics and Child Health. This training covered what to do where abuse on the part of a member of staff towards babies or children in hospital was suspected.

50. My professional body (MDU) would assist me with any safeguarding 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.

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

51. I cannot fully remember the processes and procedures for raising concerns within the hospital that were in place in 2015 - 2016, but escalating issues to the Paediatric Consultant on duty would always be the first step.

52. I had some training on the processes 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. The training was comprehensive enough to help me understand when to raise concerns or suspicions.

53. I was aware of the external scrutiny bodies with whom concerns could be raised, for example, NHS England (and its regional bodies), local commissioners, Monitor, NHS Improvement, the Care Quality Commission, Child Death Overview Panels, the police or the General Medical Council. I did not provide any information to these external bodies as I was never made aware of any concerns or suspicions the medical staff had regarding Letby.

54. I never provided any information to 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

55. I never raised any concerns about Letby with those with management responsibilities at the Trust.

Reflections

56. I think that CCTV monitoring could have possibly prevented the crimes of Letby.

57. I consider that to some extent 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.

In terms of recommendations to keep babies safe in the NNUs from any criminal action of staff, I would ask the Inquiry to consider the following:

a. More secure storage of medicines on NNUs, with closer monitoring of stock and better accountability daily.

b. More robust and impartial way of whistleblowing and ensuring that the whistleblower does not fear any form of reprisal or backlash.

c. Impartial interventions to be made after escalation to senior management. This should be made in a timely fashion. If senior management had acted sooner, then maybe some of events could have been prevented.

Any other matters

58. I do not have any other evidence, or information of relevance to the work of the Inquiry.

59. I confirm that I have reviewed my previous statements and from what I recall of the events, these statements are accurate and there is nothing that I wish to amend at this point.

60. I have never 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

61. 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 of its truth.

Signed: Personal Data

Dated: _____