Witness Name:
Dr Kaliyilil Luke George Verghese
Statement No.: 1
Exhibits:

Dated: [14.6.2024]

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR KALIYILIL LUKE GEORGE VERGHESE

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1. I, Dr **Kaliyilil Luke George Verghese**, will say as follows: -

Medical Career and employment at the Countess Of Chester Hospital (COCH)

2. I am a registered Medical Practitioner. I studied Medicine (BM BCh) at Oxford University with an intercalated BA in Medical Sciences between 2006 and 2012. I was granted full registration with the General Medical Council in July 2013.

3. I was awarded membership of the Royal College of Paediatrics and Child Health (MRCPCH) in November 2016. I was awarded membership of the Royal College of General Practice (MRCGP) in February 2022.

4. I am currently working as a sessional salaried GP, two days a week in Ormeau Health Centre in South Belfast. I have been there since January 2023. I occasionally work locums in other practices in the Belfast area and have been working as an Out of Hours GP for the Belfast Trust since April 2022.

5. As part of my training, I had to complete two foundation years (house officer) of pre speciality training at hospitals within a specific geographical deanery. I completed my foundation years within the Mersey Deanery and worked in a number of placements between Warrington General Hospital and Alder Hey Children's Hospital.

6. After my two foundation years, I applied for speciality training (ST) in the area of Paediatrics and applied to the Mersey Deanery. During my ST1 placements, I completed six months within the neonatal unit at Liverpool Women's Hospital between September 2014 and March 2015. I then moved to Alder Hey Children's Hospital within the Accident and Emergency department between March 2015 and September 2015.

7. During my ST2 placements I moved to general paediatrics at the Countess of Chester Hospital (COCH) between September 2015 and March 2016 as a paediatric SHO (senior house officer). I then moved back to Alder Hey Children's Hospital working in the renal department between March 2016 and September 2016.

8. During my ST3 placements I returned to the COCH Hospital as a registrar between September 2016 and March 2017. I do not recall holding any management or additional responsibilities. I then moved back to Alder Hey Children's Hospital working in paediatric cardiology between March 2017 and September 2017.

9. My ST4 placements were 6 months in the paediatric renal department and 5 months within paediatric emergency medicine at Alder Hey Children's Hospital between September 2017 and July 2018.

10. In July 2018, I moved to Northern Ireland I&S I worked as a paediatric ST5 registrar in Royal Belfast Hospital for Sick Children from August 2018 to February 2019 and then at Antrim Hospital from February to August 2019. I then changed to a training programme in general practice (GPST) I&S

11. For GPST1 I worked in the Mater Infirmorum Hospital between August and December 2019. I then moved to the Emergency Department in the Royal Victoria Hospital between December 2019 and August 2020. In GPST2 I worked in the Shankhill Road Surgery between August 2020 and February 2021 before moving to Elmwood Medical Practice between February 2021 to February 2022 before becoming a fully qualified GP.

The culture and atmosphere of the neo-natal unit ("NNU") at COCH in 2015-2016

12. I do not recall who the managers were between September 2015 and March 2016, when I carried out my first placement, or second placement between September 2016 and March 2017 at COCH. I would have had clinical supervisors for both posts who would have been paediatric consultants. I think Doctor V and Dr Brearey were my clinical supervisors, but I do not recall for which respective posts. As well as reporting to them if needed I think Dr Jayaram was the paediatric clinical lead who would have also made himself available if any issues arose.

13. I would be unable to describe the relationship between the clinicians, nurses, midwives, and the managers as I rarely, if ever saw the managers. I think I met Mr Tony Chambers at induction when first joining the COCH but cannot recall if I met him or any of the management team at any other time. During my 2 placements at the COCH there was always a good relationship

between medical professionals (doctors, nurses, midwives, and others) at the hospital, and that is why I requested to go back to work at the COCH for my ST3 placement.

14. I would have generally socialised with the other doctors only within the hospital. Outside of work I would have only socialised once or twice with the NNU nurses during an organised departmental social event, for example a Christmas party. There was a good working relationship between nurses on the NNU and the doctors who worked there.

15. 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. There was a good culture on the NNU between September 2015 and March 2016. Certain nurses and paediatric consultants may have been less confident managing unwell neonates, which is to be expected as everyone would have different strengths. Certain paediatric consultants would not review the neonates face-to-face as frequently as I would expect.

16. At other units I have worked in there would have been a consultant face-to-face review of NNU patients 1 to 3 times a day. However, when working in COCH if I had any concerns with regards to any specific neonate all the consultants were responsive to my concerns and would have seen the neonate either of their own accord or if I requested.

17. I am unaware of any professional relationships that affected the management and governance of the hospital in 2015 to 2016.

18. I am unaware of any change in the quality of relationships or the culture of the NNU when I returned to the hospital in September 2016 during my ST3 placement. Understandably some of the staff on NNU were disappointed in the downgrading of NICU services from a level 2 to level 1.

19. The culture between doctors and the allied health care professionals in the COCH was as good and positive as any of the other hospitals I worked in during my training during 2015 and 2016. I remember in some clinical posts in Alder Hey there was a monthly mortality and morbidity meeting (M&M), I am unaware if there was a regular one in the COCH. These regular meetings encouraged incident reporting and learning from mistakes to improve services and patient safety.

20. I am unable to comment on relationships between health professionals and managers as I had little to no contact with any managers in other posts either. However, the relationship between medical professionals (doctors, nurses, midwives, and others) at the hospital was comparable to any other hospital I worked in during my training and during posts between 2015 and 2016.

21. I was aware of the Royal College of Paediatrics and Child Health (RCPCH) review into the COCH Hospital NNU in 2015 to 2016 and some of the summary points, however, I would not be able to recall the specifics of this now from memory.

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

Child H

22. I was involved in the care of Child H on 24 September 2015. A copy of the statement I gave to the police dated 6 March 2018 in relation to Child H is exhibited as **[INQ0001032]**, as are relevant extracts from the medical records **[INQ00000972]**.

23. I am advised that Letby was charged with two counts of attempted murder of Child H, one relating to 26 September 2015 (for which the jury returned a 'not guilty' verdict) and one to an incident on 27 September 2015 (for which the jury recorded a hung verdict). I do not remember ever attending any meeting or debrief (formal or informal) about the care of Child H. During my brief time working with Lucy Letby, I had not seen anything suspicious with regards to the care of Child H otherwise I would have raised this at the time.

Child J

24. I was involved in the care of Child J on 27 November 2015 when I was working the night shift of 26-27 November 2015. A copy of the statements I gave to the police dated 6 March 2018 in relation to Child N are exhibited as **[INQ0001116 & INQ0001117]**, as are relevant extracts from the medical records **[INQ00001065].**

25. I am advised that Letby was charged with the attempted murder of Child J on 27 November 2015. The jury recorded a hung verdict.

26. I was the Neonatal SHO on-call the night of 26-27 November 2015. Having reviewed the medical notes for Child J, I can state that I was called across to the neonatal unit to see Child J due to profound desaturations. I do not recall who asked me to review the child.

27. When I arrived at Child J's cot, I assessed and examined Child J. She was alert at the time, her heart sounds were normal, her left and right femoral pulses were good, her capillary refill time was less than two seconds which is normal. Child J was working harder with her breathing than normal, her respiratory rate was up, she was sucking in her lower rib muscles but her chest had good air entry with no added sounds. Her stomach was soft and not painful.

28. I could not feel any masses and her bowel sounds were normal. I could not see any skin changes or discolouration over her stomach. I do no recall which nurse was present when I reviewed the child.

29. I was told that Child J had had two profound desaturations causing her oxygen levels to drop, the first time her oxygen saturation had dropped to 30%. Child J was being handled with her stoma care so it was difficult to know the significance of this drop as this could have been trace related.

30. During the second desaturation, Child J's oxygen saturation had dropped to 50% and she wasn't being handled. Her heart rate and cardiac output remained okay throughout these episodes. Speaking with the nursing staff they believed that Child J's desaturations were true desaturations where they needed to give some support and required manual ventilation with a neopuff (commonly known as bagging). I was told that after the episodes that Child J was pale and mottled and her work of breathing was more than what it had been previously.

31. She had been settled overnight, had not had any desaturations, had been feeding well and they had no concerns prior to these events. I cannot recall which nurse spoke to me about Child J when I arrived.

32. As the patient was stable, I would have completed on my own an A to E assessment. Once identifying an unwell child with no clear cause my first instinct would be to think that this might be related to sepsis (severe infection) in a neonate.

33. Of concern to me was the history of profound desaturations requiring intervention by the nursing staff and during my assessment that Child J was working hard with her breathing, more than normal.

34. I contacted the on-call registrar Dr Austin as she was my senior on-site that shift. One to make her aware of any unwell neonates on the ward and to check she agreed with my management plan.

35. I am not able to recall the event well from memory, having reviewed the notes also I do not think there was anything I would have done differently in respect to Child J, except now document which other health care staff were present at the time.

36. I say in my police statement **[INQ0001117]**:

    "*I can explain the events of that night as best to my knowledge but do not know the reason for the patient's collapse. The cause would hopefully have been identified over the next few days*

of her care, as the clinical investigations e.g. blood tests, blood culture results became available, and as senior doctors reviewed the baby and collated all the information together."

37. The medical team would normally undertake the review of blood tests and blood culture results. Most blood tests would have a turnaround of a few hours, with my entry at 5.15 a.m., it would be unlikely there would be results before the end of my night shift. The blood cultures take 36 to 48 hours normally to get a result so would be reviewed on the daily ward round during daytime hours.

38. I do not recall being aware of any review in the case of Child J.

39. I was not involved in the review of blood tests or blood cultures in respect of Child J during my night shift. We would have handed this over to the day team coming on at 08.30 a.m.

40. From my recollection (not the clinical notes of Child J), on the day of 27 November 2015, I think that was the day PD premature twins were born at home who needed intervention. I was only aware after the event but may have assisted Dr Gibbs overnight with any administrative tasks but I cannot recall. I am sure there would have been an informal discussion with Dr Gibbs about Child J on 27 November 2015 either after the event the same morning or at the clinical handover, but I do not recall the conversation.

41. 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 collapses of Child J on 27 November 2015. I think I should have been involved in a debrief or discussion about this incident only if senior clinicians thought there was something unexpected about the deteriorations as I had no concerns at the time from this isolated incident.

Response to Neonatal Deaths

42. I was unaware about the number of deaths on the NNU. I was aware of the occasional death but not the total number nor what number was expected for a neonatal unit of this size.

43. I am not aware of what MBRRACE-UK, the National Neonatal Research Database (NNRD) is. I was unaware of any other information NHS England, or any other organisations held about the mortality rate and number of serious adverse incidents on the NNU.

Reviews of Deaths and Adverse Events

44. I do not know how adverse incidents or deaths in the Hospital were reviewed. I was not involved in any discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

45. I do now know how deaths on the NNU were usually investigated. I don't recall being asked to participate in any investigation. I do not know when post-mortems were requested.

46. 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. I think all staff working within the department should be invited to be involved in any debrief or discussion about a particular baby death for any reason, both from a learning and safety point of view.

47. I do not recall attending 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.

48. As mentioned previously I think all staff who are working in the department should be involved in any discussions of adverse events or neonatal deaths.

49. With regards to the specific concerns of the consultants about Letby, that have come out since the Trial, I understand how that would have needed to be dealt with in strict confidence by the senior staff while building a case for possible non-accidental injury.

Awareness of suspicions

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

51. 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. I did not report any concerns because I did not have any at the time.

Safeguarding of babies in hospitals

52. As a paediatric trainee at the time, I would have been given regular safeguarding training. While non-accidental injury would have been a regular part of the training, I do not recall specifically any emphasis to suspect where an abuser might be part of the hospital staff, rather the emphasis generally always tended to be towards the family members.
53. If I had any specific safeguarding queries, I would normally deal with this within the department I was working. If I felt these concerns weren't being addressed, I could ask my medical defence union for advice.

54. However, over the years I have seen NHS whistleblowers so persistently poorly treated that it would make me very nervous to raise my concerns if I ever had any. I did not turn to any professional body for advice in respect of events at the hospital as I did not have any concerns at that time.

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

55. In COCH, I would have raised any concerns via the paediatric consultants. Incident reporting could also be completed via the computer datix system. During 2015-2016, I don't believe freedom to speak up guardians had been established.
56. I do not recall during 2015-2016 having any formal 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. When working in ED departments, "on the job", I became aware of the SUDI protocol for following the first steps when dealing with a SUDI case. I do not recall having any sufficiently comprehensive training to help me understand when to raise concerns or suspicions.
57. During that stage of my career in 2015-2016, I would have not thought much about the external scrutiny bodies with whom concerns could be raised. Partly out of ignorance and lack of teaching.
58. 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. I did not because I did not have any concerns at the time.
59. I did not ever 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

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

Reflections

61. Monitoring of the babies by CCTV could have prevented further harm to some of the latter children, identifying any perpetrators and providing evidence of non-accidental injury earlier.
62. Drug administration is supposed to be more rigorous within paediatrics with two nurses signing off before any administration, however, this can be circumvented by a rogue individual. Certain hospitals I have worked in did have security systems relating to the access of drugs.

63. Monitoring of this could have prevented further harm to some of the babies in NNUs from criminal action. However, it was not uncommon in those units for staff to share their staff card for accessing drugs as new staff did not always have a log in. This could lead to abuser hiding their actions by possibly using another person's log-in details.
64. My recommendations to keep babies in NNUs safe from any criminal actions of staff include;
    a. When carrying out safeguarding training, to emphasise with non-accidental injury the abuser can also be a staff member.
    b. Compulsory training early on in doctor training of the external bodies and process of death reviews, etc. rather than delaying this to later in paediatric training.
    c. It is important to create a positive safe environment, units that over report incidents are safer, and where reporting is used it is important it is used not to apportion blame but to learn from.
    d. With regular M&M meetings reviewing this data and more, allocating and protecting time for all grades of staff to attend, would provide a useful learning opportunity and further improve the culture and patient safety.

Any other matters

65. There is no other evidence which I can give from my knowledge and experience which is relevant to the work of the Inquiry.
66. I consider this statement accurate and there is nothing in them that I wish to amend.
67. 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

68. 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: Personal Data

Dated: 14.6.2024