Witness Name: James Smith
Statement No.:1
Exhibits:0
Dated:19 August 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JAMES SMITH

I, James Smith, will say as follows: -

1. My full name is Dr James Smith.

2. I provide this statement in response to a request dated 4 July 2024 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request"). This statement is based on my personal recollection of events and a review of various documents, as referenced in this statement.

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 qualified as a doctor in 2006 with MBBS from University College London. I hold the following qualifications B.Sc (Hons), Dip.Psych MBBS M.Sc MRCPCH MRCPsych which includes Membership of The Royal College of Paediatrics and The Royal College of Psychiatry.

5. I was awarded CESR (Consultant Certification) in General Paediatrics in February 2023. I have worked at Whiston Hospital in Paediatrics since 2015. I have 14 years' experience in Child Heath.

6. I worked at the Countess of Chester Hospital in the paediatrics department from 4th February 2016 to 29th February 2016 as a Locum Registrar in Paediatrics and Level 2 neonatology (ST5 equivalent). I was hired through Medacs locum agency via standard procedures. At the time of working at Countess of Chester Hospital, I was the equivalent of ST5 (middle registrar level) in Paediatrics with over 4 years' experience in paediatrics. I had never worked at the hospital previously.

7. After finishing my locum shifts at the hospital in February 2016, I returned to work at Whiston Hospital and have worked there ever since to the current date. My position is Associate Specialist / Locum Consultant in Paediatrics and Level 2 Neonatology and I cover bank shifts and Consultant clinics.

Inquiry questions

8. I have been asked to comment on who my managers on the neonatal unit ("NNU") were. As I only worked there for 3 weeks as a Locum Registrar, I reported to the Paediatric Consultants who I was on duty with.

9. I have been asked of my knowledge of relationships between (i) clinicians and managers; (ii) nurses, midwives and managers; and (iii) medical professionals (doctors, nurses, midwives and others) at the hospital. As I worked there for such a short time, I am unable to comment on this.

10. I have been asked whether I think the quality of relationships on the NNU affected the quality of the care being given to the babies on the NNU. As I worked there for such a short time, I am unable to comment on this.

11. I have been asked to comment on how I would describe the culture on the NNU between 2015-2016. As I worked there for such a short time, I am unable to comment on this.

12. I have been asked to comment on whether I think professional relationships affected the management and governance of the hospital in 2015- 2016. As I worked there for such a short time, I am unable to comment on this.

13. I am unable to make any meaningful comparison with any other hospitals I have worked for regarding the culture on the NNU or working relationships as I worked there for such a short time. I had not heard of any comments or reports on (a) the quality of care, (b)

the quality of the management, supervision and / or support of doctors, or (c) the nature of the working relationships at the Countess of Chester Hospital's NNU in 2015-2016.

Child K

14. I have been asked to explain the nature of my involvement in the deterioration and resuscitation of Child K at about 03:50 hours, 06:15 hours and 07:25 hours. I have explained my involvement with Child K fully in my three police witness statements dated 23rd May 2018 [**INQ0002323**], 10th March 2022 [**INQ0002321**] and 30th August 2022 [**INQ0002320**].

15. My involvement with Child K at the criminal trial on 27th February 2023 is set out in the transcript of my evidence [**INQ0010308, p.18-39**]. I also gave evidence at the criminal re-trial of 2024.

16. I have nothing to add to the witness statements I have made to the police and my court testimony in 2023 and 2024. I have reviewed these statements and I believe them to be correct to the best of my ability and in the context of being cross examined in court. I would ask that the Thirlwall Inquiry please review this evidence if they require an overall picture of my involvement in the care of Child K.

17. I have been asked to what extent, if at all, I had concerns regarding Child K's collapses. I did not have concerns at the time because I believed then that the displacement of the tube had occurred because of Child K moving. However, this was due to my lack of experience at the time. I understand now that this would be unusual in a neonate of Child K's gestation. I also now in retrospect find it concerning that this baby needed reintubating twice during a single shift but at the time, I did not find this unusual due to my lack of experience.

18. I have been asked if I discussed the displacement or blockage of Child K's endotracheal tube with anyone on the 17th February 2016 shift. I did not because I believed at the time that the displacement of the tube had occurred because of Child K moving. However, this was due to my lack of experience at the time, and I understand now that this would be unusual in a neonate of Child K's gestation. I also now in retrospect find it concerning that this baby needed reintubating twice during a single shift but at the time I did not find this unusual due to my lack of experience.

19. I was not aware of any enquiries that were made at the time regarding the displacement of Child K's endotracheal tube.

20. I did not attend any discussions or debriefs (formal or otherwise) between doctors on the NNU and/or between doctors and other medical staff in respect of Child K on 17th February 2016 or thereafter. I think that if there were concerns at the time regarding the care of Child K, I could have been included in a discussion around this. However, I understand that the situation the Consultants were in must have been very difficult.

CQC

21. I was not involved with the CQC visit to the hospital between 16th and 19th February 2016.

22. I was not spoken to by the CQC team. I did not raise any issues of increased mortality on the neonatal unit with the CQC.I am not aware whether others may or may not have done this.

23. I did not raise the issue of patient safety and/or concerns that staffing factors (whether incompetence or deliberate harm) may have a link to the increased mortality raised with the CQC. I am not aware whether others may or may not have done this.

Mortality rates

24. I have been asked how many deaths occurred on the NNU in 2015 as far as I was aware. I do remember Dr Gibbs, Consultant in Paediatrics, telling me that there had been a number of deaths on the neonatal unit over the past year and that they were very worried. I cannot remember his exact words, but I remember him telling me they were not sure why this was happening.

25. I am not sure who raised the fact that filters had been put on the taps in the neonatal unit, but I remember these, and I believe I raised this with Dr Gibbs saying I noticed the filters on the taps. I remember him telling me that this had not been found to be the cause for the deaths. I remember him looking worried, but I am unable to remember anything further from the conversation.

26. I have been asked if 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. My answer is that I did not.

27. I have been asked how lessons were learned about adverse incidents or deaths in the hospital. As I worked there for such a short time, I am unable to comment regarding this and I did not attend any perinatal mortality and morbidity meeting while I worked there. I was not involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

28. I have been asked whether I was worried about the number of deaths on the NNU. I remember being concerned by how worried Dr Gibbs seemed and this has stayed in my memory long after working there. However, this was a very short conversation and at the time, I had such a limited insight into the overall picture. As a result, I was unable to make any conclusions and I was not able to bring the situation to anyone's attention at the hospital or elsewhere.

29. I have been asked how the deaths on the NNU were usually investigated. As I worked there for such a short time, I was not involved in any investigation or decisions regarding post-mortem examination.

30. I have been asked if 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 have been asked if I think I should have been involved in a debrief or discussion about a particular baby death for any reason. The only baby who died that I was involved with was Child K and that baby died at a different hospital. Therefore, I do not think I should have been involved in a debrief discussion for that baby.

31. I have been asked if I attended 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 did not. Debriefs are conducted shortly after the clinical incident has occurred with the staff involved. I therefore do not think it would have been appropriate or possible to include me in debriefs following clinical incidents for babies in the indictment as the only baby I was involved in the indictment was Child K. The only baby's care I was involved in for which harm was prosecuted was

Child K. I believe Dr Jayaram was in a difficult position as to who to disclose what he saw that night to, and I do not think it would have been appropriate for him to disclose those concerns to me given the situation. However, as I will explain below there were two other babies that I had been asked to make police statements regarding that I do think at the time the Consultants could have explored in more detail with me what I saw and that it should have been disclosed to me that similar unusual discolorations had been seen in other babies on the neonatal unit as was disclosed at the trial in 2023.

32. At the end of this statement, I will include two babies which I have been asked to make police statements about, for which I do feel I should have been made aware of the background concerns about what had been happening on the neonatal unit.

Suspicions regarding Letby

33. I have been asked if I was aware of the suspicions or concerns of others about the conduct of Letby and, if so, when and how did I became aware of those concerns. I was not aware of the suspicions or concerns of others about the conduct of Letby. No one discussed any concerns about Letby with me.

34. I have been asked if I ever used any formal or informal process to report any suspicions or concerns about Letby, or any concerns for the safety of babies on the NNU. I did not. I did not report concerns about Letby because at the level of my experience at the time, I did not witness anything that I took to be unusual in the care of Child K. In retrospect with additional experience, I do find the fact that a premature neonate of 26 weeks gestation needed reintubating twice on that shift to be a concern.

Safeguarding

35. I have been given safeguarding training, specifically in respect of what to do where abuse on the part of a member of staff towards babies or children in hospital is suspected.

36. I have been given Level 3 Safeguarding training a number of times throughout my career and if I suspect abuse on the part of a staff member, I am to report this immediately to my manager and to the police.

37. My professional body the GMC and the Royal College of Paediatrics gives clear guidance on what to do if there is suspicion of abuse of others by a member of staff. I

would turn to my Consultants and Clinical Director and Safeguarding lead and the police for help or advice in this situation. I did not turn to any professional body for advice in respect of events at the hospital as I was not working there for long enough to understand what was happening and the wider situation.

Whistleblowing and FTSU

38. As I worked there for such a short time, I am not aware of the exact processes and procedures for raising concerns within the hospital that were in place in 2015, including whistleblowing and freedom to speak up guardians. However, if I had concerns regarding clinical care, I definitely would have raised them with my Consultant supervisor and Clinical Director and if I suspected deliberate harm, I would have raised it with the Safeguarding lead and the police.

Investigation processes

39. I did not have any training at the time 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 other than that covered in Level 3 Safeguarding. Level 3 Safeguarding covers when to raise concerns and how to do this. It covers SUDIC and Child Death review.

40. I am not sure whether it specifically focuses on the Coroner's Office.

41. I have also been asked whether I thought the training was sufficiently comprehensive to help me understand when to raise concerns or suspicions. As I did not have any suspicions at the time, I am unable to comment on this.

42. I have been asked what I considered were the external scrutiny bodies with whom concerns could be raised. As I did not have any concerns at the time, I did not consider this. 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 of these external bodies.

43. I did not provide any information to the Coroner (in writing or by telephone) about any of the deaths of the babies named on the indictment.

44. I have been asked if I raised any concerns about Letby with those with management responsibilities at the Trust. I did not because at the time I had no concerns.

CCTV

45. I have been asked if I think if the babies had been monitored by CCTV, the crimes of Letby could have been prevented. I do think that if the babies had been monitored by CCTV it may have been possible to prevent some of the later crimes as there appears to have been a clear link established early on between deaths and collapses on the neonatal unit and the presence of Lucy Letby. Examining CCTV footage once serious concerns had been raised may have revealed something that would have resulted in earlier arrest and prevented further harm.

46. However, I believe the methods of harm such as injection of air through an IV line or via an NG tube would be difficult to detect on CCTV.

NNU systems

47. I have been asked whether 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. I am not aware of the security systems relating to the monitoring and access to drugs on the NNU at Countess of Chester, but I believe these would be kept in a locked cupboard. Nurses would have access to this cupboard so that would not have prevented Lucy Letby's access.

48. Access to babies on NNU's by nurses is a necessity so I am not sure beyond swipe cards for nurses what could be done to increase safety. Police DBS is already mandatory to be a healthcare worker. CCTV may have prevented deliberate harm to babies on the NNU as it may have acted as a deterrent in that the perpetrator would know they are being watched. However, this may lead a perpetrator to come up with more covert methods of harm. As noted above, I believe the injection of air through an IV line or via an NG tube would be difficult to detect on CCTV.

Recommendations

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

50. I believe that the Inquiry should make sure that there are formal mortality morbidity meetings for any baby suffering collapse or death on a neonatal unit with the Consultants attending as a group and discussing all the cases. I believe this does occur and it certainly occurs at Whiston Hospital. However, I feel that in view of the patterns that appeared to be present as to what was occurring making sure these meetings are in place is important.

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Miscellaneous

91. I have been asked to review my police witness and court statements. I consider these accurate and I do not wish to amend them.

92. I have given no interviews or otherwise made any public comments about the actions of Letby or the matters of investigation by the Inquiry.

93. I do not have any documents or other information which are potentially relevant to the Inquiry's Terms of Reference. I do not have any documents relating to concerns that were raised about Letby or the safety of the babies on the NNU in 2015.

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: PD

Dated: 20.08.2024 | 14:10:09 BST