

Thursday, 10 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: May Ms Taylor be sworn.

MELANIE TAYLOR (affirmed)

Questions by MS LANGDALE

MS LANGDALE: Can you give us your name, please.

A. Yes, it is Melanie Taylor.

Q. You've provided us with a statement dated 16 April 2024. Can you confirm that statement's true and accurate as far as you're concerned?

A. Yes.

Q. Do you have it with you, Ms Taylor?

A. Yes.

Q. You set out at the beginning of the statement your qualifications as a paediatric nurse in September 2010, and we know that you were working at the Countess of Chester in the period 2015 to 2016.

A. Yes.

Q. Can you give us your experience before and since about neonatal care?

A. So my career history?

Q. Yes.

A. Yes, so I qualified as a paediatric nurse in 2010 and I went to the neonatal unit at Chester. That

1

Q. How long is the course?

A. Oh, gosh, I honestly -- I can't 100% --

Q. Roughly.

A. -- remember. I feel like it's about six months possibly.

Q. Right.

A. But it's part-time, so you're still working on the unit and doing -- so -- but I couldn't tell you that's definitely true. I think it around six months.

Q. About -- so it's some significant time on an induction. And then the intensive care course, how long is that one?

A. Yeah, again, I think it was -- it's a long time ago that I did it. I possibly think again it might be about -- it's either six months or a year. Again, it's part-time while you work in the unit. It -- yes, it just gives you more in detail, in-depth knowledge about looking after babies who are a little bit sicker and a little bit more premature and would be classed as intensive care.

Q. And can you be any band to do that course --

A. Yeah, any band --

Q. -- Band 4, Band 5 --

A. It's usually Band 5 --

Q. Right.

3

1 was my first job.

2 I stayed there for a few years and, during that
3 time, I did what's called an induction course, which is
4 learning more about neonatal care, and I also did an
5 intensive care course, which is a course about looking
6 after babies who are in ITU and more sick babies.

7 I left in, I think it was, 2019 and trained as
8 a health visitor, and after my training I did that for
9 about 18 months, and then came back to the neonatal
10 unit. And currently I am doing my advance neonatal
11 nurse practitioner training, so I'm a full time student
12 seconded from the unit, and I hopefully will go back and
13 work as an advanced neonatal nurse practitioner.

14 **Q.** Can you tell us something about that induction
15 course and intensive care course versus something that
16 you're doing now, the advanced neonatal practitioner
17 course, you know, what's the level of experience and
18 qualification across those areas?

19 **A.** So the induction course is a standard course
20 that I think the majority, definitely in the
21 north-west -- it's -- because neonatal care is
22 specialised it's extra training to learn to care for
23 neonatal and then premature babies, and all staff that
24 start on the neonatal unit, usually within about a year
25 or so, will go on to the induction course.

2

1 **A.** -- so there's no time limit -- I think it's

2 not a compulsory course, as far as I'm aware, in terms
3 of units across the country but our hospital we do -- we
4 do get sent on it, so --

5 **Q.** So were you all encouraged to do that Band --

6 **A.** Yeah, we all do it. So usually, once you've
7 worked on the unit -- maybe once you've done the
8 induction course, maybe a year later or so, you would do
9 the intensive care course, usually. I mean, it can vary
10 depending on timings and things like that. But, yeah,
11 it's something that everybody does if they stay working
12 there.

13 **Q.** And I think it's right that Letby had
14 undertaken that course, hadn't she, and she was a Band 5
15 was -- were there others that had done that as well,
16 then as a Band 5 or --

17 **A.** Yeah, it --

18 **Q.** -- Band 6? Is it common or not common?

19 **A.** So -- yeah, so you do it as a Band 5. You
20 wouldn't progress, on our unit anyway, to a Band 6 level
21 role if you hadn't done that course, so --

22 **Q.** So it wasn't an exceptional qualification it
23 was something of the norm for training that you're
24 describing if you were going to be on the neonatal unit?

25 **A.** In terms of our unit, yes. I don't -- it's

4

1 not compulsory in terms of being a neonatal nurse. So
 2 I couldn't tell you, for example -- ensure, you know,
 3 what units do and don't, but not all units across the
 4 country or even in the north-west necessarily will send
 5 people on that. But ideally it's a good course to go
 6 on, and it's something that we do on the unit as part
 7 of our standard training.

8 **Q.** You are -- since January 200024, you've
 9 commenced an MSC in advanced practice neonates. So tell
 10 us about that level of specialisation as a nurse.

11 **A.** Yeah. So that is -- so it's a different job
 12 role really. So an advanced practitioner is -- it's
 13 a new way of role in terms of we didn't have advanced
 14 practitioners on the unit back in 2015/2016 and it's --
 15 it's a slightly different role to the nurses, whereas --
 16 although it is nursing, so you -- you kind of bridge the
 17 gap between medical staff and nurses in a way, so you
 18 need a lot more knowledge. You need experience to do
 19 it.

20 So that course is -- what I'm doing at the moment
 21 is a full-time course and it's -- yeah, your role is
 22 slightly different, so you will take part in ward rounds
 23 and assessing babies and -- rather than the sort of care
 24 you would as a nurse, so it's a slightly -- it is
 25 a different role.

5

1 **Q.** Going to paragraph 3 of your statements and
 2 your duties and responsibilities whilst working in 2015
 3 and 2016, you were a shift leader I think at that time.
 4 Can you tell us what the shift leader's responsibilities
 5 were and particularly in terms of allocating babies to
 6 nurses?

7 **A.** Yes. So the shift leaders -- a shift leader
 8 would only be a Band 6 nurse and they -- I mean, the --
 9 the role has evolved slightly over the years, so what it
 10 looks like now is slightly different to what it looked
 11 back then. But, in theory, they are overseeing the
 12 shift, so they should take a lighter workload of babies,
 13 and they are a port of call for staff if they need
 14 support or they are struggling with anything, and they
 15 should have a general oversight of all the babies,
 16 what's going on, making sure the staff are supported
 17 and, yes, they would allocate, so -- in the morning --
 18 so it -- it varied sometimes. So there was a change in
 19 when allocation was made in the nursing staff -- to the
 20 babies allocated to nursing staff, and I can't remember
 21 when that was.

22 It used to be at one point that the shift leader
 23 coming on the day shift would allocate the babies to
 24 nurses at the beginning of the shift, and it did then
 25 switch to the night -- shift leader on the night shift

7

1 **Q.** We've asked all of the witnesses to the
 2 Inquiry in writing to suggest recommendations and one
 3 doctor came back to suggest that having Advanced Nurse
 4 Practitioners in the way that you are qualified for is
 5 really helpful on a ward to have that link between
 6 doctors and nurses, continuity and to understand what's
 7 going on.

8 Do you have a view about that?

9 **A.** Yes, so, from my personal perspective, I think
 10 they are a really valuable staff member. Like I said,
 11 it's something that's fairly new to our unit, sort of
 12 the last -- I think Ashleigh was our first practitioner
 13 to be trained. I think she's possibly done it for about
 14 five years, and -- whereas bigger units have got more
 15 established teams of ANPs that work really, really well.

16 What is good about ANPs is they are -- we are
 17 specialised in neonates. It's an area that most people
 18 have worked in for many years and know really, really
 19 well and are really passionate about it, and it -- we
 20 are based solely on the neonatal unit, so we can stay
 21 there. We are a constant. We don't move hospitals
 22 every six months. So we are constant for families,
 23 a constant for staff. We are a presence that's always
 24 there and we can help support doctors and also provide
 25 continual care for the -- for the babies.

6

1 that was handing it -- or the day shift, whichever was
 2 their shift handing over to the next shift would
 3 allocate accordingly because they knew the babies maybe
 4 a little bit better because they'd spent that shift with
 5 them, so it did change eventually, but, yes -- so it
 6 would depend -- but it would have been the shift leader
 7 that was allocating.

8 **Q.** And based on your experience before 2015 to
 9 2016 and afterwards, how busy was the unit generally?
 10 I mean, we know the NHS is stressed, but how busy was
 11 the unit, typical of other years, not typical, typical
 12 to what you experience now in places? Describe for us
 13 how it was.

14 **A.** I think what -- the nature of neonatal care is
 15 that it can be all or nothing sometimes. So you can
 16 have days or periods of time where you are quieter, and
 17 then you can have periods of time where you have babies
 18 that come through quite quickly because you can't
 19 predict -- because they are premature it is not
 20 a Planned Care sometimes.

21 So I would say when I started in 2010 it was always
 22 fairly busy, constant -- on and off you would have had
 23 quieter periods. I would say probably between -- yeah,
 24 around the time of this 2015, 2016 I would say that
 25 business -- it felt like there was shifts and days where

8

1 that was very -- it was very busy, but then again there
 2 were shifts that were not so busy. I would say it felt
 3 like it was a little bit busier around that time. Yeah.
 4 But I don't have the official numbers to say, you know,
 5 this was --
 6 **Q.** No, of course, it's a sense, you were working
 7 there.
 8 **A.** Yes.
 9 **Q.** Manageably so?
 10 **A.** I think majority of it, yes. I think -- like
 11 I said, sometimes you can't predict what comes through
 12 the door, so you can have a certain amount of staff on
 13 and you could have no admissions from labour ward and
 14 manage really well. Whereas you could have a day and
 15 it's you -- it's not something you can predict, but you
 16 could have a day where you have lots of admissions
 17 coming through, and that can sometimes -- I think we
 18 always managed really well, because I think as a team we
 19 worked really well together, but sometimes that felt
 20 like it could be a lot. But I think I could say that
 21 honestly would happen anywhere.
 22 It's not something you can predict and it's not
 23 something you can staff, you know, in advance. You
 24 can't, you know, have lots and lots of staff to think
 25 the possibility that there might be lots of babies

9

1 that mean? What kind of babies were getting?
 2 **A.** So you might -- don't completely take me at
 3 what -- I think it was 27 weeks and above we used to
 4 take. It's been a long time but I think it was
 5 27 weeks.
 6 And we would also -- if we had a baby who maybe was
 7 vent -- we managed ventilators as well. The staff that
 8 had managed ventilators for years and years and years we
 9 would manage generally stable ventilators, babies who
 10 were not going to be long-term ventilation.
 11 If there was a baby that maybe -- any ITU baby --
 12 I don't know if it was any ITU baby at that time but
 13 definitely ones that we were considering were maybe
 14 having longer stays on the ventilator or had more
 15 intensive care they would be discussed with tertiary
 16 units, so a Level 3 unit Consultant. So it would be
 17 Consultant-Consultant to manage care and discuss whether
 18 they felt that that baby needed to be transferred out or
 19 not.
 20 **Q.** We asked you about the culture and atmosphere
 21 on the unit, and at paragraph 4 -- again you say it's
 22 eight or nine years ago now, we do appreciate that
 23 Ms Taylor, so doing the best that you can, how did you
 24 feel the relationships, first of all, within the unit
 25 with the ward manager, deputy ward manager were, how was

11

1 coming through when you would be over-staffed 90% the
 2 time, so -- but, yeah, I would say majority of the time
 3 it was busy but manageable.
 4 **Q.** And in terms of how well or otherwise the
 5 babies were, I'm not asking you about the babies on the
 6 indictment, but generally coming through the unit, how
 7 was that, what you'd expect in a neonatal unit or -- in
 8 your unit or not?
 9 **A.** Say the beginning bit, the how well they were.
 10 **Q.** In terms of how well they were or unwell or
 11 sick or unsick. Again, just a sense, I know -- I'm not
 12 asking you to look at data or numbers, what was your
 13 sense, what you would expect coming through a unit or --
 14 **A.** Yeah.
 15 **Q.** -- sicker, or what was your sense about it?
 16 **A.** I would say I think what I expected. I think,
 17 again like -- it's hard to say, because obviously this
 18 is all hindsight and me looking back on lots -- many
 19 years ago now. I think I never -- I never had the
 20 feeling that I was thinking this baby shouldn't be here.
 21 It was always within our realms of knowledge and care.
 22 I would say because we had limits on the gestation --
 23 **Q.** You were a tier 2, weren't you?
 24 **A.** We were Level 2, yeah.
 25 **Q.** So just -- when you say gestation, what did

10

1 it working?
 2 **A.** Yeah, so the ward manager and deputy ward
 3 manager I felt were supportive, were approachable and
 4 led really well.
 5 **Q.** And that's Eirian Powell and Yvonne Griffiths,
 6 isn't it?
 7 **A.** Yeah.
 8 **Q.** Yeah, go on.
 9 **A.** Yeah, that was my perception at the time.
 10 I definitely still agree with that. I feel -- I felt
 11 supported and I felt -- yeah, I thought there was a good
 12 culture on the unit.
 13 **Q.** And when you say supported, how did you feel
 14 supported by them? What does that mean in practice?
 15 **A.** Yeah, so they were very visible to us. They
 16 were approachable. They would -- so I think the culture
 17 on our unit has always been a very supportive one where
 18 new members of staff were encouraged to talk to
 19 managers, to check in with new staff.
 20 I always felt very welcomed by managers, by the --
 21 Eirian and Yvonne. And I felt -- yeah, I -- yeah, just
 22 a general feeling of supported-ness, and I -- yeah,
 23 I always felt like -- and not just them, I think the
 24 whole team because that culture was -- all the nurses
 25 were very approachable and always checking in with me

12

1 especially when I was newer, so yeah.

2 **Q.** And in terms of the relationships between
3 clinicians and managers, first of all with Eirian Powell
4 and Yvonne Griffiths on the unit, you say they were
5 good; yes?

6 **A.** Yeah.

7 **Q.** And what about more senior managers, would you
8 know what the relationships were like there between
9 doctors and senior managers or not?

10 **A.** Between doctors and senior managers?

11 **Q.** Yeah?

12 **A.** Between doctors and managers I -- I don't
13 know. They -- the senior managers as a possibly more
14 junior nurse, not senior or management, they weren't
15 very visible to me, so I couldn't comment on the
16 relationships between the doctors and management.

17 **Q.** Would you have known who they were? Would you
18 know who Mr Harvey was, Mr Chambers, if you'd seen then
19 them in the corridor?

20 **A.** I would know who Tony Chambers was.
21 Otherwise, I don't think so.

22 **Q.** And the relationship between nurses and senior
23 managers then, you'd say you didn't really have one,
24 didn't really know them, so nothing either way really to
25 comment on?

13

1 I don't know. But, yes, I --

2 **Q.** How's it changed? The perception -- when you
3 say a perception changed, your impression of what it was
4 like back then or you've got different relationships
5 with midwives now?

6 **A.** So I would say I have different relationships
7 with midwives now.

8 **Q.** Mm-hm.

9 **A.** I don't think it's perfect still, but I think
10 back then there was a notable -- I would say I felt
11 intimidated to go and talk to -- mostly the senior
12 midwives or the Consultant obstetric doctors I would
13 feel intimidated to talk to them.

14 **Q.** We know from parents who have given evidence
15 that they were dependent sometimes on midwives for
16 getting down to see their newborns because there was
17 a process to get through there --

18 **A.** Yeah.

19 **Q.** -- and they'd had surgery and in some cases
20 needed assistance. If you felt that, do you think it
21 might have been difficult for them to ask for help or
22 assistance, or they may have felt intimidated or not?
23 Do you think it was because you were a nurse?

24 **A.** Yeah --

25 **Q.** I'm just interested in that communication

15

1 **A.** No, I would say from my perspective as
2 a Band 5/sort of Band 6 nurse, I -- yeah, there was --
3 there was just no visibility really that was -- yeah,
4 they were probably around on the unit but they weren't
5 really known -- made known to us. They weren't
6 introduced. They didn't introduce themselves to us.
7 I don't remember them being very visible --

8 **Q.** So your --

9 **A.** -- as a nurse.

10 **Q.** As a nurse, okay. But your direct managers
11 were Eirian and Yvonne, you say they were relationships
12 with them?

13 **A.** They were, yeah.

14 **Q.** You comment on the relationship between the
15 NNU nurses and midwives, and you say that that
16 communication by the midwives was poor, which caused
17 strange relationships -- strained relationships, sorry.
18 Could you expand on that for us, please?

19 **A.** Yeah, I -- again, this is from my perspective.
20 As a more junior nurse, I felt that I was very much
21 overlooked by midwives and not respected in the same
22 way, and that came across in their communication.
23 I felt intimidated by them. I would say now my
24 perception of that is different, and whether that is
25 because things have changed or because I'm more senior,

14

1 generally.

2 **A.** I mean, I don't feel like I can comment on how
3 they would feel. I think, from feedback that I've had
4 from parents about midwives, the care has always been
5 positive mostly. So I think that probably isn't the
6 case. But I don't -- I don't know if I could comment on
7 that from a different perspective.

8 **Q.** You say the relationships between doctors and
9 nurses on the unit, on the NNU, were good. Can you
10 expand on that?

11 **A.** Yeah, I -- I think, yeah, they worked -- we
12 worked well together. I think that we had good
13 communication. I think -- yeah, I particularly didn't
14 feel like there was any concerns with the communication
15 at all. I think -- I think as a team we're quite
16 approachable, and I think that reflected in the
17 relationships we had with doctors.

18 **Q.** So you didn't find that the Consultants were
19 dismissive of you or in any way you could speak to them
20 about things?

21 **A.** No, no.

22 **Q.** Did you find they pushed your views aside in
23 any way and their views were best about things?

24 **A.** No, quite -- quite the opposite, really.

25 I think I always felt listened to by the Consultants,

16

1 even as a junior nurse I felt listened to. So, no,
2 I wouldn't agree with that.

3 **Q.** And did you feel you could ask them things if
4 you were worried about anything or raise things?

5 **A.** Yeah. I did, yeah.

6 **Q.** You answered that swiftly. So,
7 unhesitatingly, there's nothing in your mind -- there's
8 not a gremlin there where you think, "I remember that
9 time or this time"? There's no example you could give
10 us where that wasn't the case?

11 **A.** No, I've always felt -- even -- I did my nurse
12 training on the neonatal unit and the paediatric unit at
13 the Countess, and I would say as a student they were
14 approachable and kind and friendly to students -- to all
15 members of staff, so I -- yeah, I've always found
16 them -- personally, I've always found them very
17 approachable and I feel like I can ask them questions.

18 **Q.** I'm going to ask you now, Ms Taylor, about
19 Child A. And we know from your statement that Child A
20 was the first death you had experienced in hospital.

21 We know that you had a handover from Ms Hudson --
22 with the passage of time you can't really remember
23 now -- from one shift to another, don't you -- didn't
24 you? And then what happened on your shift? We don't
25 need all the medical details but what was your

17

1 desaturate. Lucy was standing by the incubator.

2 I can't remember whether I got called over or
3 whether I went over myself because he hadn't been doing
4 that, I think he had a sustained either desat or
5 bradycardia.

6 **A.** Yes, and then --

7 **Q.** And an emergency assistance call was put out,
8 wasn't it? Dr Harkness came.

9 **A.** Yeah.

10 **Q.** And sadly we know what followed.

11 **A.** Yeah.

12 **Q.** What was your reaction at the time to that
13 death? You've explained that he was stable, you weren't
14 worried about him, and then he died. Was that
15 unexpected to you?

16 **A.** It was very unexpected.

17 **Q.** The Inquiry has received evidence from all of
18 the people that were there at that resuscitation.
19 Dr Harkness I think took some time off he was so upset
20 by it. How were you feeling about it?

21 **A.** I -- well, honestly I was devastated. I -- it
22 isn't -- will never be easy, no matter how many times
23 you encounter death of a baby. You -- all you want to
24 do is care for and look after and get these babies home
25 with their parents, and I took it very hard. I was --

19

1 experience of looking after Baby A and what happened
2 subsequently?

3 **A.** So, I mean, again, my memory is -- is not
4 fully there compared to a few years ago. This was quite
5 a long time ago.

6 I remember him being well or -- I say well, he was
7 obviously needing support, usual care, but he was stable
8 throughout the shift. I remember the shift being busy
9 and struggling with some lines. I had no concerns about
10 him throughout my shift.

11 **Q.** And what happened subsequently?

12 **A.** So I because -- I handed over to Lucy Letby,
13 I don't remember that, but I know that I've written that
14 in my -- I don't remember the actual handover but I know
15 from reading my statement again that I handed over to
16 Lucy.

17 I -- up to that point, he had still been stable and
18 I had no concerns.

19 I sat at the computer, which was visible, so he was
20 visible to me while I was writing my notes. Technically
21 I think I was either at the end of my shift or I'd just
22 finished my shift, I just needed to finish writing up my
23 notes for the day.

24 I think probably my statement has it in more detail
25 from what I remember a few years ago, but he started to

18

1 yeah, I was really upset. Really, really upset
2 afterwards.

3 **Q.** Who took the lead with dealing with the
4 parents or the mother and addressing memory box and the
5 like?

6 **A.** I don't know. I wouldn't have been there,
7 because it was the end of my shift, so I -- I stayed for
8 the resuscitation. But once he had passed away, I went
9 home. So it will have been later on in that night shift
10 that a member of staff will have managed that, and
11 I wasn't there at that time.

12 **Q.** He had died, hadn't he, in Nursery 1?

13 **A.** Mm-hm.

14 **Q.** What was the view about going back to the same
15 nursery after that experience? Had anyone discussed
16 that with you?

17 **A.** I don't remember anybody discussing that with
18 me.

19 **Q.** Do you know what thoughts you would have had
20 about that, about whether you would go back into the
21 unit?

22 **A.** Yes.

23 **Q.** What were your -- your what was your thinking
24 having experienced that on that shift in Nursery 1?

25 **A.** So my personal experience was I found it

20

1 extremely traumatic and difficult. I found it difficult
 2 to go back into work. And I wouldn't have wanted to
 3 voluntarily go back into Nursery 1. It would obviously
 4 depend on capacity and staffing, but I would have voiced
 5 my request not to go in there if possible.

6 Yeah, that -- that was my personal opinion once --
 7 when a traumatic event happened in 1 I wanted, you know,
 8 possibly call it a break from more intense unwell babies
 9 and wanted to maybe look after some special care babies.

10 **Q.** And to resume later on or at another time
 11 going back to that nursery?

12 **A.** Yeah.

13 **Q.** I'm going to take you, if I may, Ms Taylor, to
 14 some text messages between Letby and another nurse on
 15 the unit and the reference is INQ0000101, page 6. So
 16 and at the bottom it is the last message of that page,
 17 going on to page 7.

18 The last message:

19 "I just keep thinking about [Monday]. Feel like
 20 I need to be in 1 to overcome it but Nurse W said
 21 no ..."

22 So that's Letby texting to say that she wants,
 23 after the death of Baby A, to be back in Nursery 1.

24 Colleague says:

25 "I agree with her [that's Nurse W] [I] don't think

21

1 Pausing there, this was your first baby death, were
 2 you aware from Letby how many baby deaths she had been
 3 present at or experienced or not? Did that ever crop
 4 up?

5 **A.** No, not at that time, no.

6 **Q.** So she says:

7 "... I've voiced that so can't do any more but
 8 people should respect that ..."

9 Your colleague says:

10 "Ok ..."

11 And your colleague says:

12 "I think They do respect it but also trying to help
 13 you. Why don't you go in 1 for a bit ..."

14 "yeah, I've done a couple of meds in 1. I'll be
 15 fine ..."

16 "It didn't sound like you would be?"

17 Says your colleague:

18 "Forget I said anything [says Letby], I'll be fine,
 19 it's part of the job just don't feel like there is much
 20 team spirit tonight ..."

21 If we go down again. Stop there, please.

22 Again from Letby, message 31363:

23 "Unfortunately I've seen my fair share at the
 24 women's but you are supported differently & here it's
 25 like people want to tell how to think/Feel.

23

1 it will help. You need a break from full on ITU. You
 2 have to let it go or it will eat you up i know not easy
 3 and it will take time ..."

4 And we go to page 7:

5 "Not the vented baby necessarily. I just feel
 6 I need to be in 1 to get the image out of my head, Mel
 7 said the same and Nurse W let her go. Being in 3 is
 8 eating me up, all i can see is him in 1 ... It probably
 9 sounds odd but it's how i feel ..."

10 Your colleague says:

11 "Well it's up to you but don't think it's going to
 12 help. It sounds very odd and I would be the complete
 13 opposite. Can understand Nurse W [she's] trying to look
 14 after you all ..."

15 Received from Letby, if we can scroll down a bit,
 16 please, Ms Killingback:

17 "Well that's how I feel, from when I've experienced
 18 it at women's ..."

19 That's Liverpool Women's Hospital, presumably:

20 "... I've needed to go straight back and have
 21 a sick baby otherwise the image of the one you lost
 22 never goes. Why send Mel in if she's trying to look
 23 after us, she was in bits over it."

24 "Don't expect people to understand but I know how
 25 I feel and how I've dealt with it before ..."

22

1 "Anyway. Onwards & upwards. Just shame i'm on
 2 with Mel and Nurse W ..."

3 If we go down two more messages:

4 "Women's can be awful but I learnt hard way that
 5 you have to speak up to get support. I lost a baby one
 6 day. and a few hours later was given another dying baby
 7 just born in the same cot space. Girls there said it
 8 was important to overcome the image. It was awful but
 9 by the end of the day i realised they were right. It's
 10 just different here ... Anyway, forget it. I can talk
 11 about it properly with those who knew him and [Mel's]
 12 not interested so I'll overcome it myself."

13 When did you -- that can come down now, please --
 14 when did you first see that text exchange?

15 **A.** I -- I don't know the exact time but it was
 16 around the trial.

17 **Q.** Around the time of the criminal trial?

18 **A.** Yeah, the criminal trial.

19 **Q.** Can you comment on that for us, tell us what
 20 you make of all of that?

21 **A.** Yeah, so as -- the first time I saw it I knew
 22 the comments about me wanting to go into -- back into
 23 Nursery 1 were not true, because I know my own feelings.
 24 The only thing I could take from it was that I had no
 25 choice in the fact with the skill mix and the fact that

24

1 there was a more junior member of staff that needed
 2 supporting.
 3 **Q.** And you were the Band 6?
 4 **A.** I was the Band 6. I wasn't in charge, but
 5 I was the Band 6.
 6 **Q.** So you had to go back in that next day?
 7 **A.** In theory, yes. And I think I probably agreed
 8 to go in there and say -- and I -- that's -- I can't
 9 remember this but this is -- I -- the only thing I can
 10 think, reading from these, was I agreed to go in there
 11 because that was the most reasonable choice with the
 12 staffing and the babies that were on the unit.
 13 **Q.** But if you'd your own way and that wasn't
 14 required you'd clearly not --
 15 **A.** I wouldn't have.
 16 **Q.** -- have done that?
 17 **A.** No. And sometimes -- you know, it can depend
 18 on the babies that are in there as well. Sometimes you
 19 can get babies that aren't intensive care in there, so
 20 that may not have been -- I mean, I think -- but, out of
 21 choice, no, I know I definitely wouldn't have expressed
 22 a want to go in there.
 23 **Q.** And was that anything that Letby had
 24 discussed, the suggestion at Liverpool Women's Hospital,
 25 that she went straight back to the same cots? Was that

25

1 **Q.** -- which we pick up again later on in relation
 2 to Letby? I'll come to that now -- shall we move on to
 3 Child C?
 4 **A.** Yes.
 5 **Q.** So if you look at Child C, paragraph 18 of
 6 your statement, you tell us when you were first called
 7 to Child C's cot. What was the situation -- and if you
 8 look at your statement there at paragraph 18/19, what
 9 did you see, what did you observe with Child C?
 10 **A.** Sorry, could you repeat that I didn't quite
 11 hear that.
 12 **Q.** Yeah, when you -- when you went to Child C at
 13 the resuscitation, what did you observe? You tell us at
 14 paragraphs 18 and 19.
 15 **A.** Yeah, so, there was -- there's a -- I can't
 16 remember exactly who was in the room, and I know this
 17 was discussed -- this has been discussed previously.
 18 What I do remember is Lucy was in the room. What
 19 I can't recall is whether -- when I arrived in the room
 20 what I can't recall is whether Sophie was already there
 21 or came in after me. She was --
 22 **Q.** What band was she, Sophie?
 23 **A.** She was a Band 5.
 24 **Q.** Right, so the same as Louis you --
 25 **A.** She was the one --

27

1 ever discussed with you at the time or subsequently?
 2 **A.** I don't remember that being discussed.
 3 **Q.** Have you ever heard of that as a way of
 4 getting over or dealing with trauma?
 5 **A.** No.
 6 **Q.** If -- if -- I'm not suggesting that was the
 7 case, I'm just saying the assertion that that was the
 8 way of dealing with it?
 9 **A.** No, I've never heard --
 10 **Q.** Have you heard of that since?
 11 **A.** No. I think -- I mean, Liverpool Women's is
 12 a very different unit and they have a lot more babies,
 13 and they have a lot sicker babies, so it's definitely
 14 a -- you know, probably -- well, it definitely happens
 15 there a lot more.
 16 So I think the staff would be involved in it a lot
 17 more. But, I mean, it's still my personal view if
 18 you -- that a death is a traumatic event for everybody
 19 and really, really upsetting, and I think it's still my
 20 view, and I wouldn't change that, that if you go through
 21 something like that that actually ideally a break from
 22 that situation is the best.
 23 **Q.** And standing back from that communication, it
 24 is a request to go back to Nursery 1, isn't it --
 25 **A.** (Nods).

26

1 **Q.** -- and you're the most senior.
 2 **A.** -- caring for the baby.
 3 **Q.** So Sophie's caring for the baby, Letby is
 4 there, what do you observe? You described the use of
 5 a piece of equipment that you were surprised by.
 6 **A.** Yeah, she -- so, again, my memory of the
 7 specific events is, you know, not great any more.
 8 I remember -- but I do remember her using a Guedel
 9 airway, which is an airway adjunct, which if you are
 10 struggling to inflate the chest, inflate the lungs with
 11 inflation breaths or ventilation breaths that can help
 12 open the airway to assist that.
 13 **Q.** So it's a piece of equipment that's usually
 14 used, what, had by doctors or --
 15 **A.** It can be used by doctors or nurses. It's
 16 something we get training in using, but very rarely get
 17 to use.
 18 **Q.** Have you ever used it?
 19 **A.** No.
 20 **Q.** At that stage you're there more senior than
 21 the other two, and is it usual that somebody more junior
 22 is using a piece of equipment that you've never used or
 23 wouldn't use?
 24 **A.** I mean, not -- I -- I -- no. And I think
 25 that's what struck me about that situation was that she

28

1 seemed quite -- she seemed confident to use this
 2 adjunct, and I couldn't personally say that about
 3 myself. I definitely had training and I had the
 4 knowledge to use it, but I wouldn't say I was confident
 5 in using it on a real baby because I'd never actually
 6 used it on a real baby at that point.

7 **Q.** Did it strike you odd at the time or is that
 8 more in retrospect when you thought about it?

9 **A.** No, it did strike any as odd at the time.

10 **Q.** Right. Did you mention that to Eirian Powell
 11 or anyone?

12 **A.** No.

13 **Q.** And was that before the doctors arrived to
 14 help with the resuscitation that she used that or can't
 15 you --

16 **A.** Yeah.

17 **Q.** So she was using that and the doctors arrived.

18 **A.** As far as I remember, yes, it was before the
 19 doctors arrived because I think they would have taken
 20 over at that point.

21 **Q.** So she'd taken the lead when there were just
 22 three nurses and then the doctors arrived?

23 **A.** Yeah.

24 **Q.** We know from Nurse W's statement, which
 25 I think you have seen, that on that night she describes

29

1 something that was necessarily out of our scope. It was
 2 just something that I was surprised she was so confident
 3 with, but she that hadn't done necessarily -- in my
 4 view, at that time, necessarily done anything wrong.

5 I -- I don't remember if I had any conversations
 6 with Eirian after that point.

7 **Q.** I'm not going to ask you about the taking of
 8 Child C's hand and footprints or any comments. Mr Baker
 9 is going to ask you questions about that after my
 10 questions --

11 **A.** Yes.

12 **Q.** -- but you address that in your statement.

13 I'm going to move on if I may to Child I, who we
 14 know, of course, was -- we know now was murdered on
 15 23 October.

16 Child I is a child that had had a series of
 17 collapses, hadn't she?

18 **A.** (Nods).

19 **Q.** And you say she was on the unit for a while
 20 and you'd got to know the parents and the child.

21 **A.** Yes.

22 **Q.** Again, how did you respond to this death, was
 23 it expected, from your point of view, or not?

24 **A.** No, I was -- again, I was shocked and really,
 25 really upset. As we all were. It's -- yeah, it -- it

31

1 herself as being becoming "a little bit mad" with Letby
 2 during the shift because she had wanted her to be
 3 looking after her baby, and Child C wasn't the baby
 4 Letby should be looking after.

5 You nod, so is that your recollection?

6 **A.** I -- I vague -- vaguely remember the nurse --
 7 was it Nurse W?

8 **Q.** Yes.

9 **A.** -- nurse W speaking to me and asking me --
 10 that she was frustrated in that Lucy wasn't listening to
 11 her and was focusing on supporting me with the family,
 12 wanted to be in there rather than looking after the baby
 13 she was allocated, and that's about all I remember.

14 But I do remember that conversation because I think
 15 she was -- she found that a difficult situation because
 16 she had been quite explicit in what she wanted Lucy to
 17 do, and that wasn't followed through.

18 **Q.** We'll hear evidence from Nurse W about that,
 19 but you remember her saying it to you that evening
 20 itself as well. She tells us that she mentioned that to
 21 Eirian Powell. Did you have a discussion with
 22 Eirian Powell about the use of the Guedel or any of that
 23 or not?

24 **A.** I -- I honestly don't remember. I don't think
 25 I discussed the use of the Guedel because it wasn't

30

1 never gets any easier. It's always really hard. But
 2 yeah, I wasn't expecting -- it was -- it was a shock.

3 **Q.** And I think you spoke with the parents, didn't
 4 you? You had some dealings with the parents.

5 **A.** I think, yeah -- I -- I don't remember fully.
 6 I -- I don't know how much. I know I've written in my
 7 statement again that I think possibly that I had a few
 8 words with them but I -- I couldn't tell you what
 9 conversations I had with them.

10 **Q.** You tell us you don't remember if there was
 11 a debrief meeting or discussion about the unexpected
 12 death of Child I. But were you -- would you have
 13 expected to have been invited to one if there was, given
 14 your involvement with Child I?

15 **A.** Yes.

16 **Q.** And why is that? Tell us about debriefs and
 17 why you would or would not expect to attend them.

18 **A.** So debriefs are basically a meeting, an --
 19 a fairly informal meeting of members of staff who were
 20 present at a death or a traumatic event on the unit,
 21 such as a resuscitation. It's an opportunity for staff
 22 to talk about what's happened, to discuss between
 23 themselves -- to talk about things that went well and
 24 possibly things that didn't go as well.

25 Yeah -- and it's sort of supposed to be a safe,

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1 free space to -- to discuss what happened between staff
2 members.

3 **Q.** When you say a safe space, what's -- what's
4 the purpose in your mind of the debrief?

5 **A.** The purpose is to be able to process to
6 a certain extent what's happened. I think if you
7 internalise a situation and don't have those
8 conversations sometimes that situation can be a lot
9 harder, and sometimes you can hear things from other
10 members of staff's perspective, which can be helpful.
11 I would say the main purpose of it is support for staff.
12 Yeah, support for staff.

13 **Q.** Had you -- you say in one of your police
14 statements that Baby I was only your second death that
15 you'd experienced, you'd the experience earlier and then
16 you'd Baby I as well.

17 As you sit here today, how many unexpected deaths
18 have you experienced in neonates?

19 **A.** A few. I don't know the exact number.

20 **Q.** And in the Countess of Chester that year were
21 the first two.

22 **A.** Yeah, I'm not 100% sure. I have said in my
23 statement that it was the second, but I'm not sure of
24 the timeline, so I'm not sure whether there was another
25 one because obviously this was a few years later.

33

1 to Child O. Can you tell us about Child O -- by all
2 means remind yourself of what you've said in your
3 statement here -- about what nursery he was in, what
4 nursery he was moved to and so on? Do you want to tell
5 us about that?

6 **A.** What nursery he was moved to?

7 **Q.** Yeah, what nursery he was in, and you describe
8 moving him into another one. Just tell us that now
9 how --

10 **A.** Yeah, again, I can't remember the specifics.
11 It was -- it was either him or his one of his brothers
12 who was in Nursery 1, and I think, from what I can
13 remember, the other two were in nursery 2. And, yes,
14 one of -- the decision was made, at some point on that
15 shift, that they were all going to go into nursery 2, so
16 whichever sibling was in Nursery 1 got moved into
17 nursery 2 so that they could be together.

18 **Q.** And you describe having a gut feeling about
19 Baby O.

20 **A.** Mm-hm.

21 **Q.** Can you tell us about that, when you thought
22 he didn't look so well?

23 **A.** Yeah. So it's a hard one to quantify because,
24 as far as I can remember, there was no clinical
25 recordable signs that I could have said this baby is

35

1 But, yeah, there -- there was -- yeah, there was
2 quite a few and it was noticeable to staff that there
3 was a few.

4 **Q.** And in terms of unexpected, when a death was
5 unexpected, did you -- and I'm not saying you should
6 have done, but what did you think was the process or
7 what needed to follow after an unexpected death? You've
8 said the debrief and support staff?

9 **A.** Yeah.

10 **Q.** Did you think there should be referrals by
11 doctors or other people to other agencies if it was
12 unexpected or not?

13 **A.** Yeah, I think -- I know there are processes
14 now. I think at the time I -- we had specific
15 bereavement paperwork which had a sort of a checklist to
16 make sure that we had covered at nurse-wise all the
17 areas that we needed to cover in terms of who we needed
18 to let know.

19 In terms of the doctors, I would say at that time
20 I had less awareness of what processes they needed to
21 do. I knew that they had a set of processes they needed
22 to go through, but that was -- at that time it was out
23 of my realm of -- and my scope of practice, so I wasn't
24 as aware then.

25 **Q.** You move on at paragraph 27 of your statement

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1 deteriorating. So his observations, such as his heart
2 rate, breathing, stayed the same or stable as he was
3 previously. And so it is a hard thing to explain that
4 gut feeling. Sometimes you look at a baby and notice
5 that they may be have some respiratory distress. But
6 I'm assuming it is not that either. I don't physically
7 remember like I felt that, apart from the gut feeling
8 because, again, that isn't a more quantifiable thing
9 that you can record as a possible deterioration of
10 a baby.

11 However, sometimes it can be their colour or just
12 maybe they're a little bit quieter than normal, and
13 sometimes those things are hard to define or prove that
14 that is a deterioration, and sometimes it is just your
15 experience of working with babies and seeing lots of
16 babies that you maybe notice more subtle things, which
17 are hard to pinpoint to say this is a deterioration or
18 not, but maybe you have -- that's why I've said sort of
19 a gut feeling that maybe something -- but it's --
20 it's -- I know it really -- it sounds possibly
21 implausible, but I think it's -- yeah, that would have
22 been what it is. I think it is definitely a thing that
23 you can notice as a nurse that's worked with premature
24 babies for a few years.

25 **Q.** And you told the police that at one point you

36

1 said to Lucy Letby:

2 "He doesn't look as well now as he did earlier. Do
3 you think we should move him back to 1 Nursery 1 to be
4 safe?"

5 And you recalled Lucy saying closer to the time:

6 "No, no, I want to keep him in Nursery 2. I feel
7 like he's okay. We'll just monitor him here for now."

8 And that's where he was with his siblings. So to
9 you, you thought, well, he is with his siblings --

10 **A.** Yeah, and I think that's -- I think -- I can't
11 remember at that point whether that was my more gut
12 feeling or whether there were some other signs, but
13 there was clearly something that prompted me to think
14 that he wasn't as well and possibly could be moved. And
15 Nursery 1 -- the reason we put them in Nursery 1 is
16 because there's more equipment in there, so it's more
17 easily accessible if a baby deteriorates.

18 But I also understood the rationale of -- to
19 a certain extent the rationale of keeping the siblings
20 together because that's also a really important part of
21 family care.

22 **Q.** And what happened subsequently?

23 **A.** Again, I can't remember the exact details, but
24 he did deteriorate. So I know that he had subsequent
25 desaturations and bradycardias, so that would have been

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1 **A.** So, yeah --

2 **Q.** -- the manner?

3 **A.** -- it was almost in a way where she was
4 excited to tell me almost like a gossip -- in a gossipy
5 manner. But I can't remember if that is this time or
6 another time.

7 **Q.** But you have the same -- you do have
8 experience of that "in an excitable manner" saying
9 something.

10 **A.** Yes.

11 **Q.** At the time -- obviously you know what you
12 know now, but at the time, did it strike you as odd or
13 something unusual or disrespectful in some way?

14 **A.** Yes, it did.

15 **Q.** It did?

16 **A.** Yeah. I -- I mean this is -- I -- there
17 were -- I did think she was -- there were parts of her
18 personality that were a little strange to me, so I took
19 that as a personality difference between me and her.

20 **Q.** We asked you about suspicions and concerns.
21 With that hat on, any concerns about a personality or
22 comments like that, what were your concerns? I'm not
23 saying at the time where they would have led you to
24 thinking but please share them with us.

25 **A.** Yeah, I didn't have any suspicions that she

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1 significant. And the Registrar was called and we moved
2 him into Nursery 1 to be able to keep a closer eye on
3 him. And, yeah, I think he continued to -- to have
4 profound desats and bradycardias and needed -- subsequently
5 needed resuscitation.

6 **Q.** And you say in your statement you don't recall
7 if Lucy Letby said anything to you after his collapse.

8 **A.** I don't remember.

9 **Q.** We know, of course, the next day Child P died,
10 and there is a statement from another nurse,
11 Nurse Lightfoot, who says she recalls Letby commenting
12 in an excited fashion -- we'll hear from
13 Nurse Lightfoot -- to another nurse who came on to the
14 unit, words to the effect of, "You will never guess
15 what's just happened."

16 Was that you that she said that to? Is that how
17 you learnt of Baby P's death?

18 **A.** I -- I don't remember if it was me. I do
19 remember an occasion where she came up to me just as
20 I was coming on shift to tell me about a baby that had
21 died in a similar manner. I don't --

22 **Q.** What's a similar manner? You use your words,
23 I've given you Ms Lightfoot's --

24 **A.** Yeah.

25 **Q.** -- but what would you describe --

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1 was -- any of this, this didn't cross my mind.

2 I -- I wouldn't say necessarily I had concerns
3 about her care. There was obviously the incident when
4 Eirian came to speak to me about her not paying
5 attention -- as much attention to the baby that she was
6 looking after on shift with the Baby C, I think it was.
7 So I was aware of that.

8 I personally didn't have any concerns with her
9 nursing care. I think I had -- I wouldn't say they
10 were -- I wouldn't say they were necessarily concerns
11 but I -- her way of speaking to other members of staff
12 sometimes I didn't like and felt wasn't the most
13 professional. But other than that, I didn't have any
14 concerns about her actual nursing care. She was very
15 intelligent, she appeared to be able to manage babies,
16 as far as I could see, well.

17 **Q.** You describe -- just dealing with the issue of
18 the death of the baby, I'm going to ask for your police
19 statement please to be on the screen INQ0001404, page 7.
20 0001404_0007.

21 I'm not going to read it out for you, but you see
22 where you begin "As a unit" you set out there no doubt
23 the saddest aspects of your work. And in the third --
24 sorry, fourth paragraph, you set out movingly and with
25 compassion how you would perform the act that you're

40

1 describing there where you accompany the Porter, you'd
2 would like to walk with them:

3 "... as I would like to think someone was doing
4 that if it were my baby."

5 **A.** Yeah.

6 **Q.** So you have described how you feel it is
7 appropriate around infant death.

8 **A.** (Nods).

9 **Q.** When we see text messages about deaths, now we
10 know murders, what's your comment as a nurse who has
11 that aspect of your work as well to address? What do
12 you make of those comments?

13 **A.** Which comments --

14 **Q.** The comments --

15 **A.** -- specifically?

16 **Q.** That I've taken you to wanting to get back to
17 Nursery 1., the comments, "You never guess what",
18 putting them together, which, of course, my Lady will be
19 able to do at the end, I'm not suggesting you can, but
20 when you look at those comments now, and I read how you
21 describe in one of your many police statements how you
22 would conduct this or be involved in this event, what do
23 you make of it?

24 **A.** I think they're -- it's highly inappropriate.
25 I think -- yeah, like I've said there, when it comes to

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1 happening?

2 **A.** No. If they were happening -- if they were
3 happening, I was not aware of them. I wasn't aware of
4 any suspicions or concerns.

5 **Q.** Or questions -- I'm not suggesting
6 suspicions -- the questions at that stage thinking,
7 well, who's on shift? What's going on here? That's not
8 necessarily the same as having a --

9 **A.** Yeah --

10 **Q.** -- concern about an individual.

11 **A.** I don't -- I don't -- again, I don't recall
12 that. I think I did hear comments, I don't know who
13 specifically, but from staff about -- and I think we all
14 thought that that she was there for a lot.

15 My personal feelings, and from what I heard from
16 other staff, were that it was really unfortunate that
17 she'd been there for so many tragic events.

18 **Q.** Looking back now, what was it either about her
19 or the situation that took you to that place as opposed
20 to thinking, well, it's suspicious so we should get
21 someone in -- not you -- everybody to investigate it.

22 What was it about her that --

23 **A.** Well, I think that is an unthinkable thing in
24 a way. I think you don't -- you don't ever think that
25 of somebody you work with and you work closely with.

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1 the death of a baby, I would always want to be led by
2 parents, and I would always want to put myself in -- as
3 much as I can, I can't wholly, but put myself in their
4 shoes and think what would I want as a parent and how
5 would I want people to, even if they're not there,
6 discuss and talk and what kind of care I want, and
7 that's from my personal values that's really important.

8 **Q.** Compassionate?

9 **A.** Yeah. And I think that the text messages that
10 I've seen show a complete lack of compassion.

11 **Q.** You tell us in your -- that can go down now,
12 thank you.

13 You tell us in your statement at paragraph 34 you
14 weren't aware of any derogatory comments made by anyone
15 at the time, whether it was nurse (inaudible) whatever
16 the comments were, you didn't hear that kind of
17 conversation.

18 We do know from Dr Lambie that, by September 2015,
19 she had observed a group of nurses in a huddle trying to
20 work out or looking at row rotas, where in effect her
21 evidence was they had begun to think the unthinkable and
22 thinking is there a link between somebody and these
23 unexpected deaths or events and looking at rotas.

24 Do you know anything about that conversations by
25 September 2015 between nurses thinking these events are

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1 I think nursing is a profession where you put your trust
2 in each other. And, I mean, this is not an event that
3 happens in anybody's lifetime. I think it's -- it's not
4 something -- it's not a conclusion I personally would
5 ever jump to, I think, about anyone unless I'd seen
6 something specific. I think it was so unthinkable it
7 wasn't -- it was -- it almost felt that just wasn't
8 something that crossed my mind. I --

9 **Q.** So you'd needed to have to see something, see
10 a deliberate act. The thought of something being
11 unexpected and unexplained --

12 **A.** Yeah.

13 **Q.** -- needing more investigation isn't where your
14 thought process would have taken you to --

15 **A.** Yeah.

16 **Q.** -- you'd need to see someone doing something
17 Wong?

18 **A.** And I think it is such an unbelievable
19 situation that someone would do that, especially someone
20 you would work with and you had worked closely with, and
21 I -- I personally -- at the time, I would have thought,
22 well, there would be signs of that. And, you know,
23 hindsight there are things that don't match up or -- but
24 actually, at the time, I think your rational brain would
25 never go to that when you work so closely with somebody

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1 and it's -- I think your rational brain decides that's
2 what happens to premature babies.

3 When I look back now I think, well, no, that's not
4 what happens, but I think if you thought that about any
5 situation I think you'd have a very difficult view on
6 life, so it's not something that my personal brain would
7 jump to that kind of conclusion because I didn't have
8 any evidence for it.

9 **Q.** As a group premature babies are vulnerable,
10 aren't they, like old people --

11 **A.** Yeah.

12 **Q.** -- as we get older we are more vulnerable? So
13 do you think it was a false reassurance, well, they're
14 a vulnerable group that's why this has happened, we
15 don't need to --

16 **A.** Yeah.

17 **Q.** -- think the unthinkable, it seems that this
18 could happen?

19 **A.** Yeah. I think -- and that's -- and that was
20 my belief at the time. I thought that these babies are
21 vulnerable babies. When I look back now, it --
22 actually, no, it doesn't add up, but that's -- that was
23 the majority of my career was seeing lots of babies and
24 a large proportion of that was babies unfortunately
25 collapsing and dying, and that made up a lot of my

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1 hindsight, aside from the fact of the unexpected deaths
2 and deteriorations and their number, what do you know
3 now from either listening to the criminal trial, reading
4 what you have of statements of others about Letby
5 herself that could help with that signpost to how could
6 this be avoided again?

7 **A.** I don't know because that's -- that is
8 a really hard question, because I think if you took all
9 away -- all this that's happened in the last few years
10 and put me back in that situation, I still don't --

11 I still think I would probably wouldn't pick it up

12 because -- well, I don't know. I think ...

13 **Q.** It sounds like you would have questioned more
14 the assumption that premature babies die --

15 **A.** Yeah.

16 **Q.** -- with experience.

17 **A.** I think I still would find it hard to jump to
18 a conclusion that a member of staff would do that
19 without evidence of that, which I didn't have.

20 **Q.** Would you appreciate, though, going to the
21 police earlier or getting people to investigate
22 unexpected deaths --

23 **A.** Yeah.

24 **Q.** -- without knowing the answers? How could you
25 know the answers? You don't have all the investigation

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1 career --

2 **Q.** At that stage --

3 **A.** -- and that's what I saw --

4 **Q.** -- yeah.

5 **A.** So that is -- that was my belief, and I --
6 yeah, I thought --

7 **Q.** And what's your understanding now? You
8 obviously stayed in the field --

9 **A.** Yeah.

10 **Q.** -- so when you say that wasn't the case -- and
11 the babies you were involved with, they were stable,
12 weren't they, they were well, that's why you were
13 shocked at the time?

14 **A.** Yeah. And that's it, I think -- yeah --

15 I mean, hindsight is -- makes you realise a lot of
16 things, especially when these things are laid out in
17 front of you when you don't necessarily have the whole
18 picture always. But, yeah, I would say actually now
19 I think I would be suspicious of so many babies
20 collapsing, but at the time I genuinely wasn't.
21 I thought that was part and parcel unfortunately of
22 being premature.

23 **Q.** The purpose, of course -- a purpose -- a key
24 purpose of this Inquiry is to consider how this may
25 never happen again. So with that powerful benefit of

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1 tools the police have, do you? You don't get to
2 people's homes or laptops or anything else they look for
3 or at?

4 **A.** Yeah, I think -- yeah, 100% I think -- and
5 I was not privy to any of this information. I did not
6 know any of this when this was going on in the
7 background at the time. But, yes, 100%, I think that
8 was -- that they should have been involved much sooner.

9 **Q.** On that point, we know, of course, and you
10 must know now, that Letby kept 231 handover sheets
11 stored at her home, and 21 of them related to babies in
12 the indictment. Did you ever see her walk out with
13 handover sheets? What was the position about those for
14 nurses?

15 **A.** No. We had confidential waste-bins so
16 after -- at the end of a shift you were expected to put
17 your handover in the confidential waste-bin.

18 **Q.** And everyone knew that?

19 **A.** Yes. But, no, I never saw her take it home --
20 any -- I mean, it's a little piece of paper that's often
21 folded --

22 **Q.** Sure, easy --

23 **A.** -- so --

24 **Q.** Exactly.

25 **A.** -- it's easily --

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1 Q. No, I understand that. But if you'd seen
2 someone walking out with them, you would have questioned
3 that but you didn't see that, clearly?

4 A. No. And, you know, mistakes do happen
5 sometimes. If -- you -- sometimes you can go, "Oh,
6 I forgot to put this back", and go back and put it in
7 the confidential waste, because we're all human at the
8 end of the day but, I mean, not on so many occasions
9 that is, yeah.

10 Q. No. There came a time, didn't there, where
11 the RCPCH were invited to do a review?

12 A. (Nods).

13 Q. Can you remember roughly what you were told
14 about that? Did you know who was going on when that was
15 happening?

16 A. Yeah. I -- I don't remember much. I -- I was
17 aware of the fact that they were coming and it was to
18 look into the fact that we'd had quite a few deaths. My
19 understanding at the time, as far as I can remember, was
20 it was to rule out if there was any underlying cause,
21 like if there was any infection on the unit, or anything
22 that could have contributed to these -- I assumed it was
23 sort of -- would have been a routine thing that was
24 undertaken maybe if you had a -- an increased rate
25 that -- I don't know if that was explained to me but

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1 staff. This is not meant to be a blame or a competency
2 issue -- but a way forward to ensure that our practice
3 is safe. It will probably be developed into
4 a competency-based programme to be undertaken every two
5 to three years in line with our mandatory update
6 training."

7 Did you see that at the time?

8 A. I -- I don't remember specifically this email,
9 but I -- I think I probably did see the email.

10 Q. What did you make of that?

11 A. I don't remember. I don't remember this
12 specific email. I remember one of the other ones that
13 she sent.

14 Q. Shall we go to one of the other ones? Shall
15 we go to 0002879, page 75. Sorry, that one can go down
16 the 15 July. We're looking for 9 August, which is
17 0002879, page 75.

18 Was that this one?:

19 "Hi all, there are currently opportunities for
20 staff to apply for secondments throughout the Trust. It
21 has therefore come at an opportune time for us and we
22 were able to facilitate this for Lucy. Lucy is
23 currently seconded to the risk and patient office for
24 a period of 3 months ..."

25 Three months, sorry, that's my eyesight.

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1 I think that's probably what I felt at the time.

2 Q. And you weren't interviewed, I don't think,
3 you weren't --

4 A. I don't think so, no.

5 Q. We know at around the same time some emails
6 were coming to all of the nursing staff. Can I ask that
7 we put on the screen please 0002879, page 91.

8 Can you see that, Ms Taylor? So it's 15 July.

9 "Hi everyone."

10 It is an email from Eirian Powell:

11 "In preparation for the external review, it's been
12 decided that all members of staff need to undertake
13 a period of clinical supervision. Due to our staffing
14 issues it's been difficult to determine how we undertake
15 this process. We can only support one member of staff
16 at a time. Therefore, we've decided to that it would be
17 useful to commence with staff who have been involved in
18 many of the acute events facilitating a supportive role
19 to each individual. Therefore, Lucy has agreed to
20 undergo the supervision first commencing on Monday,
21 18 July 2016.

22 "I appreciate that this process may be an added
23 stress factor in an already emotive environment, but we
24 need to ensure that we can assure a safe environment in
25 addition to safeguarding not only our babies but our

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1 And so you see the email there.

2 A. (Nods).

3 Q. Did you see that one?

4 A. Yes.

5 Q. So what did you make of that one?

6 A. I can't really remember. I think at the time
7 it's -- I took it as truth that this -- she was being
8 seconded to another area. And I -- I found it quite
9 believable. I think also, because there was another
10 member of staff going on secondment, it seemed very
11 plausible that that was her decision that she wanted to
12 do and I don't think I, as far as I remember, thought
13 that much more about it.

14 Q. Did you have a conversation with Lucy Letby
15 herself about that or not?

16 A. No, not that I remember.

17 Q. And then, finally, another email that was sent
18 to everyone, 0058624, page 1. This is from Letby to
19 colleagues:

20 "Dear colleagues, I was redeployed from the Unit in
21 July 2016 following serious and distressing allegations
22 of a personal and professional nature made by some
23 members of the medical team. From then until now I have
24 been unable to visit or contact the Unit whilst these
25 matters were investigated. After a thorough

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1 investigation it was established that all the
2 allegations were unfounded and untrue and I have
3 therefore been fully exonerated. I have received a full
4 apology from the Trust but as you can imagine this whole
5 episode has been extremely distressing for me and my
6 family.

7 "I will begin my return to the Unit in the coming
8 weeks. I will need colleagues to be sensitive and
9 supportive at this time."

10 Did you receive that?

11 **A.** Yes.

12 **Q.** And what did you understand when you received
13 that?

14 **A.** As far as I can remember, I don't think I was
15 in any conversations about these allegations. I was
16 unaware. So this came as a surprise to me. I think
17 from -- possibly naively -- or what I thought this was
18 probably a clinical competence thing that maybe they had
19 questions around her clinical competence because it
20 doesn't say what the allegations are.

21 I did find it quite surprising, and I don't really
22 know further kind of my thought process on it. She --
23 she never came back to the unit --

24 **Q.** She didn't come back to --

25 **A.** -- physically to work.

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1 that point and weren't having --

2 **A.** Yeah.

3 **Q.** Were there discussions generally amongst
4 nurses about what was going on? It seems --

5 **A.** I mean, there -- there probably was. But
6 what -- I can't remember any specific conversations.
7 I don't -- yeah, I don't remember any specific
8 conversations.

9 I'm assuming probably following that email there
10 probably was some between staff, because I think that's
11 quite a surprising email. But I don't remember. There
12 certainly wasn't any kind of thoughts that she -- of
13 what she had done -- what she had found out to have done
14 at that time from conversations I had.

15 **Q.** The request for support and the need to be
16 sensitive, do you remember that being discussed or
17 whether people were supporting her and being sensitive
18 in the light of that?

19 **A.** I know that she had a couple of people on the
20 unit that she was close to. I -- so I assumed that they
21 were supporting her through that. But she -- it's --
22 personally I didn't support her through anything,
23 I didn't see her, and we weren't social outside of work.
24 So --

25 **Q.** Understood.

55

1 **Q.** -- work, did she?

2 **A.** No. Yeah.

3 **Q.** I think there was a tea party. One nurse told
4 us about a tea --

5 **A.** No, I don't think I was present for that --

6 **Q.** No.

7 **A.** -- as far as I remember.

8 **Q.** Did you see her have any other informal visits
9 at all in this period in 2017 -- from January 2017?

10 **A.** Not that I can remember.

11 **Q.** So you don't remember her popping in, and you
12 certainly weren't at that little tea party to welcome
13 her or whatever?

14 **A.** No. I don't -- I don't think I was present
15 for the tea party. I don't know if I knew about it.
16 I don't remember it.

17 **Q.** Did you --

18 **A.** But, yeah, I don't remember any other
19 occasions that she came on to the unit.

20 **Q.** Did you know if she was doing any
21 observational placements at Alder Hey or anything like
22 that, was that talked about?

23 **A.** No. That's only since more recently that
24 I found out about that.

25 **Q.** So you were getting on with your own work at

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1 In terms of reflections, you say about CCTV it
2 would be unlikely -- well, let me put it a different
3 way. What about having a little CCTV camera in the
4 incubator so you can see the baby, for two purposes,
5 one, if the unthinkable, as you have described it,
6 occurs and, two, for mothers who are separated from
7 their newborns can see them if they're on a different
8 part -- in a different part of the hospital, or if
9 they're at home -- whatever the circumstances they can
10 see their own child, do you think that would provide
11 reassurance in the future to people leaving their babies
12 in neonatal units?

13 **A.** Yeah, possibly. I think that might be quite
14 a personal opinion and maybe that may differ between
15 families to families as to whether that's something that
16 they feel is appropriate for their babies to be -- have
17 CCTV in their incubator, and I think that's something
18 that I probably can't answer.

19 But I think definitely the fact that the CCTV in
20 there -- if the parents were -- say, the mum was on the
21 labour ward or the postnatal ward and wasn't able to
22 visit, and they won't be able to -- weren't able to see
23 each other I think most parents would probably like that
24 aspect of it.

25 I think one of the issues, and, again, it's

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1 probably more information and evidence than I have, that
 2 in terms of privacy and are these CCTVs being recorded,
 3 who has access to them, I think those are possibly
 4 issues, and confidentiality, you know -- I don't think
 5 it's necessarily a bad thing but I think there's a lot
 6 of --

7 **Q.** Checks and balances?

8 **A.** -- things around it, and I think maybe it
 9 might be a personal preference between families as to
 10 whether they would like that or not. Yeah, it's
 11 a difficult one to answer.

12 I think definitely -- I mean -- and I think another
 13 thing would be is that something that would be manned
 14 24/7 because I know that later on there were concerns
 15 from some members of staff in this situation, but from
 16 my perspective I didn't know that there was any concerns
 17 about a member of staff.

18 So, yeah, I think there's -- it brings up a lot of
 19 questions, but also it could be beneficial. It's --
 20 I think it's a hard one to answer.

21 **MS LANGDALE:** Thank you very much, Ms Taylor.
 22 Those are my questions. There's a few from Mr Baker.

23 **A.** Thank you.

24 **LADY JUSTICE THIRLWALL:** Mr Baker.

25 **Questions from MR BAKER**

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1 resuscitation had stopped but Child C was still alive,
 2 and Child C was being looked after by their parents.

3 **A.** (Nods).

4 **Q.** Mother C recalls that you and Nurse Letby
 5 either together or separately at various points went
 6 into the room to provide support to them or to check on
 7 them. Is that something you remember as well?

8 **A.** Yes.

9 **Q.** Mother C and Father C describe an incident in
 10 their evidence where Lucy Letby went into the room,
 11 plugged a cold cot in and said words to Mother and
 12 Father C to the effect of, "It's time to say goodbye now
 13 and put him in this cot."

14 Were you present when that happened?

15 **A.** No. The first time I heard about that was
 16 during the criminal trial whenever that evidence came
 17 up.

18 **Q.** It's right to say, isn't it, that you weren't
 19 always going into the room alongside Lucy Letby?

20 **A.** No. So it -- I was -- it was my
 21 responsibility to look after the baby and the family.
 22 Lucy -- and this was -- this is what we discussed before
 23 about the nurse in charge having concerns that she
 24 wanted to help rather than look after the baby she'd
 25 been allocated, I -- I was aware that she wanted to

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1 **MR BAKER:** My Lady. Nurse Taylor, I ask questions
 2 on behalf of a number of The Families.

3 **A.** (Nods).

4 **Q.** You were taken to your police statement
 5 a little while ago and shown a section that deals with
 6 the unhappy time when a baby dies and how you would
 7 treat that baby. I won't read the statement out but
 8 what's said in effect is that you would care for the
 9 baby as though it were your own baby, or as though you
 10 would want somebody to care for your baby, you wouldn't
 11 leave the baby alone, you would accompany the baby to
 12 the mortuary and it would be taken there in a pram and
 13 shown dignity and respect.

14 **A.** Yes.

15 **Q.** Are you somebody who would ever be excited by
 16 the death of a baby?

17 **A.** Definitely not.

18 **Q.** Are you somebody who would ever be excited or
 19 excitable about a collapse in a baby?

20 **A.** No.

21 **Q.** You refer to an incident in relation to
 22 Mother C's evidence, and I just want to ask you a few
 23 questions about that.

24 Now, when Baby C -- when Child C died -- before,
 25 sorry, Child C died there was an interval when

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1 help, and I don't -- and at that opportunity she must
 2 have gone in when I wasn't there.

3 **Q.** Yes. But it's not your recollection, for
 4 example, that you were the person who took the cold cot
 5 in or that you were there when Lucy Letby took the cold
 6 cot in?

7 **A.** I definitely -- if -- I definitely hear that
 8 comment. I don't know who took the cold cot in but
 9 I definitely did not hear that comment.

10 **Q.** What would you have thought of that comment if
 11 you had heard it?

12 **A.** I would have been horrified. And I was when
 13 I read that. I was really sad for the family that that
 14 had been said to them in that moment and disgusted that
 15 it was a comment that was made, because I think it was
 16 really uncompassionate and cold, and not something that
 17 us as a team -- our ethos is that's not aligned with our
 18 ethos and our -- what we want to care for the baby. Our
 19 and my ethos when looking after a baby who is dying
 20 is -- or has just recently died is to ensure that we
 21 follow along with the parents' wishes about what they
 22 want to do, whether that is to spend time with their
 23 baby quietly or make memories. The cold cot is -- is
 24 there but it's not something that they need to go into
 25 straight away.

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1 So, yeah.
 2 **Q.** I mean you -- your evidence is you would have
 3 found those comments upsetting and deeply inappropriate?
 4 **A.** Yes.
 5 **Q.** You didn't hear them yourself, but you did on
 6 other occasions see Letby behaving in what you felt to
 7 be an inappropriate way surrounding collapses or deaths?
 8 **A.** Mmm.
 9 **Q.** Finally, I just want to clarify your evidence
 10 you gave a moment ago in relation to Child O whose
 11 family I also represent. I wonder if we could go back
 12 to your police statement, INQ0001404, and it's to
 13 page 3, please.
 14 So this is an extract from a statement that you
 15 provided to the police in 2019. This is the key page,
 16 but on the previous page it's referred to the fact that
 17 Child O was placed -- we don't need to go on to it, yes,
 18 thank you -- Child O is placed in Nursery 1 because
 19 although he seems well there are concerns that he might
 20 deteriorate or there are at least worries about his
 21 condition. But those worries were felt not to be
 22 substantial ones after a time and he appeared stable,
 23 didn't he, and well in fact?
 24 **A.** As far as I can remember, yes, he did.
 25 **Q.** And so a decision was made relatively early in

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1 **Q.** So does that suggest that you were based in
 2 Nursery 1 on that occasion or somewhere else if you had
 3 to go into Nursery 2 to check?
 4 **A.** I don't know. As far as I'm aware, I was in
 5 charge so I would have been shift leader. So as we were
 6 discussing before, the shift leader would have a general
 7 oversight over the babies. So it may be that I've gone
 8 in to offer support, to check charts, to kind of see
 9 what was going on, so I don't know. I may have not
 10 had -- I may have had a patient or I may not have. It
 11 would depend on kind of staffing and what acuity we had
 12 on the unit depending on whether the shift leader would
 13 take another patient load.
 14 **Q.** Yes. But in any event, you weren't with Letby
 15 in Nursery 2, save for those times when you went in?
 16 **A.** Yeah, no, I wasn't.
 17 **Q.** And in the penultimate paragraph, you confirm
 18 that when you went into Nursery 2 to see how Child O was
 19 doing, it was only Letby who was present there.
 20 **A.** And, again, I think if that's -- that's what
 21 I've written in my statement, but from my memory now,
 22 I -- I don't remember. But I've written that in my
 23 statement, so that must have been true.
 24 **Q.** But based upon what you said then, it was
 25 Letby who was alone in the room with O, P and R?

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1 your shift to place him in Nursery 2?
 2 **A.** (Nods).
 3 **Q.** And what you seem to be saying in paragraph 2
 4 of that statement is that it was Letby who prompted the
 5 move to Nursery 2. Does that help refresh your memory?
 6 **A.** Yes, and I -- in there I said I believe it was
 7 Lucy, and I think my memory has deteriorated again since
 8 then, so I can go off -- my memory can only go off what
 9 I've written in my witness statement. So in there I've
 10 said I believe it is Lucy who asked me.
 11 **Q.** Now, you say:
 12 "I am unsure if Lucy was the designated nurse for
 13 all Child O, P and R or just two of them."
 14 I think there is other evidence to suggest that
 15 Lucy Letby was Child O's designated nurse.
 16 **A.** Mm-hm.
 17 **Q.** Would that be your recollection as well based
 18 upon I think what happens next?
 19 **A.** She -- yes. As far as my memory serves, she
 20 was looking after Child O and, yeah, I can't remember
 21 further than that.
 22 **Q.** And then you go on to say:
 23 "At one point during the afternoon I recall going
 24 into Nursery 2 to have a look at Child O."
 25 **A.** Mm-hm.

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1 **A.** As far as I can remember, yeah. But, yes,
 2 I don't remember if she was in the room when I went in.
 3 **Q.** And it's at that point that you became
 4 concerned about Child O's condition and you said, "He
 5 doesn't look as well now as he did earlier. Do you
 6 think we should move him back to 1 to be safe?" --
 7 **A.** (Nods).
 8 **Q.** -- is how you recalled it there. And, again,
 9 Ms Langdale took you through the next part and how Letby
 10 responded, "No, I'd like him to stay in room 2", or
 11 Nursery 2.
 12 **A.** Yeah. So she -- I think I was -- at that time
 13 I think -- as I discussed before, I don't know if this
 14 point was the point where there was maybe more signs of
 15 deterioration or maybe more subtle signs, or whether it
 16 was still this gut instinct. I can't remember from
 17 this. However, yeah, I do remember she was fairly
 18 insistent that she wanted to keep them together in
 19 room 2.
 20 **Q.** I mean, from what's written here, it sounds as
 21 though this is the sequence of events that Child O
 22 appears to be doing well, appears to be stable --
 23 **A.** Mm-hm.
 24 **Q.** -- sufficient to be moved out of the high
 25 dependency room. He goes into Nursery 2 where he's

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1 alone with Letby and then deteriorates.
 2 **A.** Mm-hm.
 3 **Q.** Now, this isn't a criticism of you, obviously.
 4 How were you to know? And --
 5 **A.** Yeah, and I think I would not have predicted
 6 that. I definitely didn't predict that to happen, and
 7 I wouldn't have assumed that that would have happened.
 8 So I think me suggesting moving him was probably being
 9 very much on the cautious side.
 10 **Q.** Yes.
 11 **A.** Yes, it's -- again it's -- with hindsight,
 12 I wish I had pushed that.
 13 **Q.** Well, hindsight's a wonderful thing,
 14 Nurse Taylor.
 15 **A.** It is.
 16 **Q.** But with the benefit of hindsight, do you
 17 think there might have been another reason why Letby
 18 wanted to keep him alone with her in room 2?
 19 **A.** I think that's -- you know, with the trial and
 20 what she's been convicted of that is a natural
 21 conclusion of -- that you would come to now. Obviously
 22 it wasn't at the time.
 23 **MR BAKER:** No, of course.
 24 Thank you, my Lady, and thank you, Nurse Taylor,
 25 I have no more questions.

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1 We are ready to go?
 2 **Questions by MS LANGDALE**
 3 **MS LANGDALE:** Ready to go. Can you give us your
 4 name and qualifications, please.
 5 **A.** Yes, my name is Ashleigh Hudson. I am
 6 a qualified children's nurse but also now an advanced
 7 neonatal nurse practitioner.
 8 **Q.** You provided the Inquiry with a statement
 9 dated 12 April 2024.
 10 **A.** Yes.
 11 **Q.** Can you confirm that statement's true and
 12 accurate, as far as you're concerned?
 13 **A.** Yes, I can.
 14 **Q.** Can you tell us a bit more about your
 15 qualification. We know you were working 2015 to 2016 at
 16 the Countess of Chester and where you have come to now
 17 with this qualification, can you just explain for us the
 18 bands, the expertise, the courses and where you're at
 19 now and where you were then?
 20 **A.** Yes, of course. So initially I graduate
 21 window a degree in children's nursing in 2014, I believe
 22 it was, and then started working on the neonatal unit in
 23 February 2015. Later that year completed my first
 24 neonatal qualification, which was the introduction to
 25 neonates, the foundation course, and then I believe --

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1 **A.** Thank you.
 2 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
 3 Ms Langdale.
 4 **MS LANGDALE:** My Lady, that concludes the questions
 5 for Ms Taylor.
 6 **LADY JUSTICE THIRLWALL:** Ms Taylor, thank you very
 7 much indeed for coming to give evidence today and giving
 8 us a particular insight in some aspects of your evidence
 9 in respect of the compassion and kindness that is shown
 10 by you and no doubt many of your colleagues.
 11 **A.** Thank you.
 12 **LADY JUSTICE THIRLWALL:** Thank you very much and we
 13 will take the break now.
 14 **MS LANGDALE:** May I say 11.50, my Lady, ten to 12.
 15 **LADY JUSTICE THIRLWALL:** Yes, certainly. You are
 16 free to go, Ms Taylor.
 17 **(11.31 am)**
 18 **(A short break)**
 19 **(11.51 am)**
 20 **MS LANGDALE:** Thank you, my Lady, may the next
 21 witness be sworn.
 22 **ASHLEIGH HUDSON (affirmed)**
 23 **LADY JUSTICE THIRLWALL:** Sorry, Ms Hudson, we are
 24 just going to see that the noise is off so that we don't
 25 get any more. (Pause).

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1 and at that point I was a Band 5 staff nurse, so much of
 2 my responsibility was just patient centred care.
 3 I didn't really have any management or admin
 4 responsibilities at that point.
 5 Probably end of 2017 into the beginning of 2018
 6 I did my QIS, my qualification in speciality, also to do
 7 with neonates, a little bit more focused on intensive
 8 care.
 9 And then in the October of 2018 I began my master's
 10 degree in advanced practice, remaining a Band 5 during
 11 that time. But when I started my training, my -- my job
 12 role changed to that of a trainee advance practitioner.
 13 My responsibilities changed, so I went from delivering,
 14 like, bedside patient care to being more involved in the
 15 medical aspect of care, so the reviewing of patients,
 16 the formation of care plans, reviewing medication and
 17 making decisions about care as part of the team.
 18 I qualified and graduated in I think it was
 19 October/November 2020 and at which point I became
 20 a Band 7 for a consolidation year. After a year period
 21 of consolidating that learning I became a Band 8, and
 22 I continue at that now as an advanced practitioner.
 23 **Q.** So when we talk about how qualified nurses are
 24 with neonates, can you contrast -- or compare and
 25 contrast where your level of qualification would have

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1 been as a Band 5, you've been on a course, and where you
2 are now as an advanced practitioner who has done the
3 master's?

4 **A.** Sorry, I'm highlight differences?

5 **Q.** Yes, how much more -- how much more expertise
6 do you gain by that advanced course?

7 **A.** A lot more. The way -- you are taught to
8 think about neonates a bit differently, because you're
9 looking at it from a medical perspective and not just
10 a nursing perspective. The -- the goal of the advance
11 practice role is that you almost combine the two. You
12 learn how to think medically but you use your nursing
13 experience and background in that speciality, so you
14 become a bit more of a port of call and a bit more of
15 a constant presence within whatever speciality you're
16 working with. Medics rotate every four to six months
17 as -- qualifying, as wonderful as they might be, it's
18 good to have advanced practitioners who just know the
19 lay of the land, know the guidelines and can help
20 provide that support.

21 In comparison, in -- as a staff nurse, it's much
22 more patient-focused care, so you're at the bedside
23 a lot of the day, you're delivering the personal care,
24 you're supporting parents deliver that care to their
25 babies, you're monitoring their vital signs, you're

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1 **Q.** If you have concerns you are expected to
2 contact -- you said "escalate", does that mean get
3 someone who knows more really?

4 **A.** Yeah, and that could be to a senior member of
5 staff, or that could just be straight to the medical
6 team. I think it probably depends on your confidence in
7 that role at the time and what you understand. You
8 might speak to your more senior nursing colleague first
9 because they're very experienced, and you might not need
10 to speak to a doctor because it will be a nursing thing
11 not a we're worried about this baby-type thing.

12 **Q.** Did you feel able to speak to doctors? What
13 were the relationships between nurses and doctors --
14 between yourself and doctors?

15 **A.** I always found them to be quite approachable.
16 I'd done most of my training at Chester. I did
17 placements both on the neonatal and the paediatric ward,
18 and even as a student I found that they were very
19 approachable and you could ask them questions. And
20 I wouldn't often at that point escalate care because I'd
21 be working underneath somebody who was qualified, but
22 certainly as a newly qualified nurse in a Band 5
23 I always felt that they were approachable and they were
24 either on the unit or at the end of a bleep.

25 **Q.** When you say who was qualified, is that

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1 looking at their observations, you are escalating when
2 anything's changed or there are concerns, you're
3 responsible for giving medications. It's quite
4 difficult to summarise really.

5 My role now, I'm responsible for reviewing the care
6 of the babies, so I don't deliver the bedside care but
7 I look at where they're up to in terms of diagnoses,
8 gestation, care plan. Every ward round in the morning
9 I'll be part of the team that reviews the care of that
10 baby that's happened so far, looks at what we need to go
11 going forward, is there anything to change that day or
12 do we just continue? And rather than administering
13 medications, I prescribe them now and assess patients
14 and see what medications they require.

15 **Q.** You've explained that really clearly.

16 **A.** Is that enough?

17 **Q.** Very clearly. So when you were at the
18 Countess of Chester, you tell us you were responsible
19 for managing your own workload with support guidance
20 from senior nursing staff --

21 **A.** Yes.

22 **Q.** -- because, as you've explained, it's
23 a patient-facing nursing role, Band 5, even with the
24 course and you need support from senior nursing staff.

25 **A.** Yes.

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1 a Band 6 --

2 **A.** Sorry --

3 **Q.** -- or a Band 7?

4 **A.** -- I think I was -- because I referred
5 a little bit to being a student and working --

6 **Q.** Yes, yeah.

7 **A.** -- so qualified is just from Band 5 onwards.

8 **Q.** Band 5 onwards. And when you're the Band 5
9 nurse doing that feeding, cares, administering
10 medications, who would you turn to as a Band 5 then for
11 that support or help?

12 **A.** One of the Band 6s or potentially a senior
13 Band 5, because not everybody goes on to be a Band 6 and
14 to be a shift leader. It's not just a natural
15 progression, it's a job that you apply for because you
16 want to have a bit more of a leadership role. So we
17 have a lot of the Band 5 nurses who've been being
18 neonates for so years and have lots of experience.

19 It would depend on -- on the day who was the best
20 person to go to, and then if that person wasn't sure
21 you'd then go above and go to the Band 6 or potentially
22 you would speak directly to the doctor because they
23 would physically be there.

24 **Q.** Were they there on ward rounds regularly
25 enough, from your point of view, or not, the doctors?

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1 A. Yes, they -- the ward round doesn't happen
2 without them. The ward round doesn't occur without
3 the doctors. The doctors lead the ward round and they
4 come to you.

5 Q. And did they happen regularly? Do you know
6 how often?

7 A. Yeah, every -- every morning we would have
8 a ward round. I think often it would be junior doctors
9 that did the ward rounds and then I think -- I think --
10 it's hard to think back now, I think maybe twice a week,
11 on a Wednesday and Sunday, the Consultant would be
12 present as well, because at the time, this time period
13 that we're looking at, they were responsible for both
14 paediatrics and neonates, so there would be a doctor
15 there every morning but who that doctor would be would
16 be different.

17 Q. We asked you and you answered at paragraph 4
18 about the culture and atmosphere on the neonatal unit
19 and you say:

20 "Between June 2015 and June 2016, [you] felt very
21 supported as a junior member of staff. We were as
22 protected as possible as new starters, given
23 opportunities to learn with respect of our limitations
24 and developing knowledge base."

25 Can you expand upon that for us?

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1 "Regarding relationships between staff at this
2 time, I remember a noticeable divide between nurses and
3 doctors, but at the time I did not understand why."

4 Can you tell us more about that, what are you
5 saying there?

6 A. I think -- and I'm sure much of this will have
7 been discussed already -- a lot of what was going on
8 behind the scenes in terms of concerns regarding
9 unexpected deaths and potentially worrying that somebody
10 was responsible, none of that was discussed with us.

11 But I do feel like the divide was a symptom of that,
12 because certainly when I first started I didn't feel
13 that there was a divide. I think as time went on, and
14 probably following Lucy being removed from the unit,
15 there seemed to be this -- a little bit of an atmosphere
16 but I never had any information to know why.

17 I think it happened so slowly, this shift, it's
18 looking at practice now and what the team is like now
19 and how integrated we are that I can compare it to back
20 then and can see that it was different. But what I will
21 say is that I still felt all the staff were really
22 approachable. I still felt the doctors were really
23 approachable. I never had any issues with any of them.

24 Q. Yes, you say you found the medical staff to be
25 approachable and witnessed excellent teamwork when

75

1 A. Sorry, can you be more specific?

2 Q. Yes, in terms of "with respect to our
3 limitations", for example, "in respect of our
4 limitations", what do you mean by that? Are supported
5 to say when you couldn't do something or you didn't know
6 what to do?

7 A. Yeah, so experience. So, you know, you
8 come -- you do come into the Band 5 role as qualified,
9 you're a children's nurse, but you -- as any nurse, you
10 learn more on the job. So a really important part of
11 nursing is recognising what you don't know and
12 recognising where your strengths are and where -- you
13 know, if you -- many, many things within any nursing you
14 learn from experience, you don't learn from a textbook,
15 you don't learn from university. So having a really
16 solid foundation of seeing your members of staff who
17 know what they're doing was really reassuring.

18 So I never felt out of my depth, because if
19 I didn't know I would immediately go to somebody else
20 who knew the answer.

21 Q. You say you don't recall any animosity. It's
22 your opinion that the nursing and medical terms were not
23 as integrated as they are today. That's more apparent
24 in retrospect.

25 And you also say:

74

1 dealing with sick or deteriorating patients, but you
2 thought there was this divide. When did you know there
3 was discussion going on about deaths and unexplained
4 deaths and who may be present or who may have inflicted
5 harm?

6 A. Not for many years. I think this is what I've
7 been finding difficult to piece together looking at --
8 looking back at when -- when did the thinking shift.

9 I think the conversations are going on from a long
10 time before we were informed. I knew that there was
11 an increase in the amount of deaths compared to previous
12 years. I didn't know that there was suspicions about
13 anybody. I didn't know there was massive huge concern
14 about there being unexplained or unexpected. It was all
15 very hush-hush. And I've learnt a lot from the trial
16 and from this Inquiry, information that I didn't know
17 before. So I don't -- I can't pinpoint when I knew.

18 The only thing, you've last night presented me some
19 emails that -- as part of my bundle, in one of them is
20 an email from Lucy.

21 Q. Shall we go to that if that helps?

22 A. Yeah.

23 Q. So if we go to INQ0058624, page 1. This one:
24 "Dear colleagues ..."

25 A. Yeah.

76

1 Q. "... I was redeployed from the unit
2 in July 2016 following serious and distressing
3 allegations."
4 That one?
5 A. That was the -- from my memory was the first
6 time I had seen in black and white that there been any
7 accusation. She'd been removed from the unit. We had
8 been told it was for her own well-being and it was going
9 to be a short period, that she had a secondment. One of
10 our other nursing staff also had a secondment. So it
11 didn't seem out of the realms of possibility.

12 As time went on, the longer that she was off the
13 unit, it was something that you thought about. You'd
14 think something's not quite adding up and no one's
15 discussing it, no one's saying anything, and it wasn't,
16 from my memory, until this that I saw in black and white
17 that there was allegations and there was concerns.

18 Q. And this says this letter "after a thorough
19 investigation", was there a conversation, as you might
20 expect at that point, between nurse: what was the
21 investigation then? You know, even knowing that she
22 says here she's been exonerated, did you all -- did you
23 piece that it must be to do with deaths and
24 deteriorations?

25 A. Yeah, just from common sense.

77

1 reminded us of from Letby herself to all of you.

2 You see this one, 15 July. Have a read of that
3 again. So that's sent to you. (Pause).

4 It suggested:

5 "Lucy has as agreed to undergo supervision first."
6 le others of you are going to follow and she
7 started on Monday, 18 July.

8 When you got that, what did you think that was
9 about? Did you think you were going to be doing some
10 similar role or ask about that?

11 A. I mean, I can honestly hardly remember this
12 email.

13 Q. I mean, effectively it's telling you she is
14 having supervision, doesn't it, it says she's --

15 A. It says she's having supervision. It says
16 that we will all be supervised with our care, which
17 I think is quite reflective of the information that came
18 out at the time, it was all very secretive and there was
19 never any frankness with what was happening.

20 The previous email's talking about secondment and
21 it's -- she's been in.

22 Q. Yes, should we go it that one as well? So if
23 we go 0002879, page 75. In fact it follows that one
24 about supervision.

25 Supervision is 15 July and then you've got this one

79

1 Q. Yeah. So at that point, in 2017 -- in
2 January 2017, you were aware that she'd been
3 investigated for deaths and deteriorations. Did you --
4 or she says she had been, I should say -- did you
5 discuss that with any other nurses?

6 A. I can't remember. I'm positive that we did,
7 but I cannot remember.

8 Q. You're positive --

9 A. I'm positive that we must have. We all
10 received --

11 Q. Yeah, it's a big letter, isn't it, to get?

12 A. -- this email. It's big, it's very emotive --

13 Q. Yeah.

14 A. -- as well but I can't pinpoint any
15 conversations, unfortunately.

16 Q. Were you present -- we know she went back
17 for -- on the expectation that she was going to go back
18 to the unit for a tea party, did you ever go to the unit
19 when she was there --

20 A. I don't --

21 Q. -- around this time, or can you not remember?

22 A. Not that I can remember.

23 Q. Mm-hm. Just for completeness, the email that
24 you are referring to, the earlier emails, if we go to
25 INQ0002879, page 91, they pre-date the one you've just

78

1 on 9 August. It will come up in a moment. This one.

2 A. Mm-hm.

3 Q. As you say, there's suddenly a suggestion
4 opportunities to apply for secondments -- and, again,
5 reference to Lucy having done this first -- to the risk
6 in patient safety office for a period of three months.

7 So you're getting told supervision and then
8 opportunities for secondments --

9 A. (Nods).

10 Q. -- and Lucy identified for both. So you say
11 there was secrecy. Behind the secrecy, were you all
12 having a bit of a chat, "Well, what's that about. It
13 must be to do with her. It's not really aimed at us",
14 or what? Can you remember?

15 A. I can't remember conversations at the time.

16 I can only really think of what I -- was going through
17 my head, and it was very confusing. And now that I know
18 more, I can understand what was happening here. You
19 know, the previous email we just looked at said this
20 isn't -- this isn't about blame or -- that's very
21 clear, no one's being blamed for anything. Okay.

22 So that reply to the whole team, it's part of
23 process, we'll be doing it every two to three years.
24 Strange, but okay, that's what we're being told by
25 senior members of staff.

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1 And then in terms of this secondment, if -- in my
2 mind, if Lucy's been accused of harming patients,
3 whether that's on purpose or not, or through
4 incompetence, why is she in risk and in patient safety?
5 None of this information makes sense.

6 And looking back you can -- I, and probably many of
7 my colleagues, have pieced it all together and we can
8 follow a timeline of what was happening. But at the
9 time, it was very murky. And I'm not so naive as to
10 think that somebody isn't capable of doing this. We
11 have previous examples, such as Beverley Allitt, as
12 horrible as it is, to consider. We have
13 a responsibility to think of these things but I'm also
14 not going to accuse someone of something when actually
15 there's no detail about what they're being accused of.

16 So in this time period, I feel it was -- I was very
17 much on the fence and it was all very confusing.

18 **Q.** Well, it's clear, as you say, the first one,
19 the July 15th one, says it's not meant to be a blame or
20 competency issue. So that was stated by your manager,
21 Eirian Powell. So did you think "Well, it's not but
22 it's a bit confusing"? Is that what you're saying?

23 **A.** Yeah.

24 **Q.** Did -- did Eirian Powell or anyone else --
25 Yvonne Griffiths, anyone else, ever speak to you about

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1 and 2 of that.

2 So we see at the top:

3 "Hi Ashleigh. You may have heard by now but wanted
4 to let you know that we lost little Child A on Mon.
5 Know you looked after him when he was born so thought
6 you should know."

7 Scrolling down you say:

8 "I didn't know actually, thanks for letting me know
9 Lucy. That's terrible! How is his sister?"

10 She responds:

11 "It was awful. He died very suddenly &
12 unexpectedly just after handover. Not sure why, it's
13 gone to the Coroner. Child B went off Tues night & was
14 intubated but back on cpap now. They are querying
15 a clotting problem. Very sad."

16 Pausing there, that level of detail and this type
17 of information over text messaging, what did you think
18 about that at the time if anything?

19 **A.** I can -- I can actually -- I can vividly
20 remember this because I was devastated. I had only been
21 on the unit a couple of months at this point. This is
22 the first time a patient that I've looked after had then
23 passed away. I was also a bit angry because I didn't
24 think it was appropriate to get this information by
25 text, because what do I do with it? How do I then seek

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1 whether you would in fact have supervision?

2 **A.** Not that I recall.

3 **Q.** And did any of you over time say, "Are we
4 having supervision?" Or "Why?" Or did you just leave
5 it lying?

6 **A.** I can't remember.

7 **Q.** That can go down, thanks.

8 Going to the children named on the indictment that
9 you had experience with.

10 **A.** Sorry, I can't quite hear you.

11 **Q.** The children named on the indictment that you
12 had experience with.

13 **A.** Yeah.

14 **Q.** You were involved with Child A.

15 **A.** Yes.

16 **Q.** And if we go to paragraph 8 -- sorry,
17 paragraph 6 of your statement -- at paragraph 7 you tell
18 us you:

19 "... cared for Child A during the night shift of
20 June 7th-8th ... after which he unfortunately died
21 during the following night shift ..."

22 And you tell us you received a text from Lucy Letby
23 informing you of Child A's death. Can we go to those
24 text messages, please, which is INQ0000101, page 1.

25 We're going to start at page 1 and look at page 1

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1 support? But I didn't feel comfortable saying that on
2 a text message.

3 **Q.** If we go further down, 31274, you say:

4 "Oh god, he was doing really well when I left.

5 I do hope Child B continues to improve, have they done
6 bloods to check?"

7 Pausing there, did she know that was the first
8 death that you had witnessed on the unit?

9 **A.** I don't know.

10 **Q.** Okay. Carrying on with the messages:

11 "He had a really good day on [Monday] then I took
12 over [Monday] night & he passed away at 20:58 after
13 30 min resus. Just collapsed very suddenly. Awful."

14 And so it continues. You can see that.

15 If we go further down. Message 31277. So a bit
16 further up.

17 She says:

18 "I wasn't supposed to be in either, Yvonne swapped
19 my nights as unit busy! But these things happen ...
20 Parents were there during resus. They had them both
21 baptised then spent the night sitting with them both.
22 I took pictures hand/footprints etc. They are beside
23 themselves worried that they will lose Child B too."

24 And then the next bundle one message she says:

25 "Yes they had time together & got some nice little

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1 mementos when they are ready to take them. Fingers
2 crossed."
3 You will have appreciated this was a mother who
4 lost her baby after 24 hours -- or within 24 hours and
5 had managed to touch him once, once on the tummy in the
6 incubator, and this message comes to you. First of all,
7 you didn't invite that message, did you?

8 **A.** No.

9 **Q.** Are you okay?

10 **A.** Yeah.

11 **Q.** We can stop if you want for a bit.

12 **A.** No, I'd like to continue, please.

13 **Q.** Okay. The messages can go down, thank you.

14 How did you feel, then, and also how do you feel
15 now about a message that says "some nice little
16 mementos", with all that you know?

17 **A.** I think, at the time, I felt like it was too
18 much information. It's -- that process afterwards is
19 a very important and sensitive time. I don't -- didn't
20 feel like I needed that information. And the message
21 after that, that's when I kind of shut the conversation
22 down, deleted the messages off my phone, because I just
23 felt very uncomfortable having them there. I just
24 panicked that what if I lost my phone or it got stolen
25 and someone ... Looking at it now, and knowing what

85

1 **Q.** Feel free to read the paragraph if you don't
2 want -- remember events now and add it, however --

3 **A.** Okay, 11 and 12?

4 **Q.** Yes, thanks.

5 **A.** Yeah:

6 "I was the designated nurse for Child I during the
7 night shift 12th-13th October 2015, and provided
8 a statement to the police regarding her collapse
9 23rd March 2018. During the 15 minutes prior to the
10 collapse, I had left Child I in Nursery 2 in the care of
11 another member of staff whilst I assisted Senior
12 Practitioner Laura Eagles with a procedure in Nursery 1.
13 Following the procedure, I went to the milk room to
14 fetch milk and took it into Nursery 2. Whilst preparing
15 the milk on the work top in Nursery 2 at approximately
16 0320 ... Lucy Letby who was standing in the doorway of
17 Nursery 2, alerted me to Child I looking quite pale.
18 I turned on light and found Child I to be pale, floppy
19 and gasping. Help was summoned, and Senior Practitioner
20 Laura Eagles and senior House Officer ... Dr Katerina
21 Clegg attended initially followed by Registrar
22 Dr Matthew Neame and Consultant Dr Newby. Child I was
23 resuscitated successfully and care was handed over from
24 myself to Lucy Letby.

25 "This collapse was unexpected in my opinion,

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1 I know, and that terminology, it's very upsetting. It
2 just makes me feel quite sick to be honest.

3 **Q.** We have heard -- the Inquiry has received
4 evidence from a number of routes about the manner in
5 which Letby spoke about deaths or deteriorations at
6 various times. We've seen that's how you were sent
7 messages.

8 Did you have any other experience of her in the
9 hospital at the time commenting in a way that was
10 inappropriate at least or --

11 **A.** Not that I can recall. And I wasn't present
12 or responsible for much care for many of the other
13 children involved within this time period. So I -- it's
14 not something I ask questions about if I'm not involved.
15 I can provide emotional support.

16 My viewpoint, as a professional, that if I'm not
17 involved in that patient's care that information is not
18 relevant to me unless there is learning that we need to
19 take forward as a team. The rest of it is I don't need
20 to know.

21 **Q.** Paragraph 11, you tell us you were the
22 designated nurse for Child I during the night shift 12
23 to 13 October. Would you like to set out what you tell
24 us there in 11 and 12. Have a look at it.

25 **A.** I'll just find it. (Pause).

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1 child I had been stable and very well prior to this."

2 **Q.** You turned on lights. Why did you turn on
3 lights?

4 **A.** Because I couldn't see.

5 **Q.** So if you couldn't see, do you know how she
6 could see from where she was standing?

7 **A.** No.

8 **Q.** And did you think that at the time or
9 subsequently?

10 **A.** I thought it was odd at the time, but I didn't
11 think it was suspicious.

12 **Q.** Did you think of saying to her at the time,
13 "How could you see?" Or you were just focusing on the
14 baby by then?

15 **A.** I think there was no time to ask that question
16 because it was immediately we were into resus.

17 **Q.** Was there any debrief or discussion about that
18 deterioration or event?

19 **A.** Not that I can recall.

20 **Q.** Did any doctor or anyone else ask you about
21 that?

22 **A.** No.

23 **Q.** You say it could have been discussed or would
24 have been during a handover, but you don't remember that
25 now if it was?

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1 A. I wasn't -- at the time of handover, I was no
2 longer her nurse, it was Lucy, so I would have handed
3 over to Lucy after this arrest, and then Lucy would have
4 handed over care to a member of staff on the day team,
5 so I wouldn't have been part of it.

6 Q. You do -- you say at paragraph 17:

7 "In the immediate aftermath of Child I's collapse,
8 as per my statement, I did question how Lucy would have
9 been able to see Child I's colour from the doorway. But
10 I did not think anything beyond that initially."

11 And you found it unusual but you didn't have
12 suspicions about her directly at that time. You say
13 you:

14 "... developed those further down the line as
15 I reflected on the events more and as I gained more
16 experience and as a trained Advance Nurse Practitioner."

17 When did the suspicions develop then, in your mind?

18 A. It's difficult to pinpoint. I think it was
19 after her arrest, and not immediately after, because the
20 period immediately after the arrest was awful because
21 she was arrested but we didn't have any other -- we
22 weren't given any more information. In my mind
23 thinking, okay, well, the police have been investigating
24 for a year now --

25 Q. Had they taken statements from you before she
89

1 those events and I was very much from -- it's from what
2 I have been told as well that this happens --

3 Q. They're premature babies, these things happen,
4 yeah.

5 A. Very premature, they can be unexpected, there
6 can be no warning, this is what they do. And we had so
7 many that I was, like, that must be the truth. It's
8 not -- it's not the impression I got as a student nurse,
9 but as a qualified nurse that was my impression.

10 The further away I got from that time period and
11 the more experience I had in the neonates, and with sick
12 babies, that's when my suspicions grew. I still had no
13 evidence but just on reflection I just thought, God,
14 that's not normal. I've not had that experience since
15 where so many babies have collapsed or died with no
16 warning.

17 Can neonatal babies be a little bit unpredictable
18 at times? Yes, but that's not common, and they can get
19 very sick very quickly after compensating for a period
20 of time, but there's usually a reason even if you don't
21 know what it is at the time you provide all the support,
22 you give all the care, and then you get blood results
23 back or you get X-rays back and things make sense.

24 It's very rare that you have a baby, neonatal or
25 not, preterm or not, that collapses unexpectedly with no
91

1 was arrested? So you'd been contacted by the police,
2 given statements --

3 A. Yeah.

4 Q. -- then you learnt she was arrested?

5 A. Yeah. So I gave an initial statement about
6 Child I, she was arrested some time after that, and then
7 I was asked to give further information following Lucy's
8 arrest that asked me more specific questions about Lucy
9 in particular.

10 Q. So when you were asked those questions, in
11 your mind, were you thinking then this is all about her?

12 A. Yes. I think also having the opportunity for
13 the first time to unpick it forensically and look at how
14 was the room laid out, where were you stood, where was
15 she stood, and having it all laid out in front of me,
16 that's still not proof but that's when my mind was then
17 considering the possibility that Lucy had harmed my
18 patient.

19 And, as you know, time progressed. Like I say,
20 I gained more experience in neonates and I gained more
21 experience as an advanced nurse practitioner.
22 I recognised that how I felt about neonatal care
23 changed.

24 For me, I started my career 2015 when these events
25 occurred. My experience of neonates then was shaped by
90

1 reason why. But because I was so inexperienced at the
2 time I didn't recognise that.

3 Q. Did any of the doctors have a discussion -- or
4 senior nurses -- with you about the fact that that
5 wasn't common and these were stable babies and they were
6 shocked? Did you know that?

7 A. No. I can't say that there wasn't, I don't
8 remember any specific conversations.

9 Q. But you were aware that it was widely accepted
10 they were unexpected?

11 A. (Nods).

12 Q. You nod. Sorry, a nod doesn't get picked
13 up --

14 A. Yeah. Yes. Yeah, sorry.

15 Q. You tell us at paragraph 19 and 20 your
16 involvement with Baby I and when the crash call was put
17 out at midnight. Can you tell us a bit more about that?

18 A. Is that paragraph 20?

19 Q. Yes.

20 A. I'll just having a little read.

21 Q. You heard the monitor sounding.

22 A. Yeah. What specifically would you like to --

23 Q. Well, maybe read it in the statement, what did
24 you arrive at? Who called you? What happened?

25 A. As per my kind of statement I wasn't within
92

1 Nursery 1 I was just outside, and I can't recall what
 2 alerted me to go into the room, I either heard a cry,
 3 I heard the monitor go. I'm not sure which one it was
 4 but I knew that I needed to go into the room.
 5 She was very unsettled, exhibited a large and
 6 relentless cry. I've said that:
 7 "I attempted to settle her with a dummy and
 8 sucrose; when that didn't work, I repositioned her on to
 9 her tummy. Following this, she stopped crying, stopped
 10 breathing and became dusky in colour. I shouted for
 11 help, and Lucy Letby arrived to provide help. We
 12 positioned Child I on her back ..."
 13 And began resus measures.
 14 **Q.** And you were involved in the aftercare,
 15 weren't, you for Child I? Can you tell us about that,
 16 and we know Letby insisted with that because you'd never
 17 done before? Did she tell you she had?
 18 **A.** And I knew that she had because I knew that
 19 she's lost a patient before, more than one, and I knew
 20 that she -- I knew that she delivered that because
 21 generally whoever is responsible for the care of that
 22 baby then delivers the aftercare.
 23 **Q.** And you were actually on -- you were
 24 designated for that baby --
 25 **A.** Yeah.

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1 and I had no idea that that was happening at the time,
 2 so I didn't have an opinion when it was happening.
 3 **Q.** Because you didn't know it was being done like
 4 that?
 5 **A.** No.
 6 **Q.** You thought she was helping you not taking it
 7 over really?
 8 **A.** Yeah.
 9 **Q.** You say at paragraph 22:
 10 "Child I's collapses and subsequent death were
 11 unexpected events in my opinion. Despite her medical
 12 history prior to this point, she presented as a stable
 13 baby."
 14 You said that you knew that at the time as well and
 15 there was a debrief, wasn't there, following on from
 16 that?
 17 **A.** Yeah.
 18 **Q.** If we go to INQ0000429, page 1543. We see
 19 here it looks as though it's between yourself,
 20 Lucy Letby, Dr Gibbs, who was present at the
 21 resuscitation, and the chaplain.
 22 **A.** Yeah.
 23 **Q.** And we look there we see:
 24 "Discussed briefly overall cause of illness since
 25 prem delivery."

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1 **Q.** -- not her --
 2 **A.** Yeah.
 3 **Q.** -- but because she had done this before, did
 4 she want to do that and assist with that?
 5 **A.** Yeah.
 6 **Q.** So although you're the designated nurse, she
 7 wants to assist she does assist --
 8 **A.** (Nods).
 9 **Q.** -- with that?
 10 **A.** Mm-hm. Yeah.
 11 **Q.** Again, looking back, and maybe at the time,
 12 what did you think about that, her wishing to assist
 13 with that?
 14 **A.** I thought she was being helpful. I would
 15 expect that from any colleague. I have never -- there
 16 is the pastoral side, the emotional support, but there's
 17 also a lot of paperwork and things that have to be done
 18 when a child dies, and I was just aware that I hadn't
 19 done it before, I was really worried about not doing it
 20 right, so I just wanted that guidance from somebody.
 21 And I didn't specifically ask Lucy, I asked just the
 22 staff that were there if somebody could help me.
 23 Since then I've -- I think within the trial there
 24 was information that she'd gone into the room without me
 25 and discussed things with parents that then upset them,

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1 And then:
 2 "Discussed episodes of sudden cardio respiratory
 3 deteriorations the week before death, then again at time
 4 of death seemed fine and stable prior to the episode of
 5 sudden collapse."
 6 So right close to the event Dr Gibbs, yourselves
 7 acknowledging that came from nowhere, sudden and
 8 unexpected collapse.
 9 **A.** (Nods).
 10 **Q.** At the bottom, it a reference to nursing
 11 staff -- quite difficult to read this -- but nursing
 12 staff --
 13 **A.** Yes.
 14 **Q.** -- felt ...
 15 **LADY JUSTICE THIRLWALL:** "... resuscitations were
 16 well run."
 17 **MS LANGDALE:** Yeah:
 18 "... must have been due to ..."
 19 Actually let's go to the next paragraph:
 20 "Nursing staff felt resuscitations ..."
 21 **A.** "... were well run."
 22 **Q.** "... were well run."
 23 Do you remember that discussion now?
 24 **A.** Barely. I knew that we had a debrief.
 25 I didn't really get any information from it.

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1 Q. And it look likes John Kingsley, the reverend
2 has said that:
3 "Someone will come to talk to parents whether or
4 not a child has already been baptised."
5 A. Yeah.
6 Q. There seemed, amongst all the deaths that we
7 are looking at in the context of the Inquiry, references
8 to baptism --
9 A. Mm-hm.
10 Q. -- and would they like babies baptised. Was
11 that something you all had training in or discussions
12 about when that should be raised, how that should be
13 raised, if it should be raised?
14 A. Yeah, so -- I can't remember the nature of the
15 training at the time but we get regular updates about
16 what support can we provide to parents, and it's --
17 a big part of that has always been: are they of
18 a religious denomination? Would they appreciate having
19 a baptism? Having a christening? Regardless, even if
20 they are not religious, would they appreciate
21 a blessing? And that comes from parent feedback, from
22 charities -- bereavement charities where parents have
23 said that would have helped to be offered that at the
24 time and be offered that maybe when their child was sick
25 and not after the fact when their child has already

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1 a lot of resource to have somebody specifically who
2 could provide that support. We have it now.
3 Q. What do you have now?
4 A. We have bereavement links on the unit, nursing
5 staff who help deliver training, help liaise with parent
6 advisory boards. We have a bereavement midwife whose
7 sole -- her job is to provide bereavement support to
8 families, and sometimes she will be involved before the
9 baby is even born if there is knowledge that the baby
10 might not survive or they might have severe health
11 problems.
12 We on the unit now have well-being practitioners
13 that come to the unit twice a week who can deliver
14 counselling whether the baby is in hospital, whether
15 they've gone home, whether they've lost a baby. And
16 they can also assess and signpost and refer parents to
17 further support if necessary. None of that was
18 available at the time.
19 Q. And it sounds like the fact that you hadn't
20 dealt with it before and you were unsure of your own
21 position, let alone supporting somebody in a deeply
22 distressing position --
23 A. Yeah.
24 Q. We've had evidence from at least one parent
25 that they were given a leaflet, and leaflets how

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1 passed.
2 Q. If it is a sudden deterioration or a sudden
3 death, I suppose you may not have asked about those
4 preferences in any event at all, mightn't you?
5 A. No, I -- no, and that's -- you are so
6 focused -- rightly or wrongly, you're so focused on
7 helping that patient and giving them what they need and
8 the emergency at the time, you don't really think about
9 things like baptism. I know that Child I had been
10 baptised and that had been following the initial episode
11 before she was transferred out where I think she was not
12 quite stable but there was a time period where that was
13 thought of by somebody.
14 I think it just didn't cross our minds to offer
15 that again. So John Kingsley very rightly said, "I'm
16 happy to come. I can come again. There is no limit
17 there is no restrictions."
18 Q. And dealing with managing bereavement
19 generally, were there other options of support or care
20 or assistance that you were trained about or discussed
21 that people might want in that hour or time of need?
22 A. No. I feel the bereavement care in general in
23 neonates was very poor at the time. We -- we did what
24 we could, but we're not -- although you can -- you can
25 attend study days and you can get training, there wasn't

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1 effective can they be in these circumstances compared
2 with a real person, what's your view about that?
3 A. I agree. I think things like leaflets and
4 booklets it's very impersonal, and this is a very
5 sensitive and personal subject. There are some
6 fantastic charities such as SANDS that have been set up
7 by grandparents or parents who have been bereaved who
8 provide a lot of that literature from experience. But
9 we cannot just depend on goodwill and charitable causes
10 to provide this support. It should be integral to the
11 healthcare that we provide. It should be a continuation
12 of the neonatal care, and I think only recently has that
13 been properly recognised, and even so it's having the
14 funding.
15 We in neonates work in a certain area where we
16 expect that sometimes outside of this period babies will
17 pass away unfortunately for many reasons. So we're
18 acutely aware of what these families go through. And at
19 the time, not being able to provide that support was so
20 difficult because we would know what they need but we
21 just had no funding and no staff to provide that.
22 I think recently, and publicly, that has been more
23 recognised and there are more conversations about the
24 neonatal period, things like maternity and paternity
25 leave, things like bereavement care because it's a very

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1 unique time period and it's very unique to these
2 families. Many, many people will not experience a loss
3 like this. It's very different. I just wish that we
4 could have provided -- the care that we have now I wish
5 that we could have provided it then.

6 **Q.** Were you aware as a nurse at the time what
7 information parents were being given about concerns
8 about Letby or the RCPCH investigation or anything like
9 that? Was that something as nurses --

10 **A.** It's --

11 **Q.** -- you'd consider or was that --

12 **A.** It was not something that was discussed with
13 us. And we had very little information ourselves. It's
14 only through following the trial and also some of the
15 transcripts of this Inquiry that I've recognised that
16 actually parents were kept in the dark for a really long
17 time and not informed that the deaths were felt to be
18 unexpected, and that -- it did very much surprise me.

19 **Q.** You were also involved with Baby M and you
20 tell us that you heard Letby shout for help and you
21 attended Nursery 1 to find her and another nurse
22 resuscitating Child N, and you placed a crash call via
23 the switchboard. You say you don't recall a debrief
24 following Child M's collapse but say when there was
25 a deterioration as opposed to a death that was less

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1 review to go for an interview, weren't you? And you've
2 helpfully set out for us at paragraph 33 of your
3 statement various things you raised and we have also got
4 notes of that. If we can go, please, to INQ0014605,
5 page 1 to 5.

6 You say there were a couple of people interviewing
7 you. I think in fact the note -- the reviewers
8 record -- this interview id recorded as Clare, David and
9 Sue. So were there three people? Does that accord with
10 your recollection or not? Maybe --

11 **A.** Yeah, I think so. I have to apologise, I only
12 received this transcript this morning, so --

13 **Q.** You did --

14 **A.** -- when I answered --

15 **Q.** -- apologies.

16 **A.** -- I think I've gone from memory, but whatever
17 is there is correct.

18 **Q.** Well, it looks like you were with Band 5
19 nurses together, weren't you --

20 **A.** Yeah.

21 **Q.** -- at this meeting? And you set out various
22 things.

23 If we go to page 1 you're setting out really nice
24 unit, really supported, friendly, tight-knit, all get to
25 know each other and babies, feels like everyone wants to

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1 likely that there would be a discussion about
2 a deterioration; is that right?

3 **A.** Yes. I think the debrief process back then
4 was just a little bit sporadic. Compared to now, and
5 what we do now, and what -- a debrief is very -- very
6 much meant to be, like, pastoral support, it's meant to
7 be emotional support. Yes, you might get some
8 information if there has been a post-mortem or
9 something. But a lot of it was that emotional support.
10 And I think the unit was so busy and there was -- we
11 know the doctors were short-staffed, the nurses --
12 I just think it was an oversight.

13 An unexpected collapse is really difficult to deal
14 with as much as an unexpected death. I just don't think
15 there was that recognition or maybe not the time
16 dedicated to providing a debrief for those episodes.

17 **Q.** Would it happen informally on a ward round if
18 you saw the doctor again and say, "What happened the
19 other day?" Or have a discussion like that or not?

20 **A.** Not -- wouldn't necessarily discuss it on the
21 ward round because that's not a private space, it's not
22 appropriate. There may well have been conversations
23 that were not documented but I wasn't part of them, so
24 I can't be sure.

25 **Q.** You were invited as part of the Royal College

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1 educate -- things you've set out earlier, but this was
2 obviously fresher in your mind. Everyone pulls you in
3 to see anything interesting, lots of bands on experience
4 with support.

5 If we go over the page it says at the bottom,
6 sorry:

7 "Can be really busy especially if new people are
8 aware and acknowledge it."

9 So can be really busy. So like your colleague
10 earlier, you could have busy parts -- busy times and
11 less busy times. Is that your experience with neonates
12 generally because it's --

13 **A.** Yeah --

14 **Q.** -- not Planned Care, is it?

15 **A.** -- there's no pattern. Yeah, there's no
16 pattern. There's no seasonal difference really that
17 I can recognise. Every day is different.

18 **Q.** It looks as though here:

19 "Normally a positive environment but been very
20 difficult. "

21 "Been very difficult", this is at the time of this
22 review.

23 **A.** Sorry, okay.

24 **Q.** You see at the top of the page 2.

25 **A.** Yeah.

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1 Q. "Normally a positive environment but been very
2 difficult. Dips in morale when it happened.
3 Uncertainty. Told the review would take place and not
4 sure how going to Level 1 will change it."

5 We know there's been an announcement in the press
6 by now that effectively there's going to be a RCPCH
7 review and the downgrade, so it looks like there was the
8 downgrade being discussed there, the fact there was the
9 downgrade, how are parents going to feel about that,
10 does that make sense?

11 A. It's quite difficult to remember, and I'll be
12 honest, I find this really hard to follow.

13 Q. Fair enough. Okay.

14 Let's just go over the page on page 4. What we do
15 see:

16 "Experience of death. Overwhelmed first
17 unexpected, felt very supported. Nurse W door always
18 open? Debrief. Never found out why."

19 Does that bit make sense, given whether you have
20 been saying about --

21 A. Yes.

22 Q. So it looks like you did raise unexpected
23 deaths, and the short debrief and question mark still
24 didn't know why, was that the position that you didn't
25 have any feedback or know why?

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1 And it was my understanding at the time that
2 a debrief was supposed to be largely emotional support,
3 and I just felt like that that wasn't being delivered
4 consistently and it was undervaluing their input on the
5 unit.

6 Q. Thank you, the document can go down.

7 There's no time limit for you to have a look at
8 that, Ms Hudson. If you read it in your own time and
9 you think there's anything inaccurate or you don't
10 follow please let us know.

11 A. Of course.

12 Q. But the parts I've taken you to you've
13 elaborated upon, so thank you from that.

14 In your statement you do say at paragraph 33 you
15 can recall voicing concern, and that won't be
16 a comprehensive note presumably:

17 "I can recall voicing concern at the lack of
18 consultant ward rounds in comparison to the Children's
19 Ward, as I felt that well long-term patients would often
20 get overlooked and lack a proactive plan of care."

21 A. Yeah. It just -- it just felt that we had --
22 we had many wonderful junior doctors, but we also had
23 some junior doctors that didn't have a great deal of
24 experience in neonates and wouldn't want to make
25 decisions on the day, they'd want to -- you'd say. "Oh,

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1 A. No, I think -- I think the -- the -- from what
2 I can recall, it was almost written off as prematurity
3 verbally, but it just didn't -- it just didn't quite
4 make sense.

5 Q. If we look at the bottom of that paragraph 2:
6 "Only thing we need is a unit debrief
7 [underlined]."

8 So it looks like you're flagging up there there's
9 not a unit whole debrief. Does that ring a bell?

10 A. Yeah. I've put:

11 "Affects everyone. So would need a local debrief
12 with a resus team".

13 And I've -- I think I've alluded to it a little bit
14 further down, but what -- at the time what we found was
15 is that the nursery nurses, the Band 4s, were never
16 invite today a debrief, and I felt like it should be the
17 whole -- everyone that's on -- everyone that's on that
18 shift, it's a small team, it's only about five or six of
19 us, everyone should be at the debrief, not just the
20 people who were involved in resuscitating at that time.
21 Because although the Band 4s wouldn't have been hands
22 on, giving medications and resuscitating, they would
23 have been running in and out of the room, fetching
24 equipment, they would have been care for other babies on
25 the unit and they would have seen a lot.

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1 can -- what do you think about, for example, weening the
2 high flow or" -- and they'd go, "We'll wait to when for
3 the grand round. We'll wait for the Consultant". So
4 I just felt that the care of the well babies that maybe
5 had been on the unit for a long time wasn't as proactive
6 as it should be. I feel like every day we should be
7 looking -- assessing that child. Even if nothing's
8 changed, is there anything that we can do to get them
9 closer to going home.

10 Q. A management plan --

11 A. Yes.

12 Q. -- where you're going?

13 A. An active management plan rather than
14 "continue".

15 Q. You also say:

16 "I ... remember contributing to conversations
17 regarding acuity of the unit and staff levels, the unit
18 was very busy, and staff were taking on bank shifts to
19 help."

20 Is this the part we've gone to that sometimes it
21 was busy, sometimes it was not, you know, it was
22 difficult to plan it could be very busy.

23 A. Yes.

24 Q. You then summarise your concerns in the
25 statement and say you had been there for the collapse of

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1 Child I and you were involved in the care of A and M as
2 well.

3 Were you aware of the triplets deaths, O and P,
4 later on?

5 **A.** I was. I didn't -- I was on annual leave at
6 the time.

7 **Q.** Annual leave?

8 **A.** Yes.

9 **Q.** So you didn't feel the atmosphere in the
10 hospital on those days?

11 **A.** No.

12 **Q.** When you did hear of those, were other nurses
13 or doctors expressing real concerns about a person by
14 then or not to you?

15 **A.** Not out loud, and not to me.

16 **Q.** Not out loud. In any other way, was it --

17 **A.** Well, we can see that there was discussions
18 going -- that's what I mean, we can see that there were
19 discussions going on amongst the Consultants and senior
20 members of staff, but there was nothing said to us as
21 a nursing team.

22 **Q.** So nothing was formally shared with any of the
23 nurses?

24 **A.** No.

25 **Q.** Dr Lambie's evidence was to the Inquiry that,
109

1 police and you didn't discuss generally the events as
2 they were confidential. Obviously moving towards that
3 criminal trial, you were all witnesses or potential
4 witnesses, weren't you?

5 **A.** Yes.

6 **Q.** So how did that impact on being able to
7 discuss with others any suspicions or concerns?
8 Presumably, you couldn't at that point.

9 **A.** No, we were told that legally we weren't
10 allowed to discuss what we'd discussed within our
11 statements.

12 **Q.** Now that the trial has happened and with the
13 benefit of hindsight, which is a wonderful thing, what
14 are the concerns or features you could draw together
15 that others might be alert to in the future were they to
16 find themselves in a situation you all were working
17 alongside Letby?

18 **A.** I think things have been -- I think
19 highlighted within this Inquiry already. Very
20 interesting that we get training on safeguarding and
21 what to do when we suspect a parent might be harming
22 a child. We don't have anything that tells us what to
23 do if we think a staff member or what -- or behaviour to
24 look out for.

25 We have training on radicalisation and spotting
111

1 in September 2015, she'd seen:

2 "... a huddle or a small group of nurses at the
3 nurses' station going through rotas thinking the
4 unthinkable, in effect, looking at who might be
5 connected to the same unexpected events."

6 From what you're saying, that wasn't -- you weren't
7 one of those nurses?

8 **A.** No.

9 **Q.** Do you know that some of your colleagues were
10 doing that at the time or not?

11 **A.** No.

12 **Q.** How many nurses, roughly, were -- you had
13 people on bank shifts coming in, was it a very busy
14 nursing group?

15 **A.** You'd have -- because you would have a nursery
16 nurse as well, you could have from four to -- probably
17 four or five nurses on a shift.

18 **Q.** Did you -- did they sit around in groups or
19 huddles at times, if they could, at points of handover
20 or generally?

21 **A.** At points at handover, yes, when the unit was
22 quieter, and there was certainly times where we would
23 have one patient.

24 **Q.** You explain in your statements that after the
25 time of her arrest, you had given statements to the
110

1 people who may have been radicalised into terrorism.
2 But we don't have any training that tells us that there
3 are certain characteristics or things that might cause
4 you to raise concern about a member of staff.

5 I think the information sharing was really poor.
6 For a long time, nobody really said what the accusations
7 were and what was happening. None of that was laid out.
8 It was all very secretive. There was a lot going on
9 behind closed doors. And for us that were working on
10 the shop floor much of our focus was the patients that
11 were there that day and keeping them safe and working,
12 and there was always this background of what is -- what
13 is actually happening? What is going on?

14 So going forward I think just better communication,
15 better identification, like, of trends. So we knew that
16 there was an increase -- a significant increase in
17 deaths and collapses that were marked as "unexpected or
18 unexplained", and be frank about that with the nursing
19 staff.

20 **Q.** And stop just saying "deaths", because there's
21 a reference, isn't there, to lots of neonatal deaths,
22 mortality rates. It was unexpected. It was the
23 unexpected deaths --

24 **A.** Unexpected.

25 **Q.** -- that were significant.
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1 **A.** It's not just the increase in the statistics.
2 It's this word "unexpected". What does that actually
3 mean? Because we'd say unexpected, but then there would
4 be narratives about each baby of why they think that
5 happened and this is what happens in neonates.

6 And I just think -- wish that things were more
7 frank and more on the surface. I can see why they
8 weren't, but we're not going to be able to prevent this
9 again unless we are frank and unless you have somebody
10 who can come in with a bird's eye view that has -- who
11 is impartial, who can look at trends, but also look at
12 the patients themselves and the personal characteristics
13 and the care of that patient to identify these things
14 much earlier.

15 **Q.** And Lucy Letby obviously had her friends and
16 allies on the unit, didn't she, with the nurses, people
17 who really liked her? How do you think that impacted --
18 when you say on impartiality -- impacted on recognising
19 when it needed to be investigated externally by the
20 police?

21 **A.** I think you can't be impartial about somebody.
22 I personally wasn't friends with Lucy, but I think you
23 can't -- it's difficult to be impartial about a friend,
24 and if you haven't seen them do anything people think,
25 well, that's not possible, that can't possibly happen

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1 And, like you say, that's not how we conduct care
2 in the community. It's not how we -- if we think
3 a child has been harmed, yes, there's lots of
4 information gathering. But if you see a worrying
5 interaction on the unit you speak to social care and you
6 flag that concern.

7 So why is it different if it's a member of staff?

8 **Q.** Do you think it would be easier if you could
9 do that confidentially in some kind of hospital
10 helpline, "I'm worried about this because the
11 colleagues, this was said, this was said", where
12 effectively whether it's a safeguarding unit in
13 a hospital or an independent unit that that information
14 can be gathered --

15 **A.** Yes.

16 **Q.** -- would that help, do you think, from a nurse
17 perspective?

18 **A.** I think -- I think so, and I think that people
19 are innocent until proven guilty, and I think that it
20 has to be a process which is respectful of both parties
21 and has some protective factors for the person being
22 accused and the person doing the accusing.

23 It needs to be looked at with a fair, impartial
24 point of view. That is the most important thing.
25 Because when emotions and friendships and biases become

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1 here. I think it's like a two-thing approach. If we
2 can't imagine that she would do this and we haven't seen
3 anything specific, so it can't possibly be true.

4 For me personally it was the lack of communication,
5 the lack of facts. I wasn't friends with her, so I over
6 time, with my experience, formed an opinion based on my
7 ongoing experience in neonates. That is still my
8 opinion. That's not fact until it's proven, which it
9 has been now.

10 But, how can you form an opinion when you don't
11 have all the information? I don't know.

12 **Q.** All the more reason, when there is any
13 possibility of harm being caused to a baby, to refer
14 externally, whether it's local authorities, the police,
15 for investigation. As you've described, you would know
16 as a nurse, you do if you're suspecting parents of
17 harming children, you don't need proof, you just need
18 the concern, don't you --

19 **A.** Yeah.

20 **Q.** -- that there's a possibility of harm being
21 caused?

22 **A.** Yeah. I feel as though being able to look
23 back at the information that now is available to me and
24 everyone else it was like there's no concrete proof this
25 is happening so, therefore, it can't be happening.

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1 involved, if that is what's happened here, I'm sure we
2 will find out, that complicates things and we just can't
3 let that happen.

4 **Q.** When you were training, you mentioned the
5 Beverley Allitt report. That's on the training
6 programme, isn't it, for nurses?

7 **A.** Yes.

8 **Q.** What do you actually learn about the
9 Beverley Allitt case? Do you learn -- well, you tell me
10 first.

11 **A.** I can't -- I can't remember a great deal from
12 university now, I'll be honest. It's a short session.

13 **Q.** Is it -- one of the recommendations from the
14 Inquiry that followed Beverley Allitt's conviction was
15 that there should be heightened awareness of that
16 Grantham case so that within the NHS people like
17 yourselves on wards should know that this can happen,
18 somebody can come to work with the intention of causing
19 deliberate harm.

20 **A.** Yes.

21 **Q.** The unthinkable. That was one of the
22 messages. So was that part of the learning or was it
23 more practical about medication doses? What was it
24 about? If you can't remember say.

25 **A.** I can't remember.

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1 Q. You just know there was a session. So it does
2 form part of nurses' training?

3 A. Yes.

4 Q. In your mind, although -- and you recognised
5 she was somebody convicted of killing babies as part of
6 that training --

7 A. Yes, yeah.

8 Q. -- and yet roll forward to your first
9 experience, not as long after you've had that training
10 than some might, that would still be something really
11 difficult for you to take on board unless you had seen
12 something directly?

13 A. Yeah. And it's also -- you know, that
14 recommendation "heightened awareness", what does that
15 actually mean? We're all aware that these things can
16 happen, but people have a really hard time believing
17 it's happening when it's happening. That's why we need
18 that impartiality. That's why we need that outside eye
19 looking in.

20 Q. You do say in your statement at paragraph 41:
21 "Due to working on the unit as a student nurse,
22 I knew the average death rate had previously been much
23 lower. I was worried about this increase, especially as
24 they all seemed to be unexpected or sudden -- and there
25 was no explanation ..."

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1 Countess of Chester anonymously made about how night
2 shifts were. You worked night shifts sometimes; right?

3 A. Yes.

4 Q. So do you recognise this. She described how
5 during night shifts:

6 "... nurses on the ward would pull a name out of
7 a hat and whoever got picked would be able to leave
8 early despite still being in charge of a baby."

9 Do you recognise anything like that?

10 A. What I know of that time period is there would
11 be times where staff would have time owing, where
12 they've overworked their hours on different shifts. If
13 the unit was quiet and there was three babies, if
14 a nurse could leave a little bit early and claim that
15 time back they were allowed to do that.

16 Q. Right.

17 A. There was never a baby left alone. There was
18 never a shortage of staff because we had sent someone
19 home. Nobody would leave the unit if their help was
20 needed, and that's displayed quite often in times of
21 resource where staff would stay hours beyond what they
22 were paid for because they just didn't want to leave.
23 They didn't want to leave the family, the baby, and they
24 didn't want to leave their fellow nursing staff in the
25 lurch.

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1 So you were worried, but presumably you didn't know
2 what to do with that worry or what -- or take it to
3 anyone. What do you do with that? You're worried about
4 it.

5 A. I think I was just -- I was worried, but I was
6 so junior and I think I just -- over time, I believed
7 that narrative of this is what neonates do, this is what
8 prem babies do, because my frame of reference, even
9 though I had been a student, was just so small.

10 Q. Can you remember where you were getting that
11 narrative from?

12 A. No, I can't. I can't remember specifics.
13 I think it was just general conversation. I can't
14 remember a person or a time.

15 Q. Well, we've heard that. I mean, that's been
16 repeated since, hasn't it, it's what happens.

17 So that was your impression that that was the
18 answer to an increase in sudden and unexpected deaths,
19 that they can happen --

20 A. Yes.

21 Q. -- a bad run, have a number.

22 A. (Nods).

23 Q. One final question from me. There's obviously
24 been a wide amount of newspaper reporting, and I think
25 one article referred to a nurse's comments from the

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1 Q. This suggestion is:

2 "Instead of carrying out a correct handover they
3 would leave a written note by the infant leaving the
4 baby without oversight for hours at a time."

5 A. No. The shift leader knew all the babies on
6 the unit, so if that nurse wasn't available they'd hand
7 over to the shift leader. They might leave bullet
8 points of when things are due, but it's up to that nurse
9 to check that those things are correct times.

10 Q. It becomes quite easy, doesn't it, to make
11 comments on the generalities about how the neonatal unit
12 was staffed and run. Can you give your honest, open,
13 candid appraisal of that? How did you feel it was? And
14 just say it how it was. There's no right answer.

15 How was it?

16 A. I feel as though it was run relatively well.
17 I feel like the staff -- and it's what I'd experienced
18 as a student, it's where I decided to work, on that
19 unit -- is that everyone just seemed really passionate
20 about neonatal care. They were passionate about
21 learning. They were passionate about improving care.

22 There would be times where we were short-staffed.
23 Staff get sick, staff have personal loss and they have
24 to take time away. I found that many of the staff would
25 do overtime, bank shifts because they had that

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1 dedication to the job and to the unit to make sure that
2 the care we provided continued to be consistent and
3 continued to be safe.

4 **Q.** You say finally on reflections:
5 "I don't think the crimes of Letby would have been
6 prevented if there had been CCTV present."

7 **A.** Yes.

8 **Q.** "Many of her crimes were ..."

9 Well, tell us. Tell us, why do you think that?

10 **A.** I think that -- and I would caveat by saying
11 if parents would be more confident with CCTV that's not
12 what I'm questioning. That is if that's going to make
13 them feel safer, by all means.

14 That's not for me to decide.

15 **Q.** And in the incubator a camera so they can see
16 if they're off the ward because they can't get to their
17 babies?

18 **A.** Yeah. Wherever they are, whatever helps
19 parents feel safe and feel that they can see their baby
20 I have no questions over. I just don't want us to fall
21 into the trap of thinking that that might stop somebody
22 from doing this again.

23 **Q.** So not to get a false reassurance from it.
24 Why do you say that, because it's so hard to see the
25 actions?

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1 **Q.** How's that changed?

2 **A.** Well, now we have each -- each patient not in
3 ITU, HDU, but in the special care rooms every patient
4 has their own fridge, so milk is kept separate.

5 We have two people checking the milk and signing
6 for it. That can be a parent, two people check the
7 label. I know there was incidents where babies received
8 the wrong milk, but I don't know of any incidents of
9 milk going missing. So I can't comment on that.

10 **MS LANGDALE:** Thank you very much, Ms Hudson.

11 Those are my questions. My Lady, nobody else is
12 asking questions of this witness.

13 **LADY JUSTICE THIRLWALL:** Well, thank you very much
14 indeed, Ms Hudson, for coming along and giving so much
15 evidence.

16 **A.** Thank you.

17 **LADY JUSTICE THIRLWALL:** We are very grateful to
18 you and you are free to go now, but if you would just
19 stay there until everyone else is out of the room.

20 **A.** Thank you very much.

21 **LADY JUSTICE THIRLWALL:** We will rise until ten
22 past 2.

23 (1.07 pm)

24 (The luncheon adjournment)

25 (2.10.00 pm)

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1 **A.** I think because Lucy attacked these babies
2 under the guise of normal care. Nobody saw her do
3 anything that was -- in a stereotypical way, that was
4 violent or malicious or -- and on CCTV, how do you know
5 what's in a syringe?

6 I don't -- I think it could be part of the process.
7 I don't think it's the answer.

8 **Q.** One other thing if I can ask you, if I may.
9 We have had more than one parent tell us of an
10 experience of expressing breast milk, you know how
11 important that is for a newborn, for the mother and the
12 baby, leaving it in a fridge on the unit and then it's
13 gone with no explanation from anyone. It's just not in
14 the fridge.

15 Did that happen very often and do you think that --
16 it's an important issue, isn't it?

17 **A.** Yes. It's not something that I'm aware of
18 that it would just be gone. It's not something I've
19 heard before.

20 **Q.** Because there should be systems around that,
21 shouldn't there, where the milk is?

22 **A.** Yes.

23 **Q.** Who has access to it?

24 **A.** Yes, and much of that has changed since then
25 as well.

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1 **LADY JUSTICE THIRLWALL:** Yes, Ms Lyons.

2 **MS LYONS:** My Lady, may Mrs Kathryn
3 Percival-Calderbank be sworn in, please.

4 **LADY JUSTICE THIRLWALL:** Yes.

5 **KATHRYN PERCIVAL-CALDERBANK (sworn)**
6 **Questions by MS LYONS**

7 **MS LYONS:** Can we please begin with your full name.

8 **A.** My name is Kathryn Lesley Percival-Calderbank.

9 **Q.** Mrs Percival-Calderbank, you have provided
10 a witness statement to the Inquiry dated 18 April 2024,
11 are the contents of that statement true to the best of
12 your knowledge and belief?

13 **A.** Yes.

14 **Q.** We're going to begin by going through your
15 career. It's right that you qualified as a nurse in the
16 British army 1988.

17 **A.** Yes.

18 **Q.** And you left the army in 1989, and you
19 commenced employment within the NHS. When did you start
20 working at the Countess of Chester Hospital?

21 **A.** I started in I think it was 1991 and I was
22 a student midwife.

23 **Q.** And you qualified as a midwife in 1992; is
24 that correct?

25 **A.** It was probably nearer 1993, at the end.

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1 I think I got my dates slightly wrong.

2 **Q.** Were you aware around the time of your
3 training to become a midwife of the case of
4 Beverley Allitt?

5 **A.** Yes.

6 **Q.** And so you were aware that insulin could be
7 used as a drug to harm babies?

8 **A.** Yes.

9 **Q.** After you qualified as a midwife, in your
10 witness statement at paragraph 5, you say that you took
11 up a position as a midwife on the neonatal ward; is that
12 correct?

13 **A.** That's correct, yes.

14 **Q.** And at some stage you were no longer a midwife
15 on the neonatal ward and you became a nurse --

16 **A.** Yes.

17 **Q.** -- on neonates. So can you just explain that
18 transition?

19 **A.** When the NMC decided that you had to keep with
20 dual training, you had to do so many hours in one
21 qualification and the other I couldn't adhere to the
22 full qualification as a midwife because I wasn't
23 practising on a labour ward to fulfil that requirement.
24 So I -- I kept my registration for nursing and not
25 midwifery.

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1 your -- in your view why that was?

2 **A.** Because we were -- we had a lot of babies --
3 intensive care babies and there was a lot of work to do
4 for the amount of babies towards the staff. Even though
5 we were BAPM compliant it was still very busy.

6 **Q.** Busy but manageable?

7 **A.** At the time -- most of the time it was
8 manageable but at times it wasn't because of the
9 requirements of taking babies from the maternity unit
10 that were unable -- that mothers weren't able to be
11 transferred out in utero or because the mothers had come
12 in and delivered, and the babies then needed further
13 care with -- with us, so we were indebted to take
14 that -- the care of the baby over for them. The care of
15 the baby to ensure its safe -- it's -- help it -- help
16 the baby out.

17 **Q.** And what about medical cover, did you feel at
18 the time that there was adequate medical cover, enough
19 doctors -- junior doctors, middle-grade doctors,
20 Consultants on the neonatal unit at that time?

21 **A.** Yes. I -- the only difference was that they
22 had to cover an awful lot of -- they weren't just for
23 neonates -- looking after neonates, they were looking
24 after the -- any babies that were born on labour ward
25 and also the paediatric. At times they were also

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1 **Q.** And that was in 2013?

2 **A.** I can't remember what date that really was.

3 **Q.** In paragraph 6 of your statement you say you
4 became a senior neonatal practitioner at the Band 6
5 level in 2013 is what I inferred from your statement,
6 but if you don't remember.

7 **A.** Yeah, because I did extra qualifying cases
8 towards it as well, towards getting that -- that
9 qualification. So I'd done my -- what was known as the
10 405, which was part of the looking after neonates, and
11 then I then did my R23, which is a -- an advanced
12 training to further my position.

13 **Q.** And are you still employed as a neonatal nurse
14 on the -- at the -- on the neonatal unit at the Countess
15 of Chester Hospital?

16 **A.** Yes.

17 **Q.** I would like to move now to some questions
18 about how the unit was in 2015/2016 and your
19 relationships with your fellow staff members.

20 At paragraphs 26 and 69 of your statement, you
21 describe the working environment on the neonatal unit
22 during the period that we're concerned about, 2015 to
23 2016, as very busy and particularly stressful for the
24 nursing staff.

25 Can you -- can you tell us why that was? In

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1 covering the paediatric ward and -- and A&E at times as
2 well.

3 **Q.** But if you needed a doctor on the neonatal
4 unit, would they come if you called them?

5 **A.** Yes, we would bleep them and they would answer
6 the bleep and come to us.

7 **Q.** And I'm going to ask you some questions now
8 about Datix reporting. Now, I think by 2015 you would
9 have been employed on the neonatal unit for about
10 I think 22 years or around then.

11 **A.** Yeah.

12 **Q.** So you've probably seen different systems come
13 and go?

14 **A.** (Nods).

15 **Q.** Do you remember when the Datix incident
16 reporting system was introduced?

17 **A.** I -- I can't -- can't recall the dates, no.

18 **Q.** And you explain very helpfully at paragraph 29
19 of your statement how it was used, and if I understood
20 your evidence correctly, there are two scenarios.
21 I think you say in response to a specific concern, and
22 you give an example, closure of the ward due to acuity
23 or lack of staff or admissions above the allocated
24 number of beds, and the second scenario is if a mistake
25 was made in the clinical care of a baby, for example

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1 a drug administration error.
 2 **A.** Mm-hm.
 3 **Q.** Would you or any of your nursing colleagues
 4 complete a Datix form if a baby suddenly and
 5 unexpectedly collapsed and died?
 6 **A.** No, we wouldn't have done that. It would have
 7 probably been left to the medical staff to complete
 8 that.
 9 **Q.** And would there be a discussion -- so if
 10 a baby has to be -- had -- was being resuscitated and
 11 the resuscitation was unsuccessful and the baby sadly
 12 died and you have the nurses in the room and you have
 13 the doctors in the room, how would the conversation go,
 14 in terms of who's deciding to fill out the Datix form?
 15 In practice, how did it work?
 16 **A.** It was just understood that the doctors would
 17 complete that -- that side of it.
 18 **Q.** Understood, by whom?
 19 **A.** By -- by the nurses.
 20 **Q.** And what was your understanding about if
 21 a baby suddenly collapsed unexpectedly, needed to be
 22 resuscitated but did not die, so recovered --
 23 **A.** Then --
 24 **Q.** -- would a Datix form be --
 25 **A.** It should have been --
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1 opportunity to cover the shifts.
 2 **Q.** So was it monthly, or weekly?
 3 **A.** I think it was trying to be done -- be done on
 4 a monthly basis. But sometimes that might alter
 5 depending on staffing and if somebody's not feeling well
 6 that they couldn't take the responsibility of being
 7 a shift leader, then one of the other Band 6s would take
 8 that shift over.
 9 **Q.** And one of your responsibilities as a shift
 10 leader, I think you say at paragraph 8 of your
 11 statement, was that you were:
 12 "... responsible for coordinating shifts and for
 13 allocating duties to junior members of the team and
 14 ensuring patient safety."
 15 Now, can you explain, what was the process between
 16 June 2015 and June 2016 for allocating nurses to babies?
 17 **A.** It tended to be the shift leader who allocated
 18 for the next shift on. So if you were on nights you
 19 would allocate for the day shift looking at the acuity
 20 of the ward and what -- what staff you had on that --
 21 coming on to that day shift or that night shift, and
 22 then you would also look at who had been caring for the
 23 babies previously, so if they'd worked the day before,
 24 then you would -- for continuity of care, then you would
 25 then perhaps give that person that baby again so that
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1 **Q.** -- filled out in that situation?
 2 **A.** It should have been, yes.
 3 **Q.** And, again, would that be the responsibility
 4 of the doctors to do or the nurses --
 5 **A.** As far as I'm --
 6 **Q.** -- or a joint responsibility?
 7 **A.** As far as I'm concerned, yes.
 8 **Q.** As far as you're concerned it would be the --
 9 **A.** The doctors' responsibility.
 10 **Q.** Now, if I can turn now to your roles and
 11 responsibilities in the neonatal unit during 2015 to
 12 2016. You set these out at paragraphs 7 to 21 of your
 13 witness statement. I would like to ask you some
 14 questions about your role as a shift leader.
 15 **A.** Mm-hm.
 16 **Q.** Now, you were a shift leader between 2015 and
 17 2016, and are you still a shift leader?
 18 **A.** Yes.
 19 **Q.** And how often would you work as a shift
 20 leader? Because it's an additional -- you know, you
 21 have additional responsibilities when you work as
 22 a shift leader so --
 23 **A.** It was -- tended to be allocated throughout
 24 all the Band 6s who were -- who were working that it
 25 was -- that we all covered the shifts and had an equal
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1 there would be continuity for the parents and for the
 2 baby.
 3 **Q.** What about -- did you take into consideration
 4 any welfare concerns that you may have had for the
 5 nurse, for example if the nurse had experienced
 6 a bereavement in the previous shift, would you --
 7 **A.** Yes.
 8 **Q.** Would that play a part in your
 9 decision-making?
 10 **A.** Yes, that would have done as well.
 11 I had on occasions moved staff -- staff not to be
 12 in an intensive care setting and put them outside in the
 13 outside nurseries so that they weren't -- to help with
 14 their mental well-being and so that they could not be
 15 put in that stressful situation again.
 16 **Q.** And is that something that you would do of
 17 your own volition or is that something a nurse might
 18 request.
 19 **A.** Both. I would do both if I -- if I was able
 20 to.
 21 **Q.** And by outside nurseries, can you explain what
 22 you mean by that, please?
 23 **A.** The -- we would have intensive care nurseries
 24 and then we would have high dependency nurseries, and
 25 then there would be -- in the unit, as it was, there
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1 were two special care nurseries, and so the intensive
 2 care were the babies that might need ventilating or
 3 additional support with their breathing. High
 4 dependency they didn't need as much support but still
 5 needed more specialised care. And then the outside
 6 nurseries the special care babies were the babies that
 7 were -- had maybe gone past all those intensive and high
 8 dependency and were getting ready towards going home,
 9 really, so they were -- you were trying to get them to
 10 feed and to grow so that they were big enough and well
 11 enough to be able to go home with the support of the --
 12 with the parents in being supported as well.

13 **Q.** And how was the allocation communicated to the
 14 nurses?

15 **A.** We had a sheet that we would have and the
 16 baby -- the nurses' names would be written next to each
 17 baby and then that was allocated -- they would have the
 18 sheet.

19 **Q.** So if we -- just if we use an example. We
 20 have nurses coming on to a day shift and on your
 21 evidence the shift leader for the night shift would have
 22 done the allocation.

23 **A.** Yes.

24 **Q.** So when would the nurses coming on to the day
 25 shift find out which babies they would be caring for?

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1 **Q.** Turning now to relationships between staff.
 2 You've told us that -- in your statement at
 3 paragraph 6 that Eirian Powell was your manager.

4 **A.** Yes.

5 **Q.** And it seems that -- I think Eirian Powell
 6 says in her statement at paragraph 6 that she returned
 7 to work on the neonatal unit in 1993, which is the year
 8 I think you joined --

9 **A.** Yes.

10 **Q.** -- the neonatal unit.

11 So by 2015 you'd been working together a long time.

12 **A.** Yes.

13 **Q.** And how was your relationship with her?

14 **A.** I had a good working relationship with her.

15 I -- I didn't have any issues with her. She had quite
 16 a brash sense of humour, which some people might --
 17 might not like, but -- but generally I -- I worked --
 18 worked well with her and was able to communicate with
 19 her both before she was the manager and then after when
 20 she became the manager. And if I had any issues I was
 21 able to go to her to -- to voice them.

22 **Q.** And you say at your paragraph 33 of your
 23 statement that you were aware that she treated some
 24 staff differently from others and the staff she liked
 25 more would get certain advantages; is that correct?

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1 **A.** That morning of the -- they were coming on to
 2 the shift.

3 **Q.** And would that be during the handover?

4 **A.** It would just be just -- just beforehand over,
 5 yes.

6 **Q.** So was the sheet given to the nurse or would
 7 there be --

8 **A.** They were given to each -- each trained nurse
 9 had -- would have a handover sheet, yes.

10 **Q.** Provided by the shift leader?

11 **A.** Yes.

12 **Q.** And did you consider, when you were a shift
 13 leader, that you had enough skilled nurses to allocate
 14 to the sickest babies, so your nursery -- the babies in
 15 Nursery 1 and perhaps the babies in Nursery 2?

16 **A.** Most of the time, yes.

17 **Q.** Or were there times when you allocated
 18 babies -- the sicker babies to nurses where you felt
 19 maybe they didn't have quite the experience but they
 20 could rely on the support of a more senior nurse?

21 **A.** Yes, that's -- that's correct, you would --
 22 you would -- so that they were supported by the senior
 23 nurses, so that they gained the experience as well.

24 **Q.** And senior would be a Band 6 nurse?

25 **A.** Yes.

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1 **A.** Yes.

2 **Q.** And you say it was "subtle but noticed".

3 **A.** Yes.

4 **Q.** Was Letby one of the nurses who Eirian Powell
 5 liked more than others?

6 **A.** It wasn't just one, it could be -- it was just
 7 little, little things that you -- we noticed --

8 I noticed. It wasn't -- they just -- they seemed to --
 9 if they were able to go into the office they were able

10 to -- to -- if they wanted to go on certain study days

11 or something like that they were able to get it, whereas
 12 other people might not have been able to.

13 **Q.** So just going back to my question, would you
 14 say that Letby was one of the nurses that Eirian Powell
 15 liked more than some of the other nurses?

16 **A.** I know that she did like Nurse Letby, yes.

17 **Q.** And why do you think that?

18 **A.** I don't know. I don't know.

19 **Q.** Well, what gave you that impression?

20 **A.** It was just --

21 **Q.** Did she say so?

22 **A.** She did. She just said that she did like --
 23 she did like her and she was happy -- when she got her
 24 position on the unit she was happy that she was working
 25 with us and she felt confident that she was a caring and

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1 compassionate nurse.
 2 **Q.** Do you think others picked up on what you
 3 picked up, that she liked Letby a lot?
 4 **A.** I don't know.
 5 **Q.** So it wasn't something that was discussed on
 6 the unit?
 7 **A.** No.
 8 **Q.** Looking back, do you think Eirian Powell's
 9 positive attitude towards Letby might have affected how
 10 she would have responded to any concerns about her?
 11 **A.** I don't know, it might have done.
 12 **Q.** If you had had any concerns about Letby, would
 13 you have felt comfortable raising them with
 14 Eirian Powell?
 15 **A.** Yes, and I did. On an occasion I did raise my
 16 concerns because after --
 17 **Q.** Let's talk about that now. So can you tell us
 18 about that occasion, please.
 19 **A.** Yes, it was I had been asked by Eirian Powell
 20 to try and not put Lucy Letby into the intensive care
 21 nursery --
 22 **Q.** So can you just pause there, can you tell us
 23 when that happened?
 24 **A.** I -- I can't -- I can't know the exact dates.
 25 I know it was --

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1 after the special care babies where --
 2 **Q.** Do you remember whether this was a night shift
 3 or a day shift?
 4 **A.** It was a night shift.
 5 **Q.** And do you remember if any of the babies on
 6 the indictment were in Nursery 1 at that time?
 7 **A.** Sorry?
 8 **Q.** Do you recall whether any of the babies on the
 9 indictment, Child A to Child Q, were in Nursery 1 at
 10 that time?
 11 **A.** I don't know, no.
 12 **Q.** And -- so were you the -- sorry, did you say
 13 it was a night of the shift?
 14 **A.** I believe it was a night shift because I'd had
 15 to change --
 16 **Q.** So you were -- you were coming off shift?
 17 **A.** I was actually coming on shift but I had to
 18 swap the off duty -- the -- the shift lead, the shift
 19 pattern. I'd gone to the previous shift leader and
 20 said, "I need to put Lucy in a different nursery out
 21 of -- out of the intensive care into one of the ITU,
 22 I've been asked to do it by Eirian."
 23 **Q.** When you informed Letby, what exactly did she
 24 say to you?
 25 **A.** That she was really angry with me for doing

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1 **Q.** No, not the exact date. Can you tell us, was
 2 that in June, July, summer of 2015 or by Christmas 2015?
 3 **A.** I -- I probably -- I don't know to be honest.
 4 I don't know what dates it was. I don't know what year
 5 it was. It's so many years ago now, I'm afraid.
 6 **Q.** What -- did you have this conversation during
 7 the period that this Inquiry has focused on 2015 to
 8 2016?
 9 **A.** Yes, it was, yes.
 10 **Q.** Okay. Sorry, continue.
 11 **A.** So because the -- there had been -- I think it
 12 must have been probably in the early stages, I don't
 13 really know, but that I'd asked -- she'd asked me to try
 14 and not let Nurse Letby work in intensive care for
 15 her -- for her mental health and well-being after
 16 dealing with a death. So I -- I -- she'd asked me as
 17 shift leader not to put her into the intensive care
 18 nursery, to put her into the outside nurseries for
 19 her -- for her own mental health and well-being, which
 20 I had -- had put down on one of the -- for the shift,
 21 had asked -- asked to put her into one of the outside
 22 nurseries, and I was -- nurse Lucy Letby then shouted at
 23 me for doing so because she felt she didn't want to be
 24 in outside nursery she wanted to be in the intensive
 25 care setting because she felt that it was boring looking

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1 so. She'd felt that it was -- that she -- she needed to
 2 be in Nursery 1. She didn't want to be in the outside
 3 nursery, it was boring looking after the special care
 4 babies, because I tried to say to her about it's
 5 sometimes you need to go out in the outside nurseries
 6 not to be in that intensive care settings where it's --
 7 you've had a -- an experience with a -- with sick
 8 babies, you need to go outside and do some nice things
 9 like feeding and cuddling the babies and getting them
 10 ready for home, and -- and experiencing that situation
 11 rather than that intensive care setting all the time,
 12 because it is draining and emotional on you as a person.
 13 **Q.** Were you able to persuade her to work in --
 14 **A.** I did --
 15 **Q.** -- the outside nurseries?
 16 **A.** I did, but I did find at times she would
 17 then -- find her into the other nurseries at times.
 18 **Q.** During that same shift?
 19 **A.** Yes.
 20 **Q.** And what would you -- what did you do when you
 21 saw her?
 22 **A.** I just asked her -- I said, "You've got other
 23 babies outside, you need to go and look after them."
 24 **Q.** And how did her -- did -- her reaction was --
 25 did it surprise you, were you concerned by it?

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1 A. It did surprise me and it did raise concerns
2 with me, because I felt that that wasn't -- I had done
3 it for her best interests rather than upsetting her
4 for -- you know, it wasn't that I didn't think she was
5 capable of looking after the babies -- the intensive
6 care babies, I was doing it more because I felt that she
7 needed it for her -- herself really emotionally.

8 Q. And what did you do, did you report this
9 conversation to Eirian Powell the next -- the next shift
10 when you saw her?

11 A. As soon as Eirian -- I was able to speak with
12 Eirian I spoke with her and raised my concerns and said,
13 "I have tried to keep Lucy out Nursery 1 but she still
14 wants to keep moving back in", and told her about the --

15 Q. And what was --

16 A. -- conversation I'd had with her.

17 Q. What was Eirian Powell's reaction?

18 A. She said, "Oh, we'll just have to try and stop
19 her -- stop it again when you can."

20 Q. And was that instruction to you to keep her in
21 the outside nurseries just for that shift or was that
22 sort of an ongoing instruction for you and other shift
23 leaders?

24 A. I don't know whether other -- other people had
25 been asked to do so or not, but I had definitely been

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1 full term, they would let us know, or any problem -- any
2 babies that they felt there was -- there might be
3 an issue at delivery with them would let us know.

4 Q. So you worked well together --

5 A. Yes.

6 Q. -- with the midwives?

7 A. (Nods).

8 Q. And what about your relationships with the
9 doctors, the junior doctors, middle-grade doctors,
10 Consultants, how was that?

11 A. I didn't -- I found that we had a good working
12 relationship with all the doctors, the Consultants and
13 the doctors, junior doctors.

14 Q. Did you feel able to express your views or
15 challenge them --

16 A. Yes.

17 Q. -- if you disagreed with the management of
18 a baby?

19 A. I felt I was able to. And if I had any -- any
20 concerns I would be able to speak to them and say what
21 my concerns were as well.

22 Q. And did you have any involvement with the
23 senior management?

24 A. We had -- on the ward we had our ward managers
25 and then the next I -- think it was the head of --

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1 asked to for -- for -- definitely for that week anyway.

2 Q. For that week?

3 A. Yes.

4 Q. You have described your colleagues -- your
5 nursing colleagues at para 26 of your -- paragraph 26 of
6 your statement as family.

7 A. Mm-hm.

8 Q. What did you mean by that?

9 A. Because we spend so much time together we
10 support each other so much. We socialise together at
11 times. It -- and I think because we do -- are so
12 supportive of each other we -- we actually know a great
13 deal about each other because we spend sometimes more
14 hours on the unit together than we do with our own
15 family at times.

16 Q. And what about the relationship with the
17 midwives at the hospital, what was that like in
18 2015/2016?

19 A. I didn't -- never had an issue with the
20 midwives on -- on the labour ward. We would go through
21 twice a day to find out what was happening on the labour
22 ward, if there was any concerns that would involve us
23 during the day, and if they had any concerns they would
24 come through and tell us. If they got a lady who was --
25 they thought was going to go into labour who was not

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1 I think it was the matron because the -- there were so
2 many changes --

3 Q. Do you mean Ann Murphy? Is that --

4 A. Yes --

5 Q. Yes.

6 A. -- yes, she would always come and check that
7 we were okay. But other than that, I wasn't aware of
8 many people coming. We used to have -- the shift
9 co-ordinators on -- at night shift they would always
10 come and check how we were. But other than that,
11 I don't remember many other people coming very often to
12 ask how -- how things were.

13 Q. Now, you say at paragraph 30 of your statement
14 that senior management:

15 "... did not listen to staff who had concerns about
16 how busy the unit was ...

17 A. Mm-hm.

18 Q. Can you tell us a bit more about that?

19 A. As we were filling out we felt we were very
20 busy and we were filling out Datixes to -- to put that
21 in so that there was evidence that we were busy and our
22 concerns with it. We just felt that nobody was really
23 listening to us at the time because we were -- there was
24 so -- we were so busy at some times that we felt that we
25 were -- we weren't giving -- we were giving the best

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1 care that we could give at the time but it wasn't as
 2 good as we could have given I think at times.
 3 **Q.** So what did you think would happen once you
 4 completed the Datix form? How did in your mind did you
 5 think that would get up to senior management and cause
 6 some --
 7 **A.** I know that --
 8 **Q.** -- sort of response or change?
 9 **A.** I know at the moment it would -- it goes to
 10 a Datix meeting and then it's -- it's looked at there
 11 and then it's progressed further, but I don't know what
 12 the process was in 2015 and 2016.
 13 **Q.** But you didn't feel the process was working?
 14 **A.** No.
 15 **Q.** You describe the visibility of senior
 16 management before and after Letby was removed from the
 17 neonatal unit in your statement. How did senior
 18 managers become more visible after Letby had been
 19 removed, which is what you say?
 20 **A.** They would visit every day after -- after
 21 Letby was -- was moved. And especially when she was
 22 first taken in for questioning, we were aware of them
 23 coming to see how we were, but other than that --
 24 **Q.** Who would visit every day?
 25 **A.** It would depend on who the managers were. At
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1 collapse?
 2 **A.** Other than what is written in my police
 3 statement?
 4 **Q.** So in your police statement you describe that
 5 Child D had become mottled over her trunk and legs, and
 6 you say:
 7 "I have seen babies in the past with discolouration
 8 from circulation issues or from sepsis but on this
 9 occasion it looked unusual and we did not know what was
 10 causing it at the time. Discolouration later
 11 disappeared and she became a normal colour again."
 12 Do you recall any discussions at the time about
 13 Child D's skin discolouration with either the nurses or
 14 the doctors who attended the resuscitation?
 15 **A.** Yes. It would have been whoever was there at
 16 the time we would be discussing it because it was -- was
 17 so unusual because of this mosaic red, mosaic rash that
 18 appeared on the baby.
 19 **Q.** So you weren't alone in thinking it was
 20 unusual?
 21 **A.** No.
 22 **Q.** And were you aware that Child A and Child B
 23 had displayed an unusual rash or skin discolouration?
 24 **A.** No.
 25 **Q.** Now, you tell us at paragraph 42 of your
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1 one point I think it was Karen Rees came. Occasionally
 2 the chief exec would come who was --
 3 **Q.** Tony Chambers?
 4 **A.** -- tony Chambers.
 5 **Q.** Ian Harvey?
 6 **A.** Sorry?
 7 **Q.** Did Ian Harvey visit the NNU?
 8 **A.** Very infrequently. But not on a -- not on
 9 a very regular basis, though.
 10 **Q.** What about Alison Kelly?
 11 **A.** And Alison would come on a regular basis as
 12 well.
 13 **Q.** Before or after Letby was removed?
 14 **A.** I felt it was after she was removed.
 15 **Q.** I would like to ask you now some questions
 16 about Child D.
 17 **A.** Mm-hm.
 18 **Q.** You deal with this in your statement at
 19 paragraph 38. You may want to turn it up.
 20 Now, we can see from your police statement, which
 21 you don't need to look at, that you worked the night
 22 shift on 22 of -- well, on 21 to 22 June 2015. And you
 23 tell us in your police statement that at around 1.30 in
 24 the morning you became aware that Child D collapsed.
 25 Do you have any independent recollection of the
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1 statement that:
 2 "On the NNU we expect babies to survive. Some have
 3 increased risk factors ..."
 4 And you go through those risk factors:
 5 "Child D did not appear to fit any of those
 6 concerns as far as I was aware."
 7 So is it fair to say that Child D's death was
 8 a shock for you?
 9 **A.** Yes.
 10 **Q.** And were there any discussions on the unit
 11 about how unexpected Child D's death was?
 12 **A.** Yes, I think there was at the time of the
 13 death. We weren't expecting that to have happened, to
 14 have occurred.
 15 **Q.** And earlier in the month of June, we know that
 16 Child A had died on 8 June and Child B had collapsed on
 17 9 and 10 June. Now, you worked the shift -- the night
 18 shift I think it was, is that correct, when Child B
 19 collapsed?
 20 **A.** I don't know. I can't remember.
 21 **Q.** Okay. And then -- well, were you aware that
 22 Child B had collapsed and had to be resuscitated?
 23 **A.** No.
 24 **Q.** Were you aware that Child C had collapsed and
 25 died?
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1 A. We were aware that there had been a collapse
2 but I -- I wasn't -- I don't think I ever looked after
3 Child C.

4 Q. So when Child D sadly died, you weren't aware
5 that two other babies had died?

6 A. I was -- we were aware that there had been two
7 other deaths. But not -- not so I wasn't aware that
8 they were so close together.

9 Q. Now, Dr Rachel Lambie gave evidence to this
10 Inquiry in the form of a statement but also in her
11 oral -- she came and gave oral evidence, and what she
12 says in her statement is that a number of junior medical
13 staff and nurses were talking about the collapses of
14 Child A and Child B following the events that happened
15 on 10 June.

16 I take it you were not involved in those
17 conversations?

18 A. I can't recollect anything of that, no.

19 Q. And we've -- we've also seen -- the Inquiry
20 has seen minutes of a senior clinicians meeting that
21 took place on 29 June and they heard evidence from
22 Registrars who were worried about the three neonatal
23 deaths of Child A, Child C and Child D, and they felt
24 nothing was being done.

25 Were you aware that some of the Registrars were
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1 are they?" Because you worry about -- about people
2 who've had to deal with it.

3 And then when I was told it was -- that Nurse Letby
4 had been -- had been involved with it, there was
5 thinking -- there was concerns and I can remember saying
6 to one of my colleagues, "If somebody's not careful,
7 they're going to think there's something untoward
8 happening here because it's not" -- you know, because
9 you start worrying about your colleagues' well-being and
10 things like that, but you also start worrying, what are
11 we missing? What's -- what are we not seeing here?
12 Why -- why is this occurring?

13 Q. Do you remember when that conversation was?

14 A. I don't know when it was, the conversation,
15 and I don't know who I -- I spoke to at the time. But
16 I just remember exclaiming.

17 Q. And what did you mean when you said "something
18 untoward", were you referring to incompetence or
19 deliberate harm or something else?

20 A. Just because it was -- it -- you know, I'd
21 been there a long time and in the period of the time
22 before this -- these -- these four deaths, I'd never
23 known to have that many deaths in such a short period of
24 time. I'd been there, you know, for -- you know,
25 over -- over 10 years by then, and in that are period of
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1 concerned about the three neonatal deaths?

2 A. No.

3 Q. All three deaths were unexpected and we know,
4 at least in the case of Child A, Child B and Child D,
5 that there were an unusual rash or skin discolouration.

6 A. Mm-hm.

7 Q. Do you recall any conversations about these
8 deaths?

9 A. No.

10 Q. A few weeks after Child D died, on 4 August
11 Child E died. So by August, so from 8 June to 4 August,
12 four babies had died. Do you recall any conversations
13 in the unit about these deaths?

14 A. I don't recall any -- any conversations about
15 them, no.

16 Q. Do you recall an atmosphere of worry or
17 concern?

18 A. I -- I can remember myself because I think I'd
19 had a period of absence and then came on and had
20 enquired after one of the babies where -- had it gone
21 home? Had it been discharged home? Had it gone
22 somewhere else? And then to be told that the baby had
23 actually collapsed and died, that was a surprise. And
24 then to -- then you ask -- you always ask, "Oh, which --
25 which person was involved when they died, you know, how
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1 the 10 years prior I'd not dealt with as many deaths
2 before that.

3 Q. So you -- just based on what you've just said
4 it sounds like maybe you'd this conversation after the
5 three or four deaths, do you think?

6 A. I -- I think -- I don't know how many deaths
7 it was, I just know that I'd had a period of absence,
8 I'd come back on, and then when I exclaimed that -- you
9 know, finding out that another baby had died, that I was
10 worried -- that there was a worry.

11 Q. Do you remember when your period of absence
12 was?

13 A. I don't know whether it was -- that I'd had
14 a holiday and then came on -- back after a couple of
15 weeks.

16 Q. But your nursing colleagues were updating you
17 as to what had happened?

18 A. Yeah, because you would come on and you'd look
19 on the board and say, "Oh, so and so, did that baby go
20 home? Did that one go home?" Because you spent a lot
21 of time with -- with parents or with the babies if
22 they'd been on the unit for a while -- a long time, so
23 you would always sort of like look at -- look at a board
24 and scan where -- and ask -- you know, knowing if the
25 baby was going to be well enough to go home within
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1 a short period of time you would ask about it.
 2 **Q.** I want to ask you about an incident which we
 3 heard evidence about from Dr Rachel Lambie. She
 4 described an occasion when she walked into the neonatal
 5 unit, and I think she might have been in the intensive
 6 care room, and she found there were some nurses huddled
 7 over a computer and they were going through the staff
 8 rota, and the reason they were going through the staff
 9 rota is because they were trying to enquire, investigate
 10 as to who might have been on duty when the recent events
 11 had occurred.

12 Now, she thinks this happened before she left the
 13 hospital in September 2015, and she remembers a nurse
 14 saying words to the effect that, you know, "It would be
 15 awful, but we are just checking", something along those
 16 lines.

17 Were you, were you part of that conversation?

18 **A.** Not as far as I'm aware, no.

19 **Q.** Were you involved in sort of looking at the
 20 staff rota just to try and find out if this was --

21 **A.** Was the staff rota on a computer.

22 **Q.** It was -- that was her recollection.

23 **A.** We never -- our staff rotas were not
 24 computerised by that period of time. They -- they were
 25 all on paper.

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1 the staff allocation already?

2 **A.** Yes.

3 **Q.** And had you allocated Letby to Child N?

4 **A.** Yes, because she had had the child the day
 5 before and so because they were getting ready for home
 6 I thought it would be -- there would be a continuity and
 7 all the -- all the talk of the baby going home there
 8 would be all the continuity of getting all the discharge
 9 papers together ready for the baby to go home so that
 10 all the notes and discharge letters would be done by
 11 her.

12 **Q.** So Letby's shift would have started at 7.30;
 13 is that correct?

14 **A.** Yes.

15 **Q.** And she arrived at 7.15. Would she have been
 16 aware that she had been allocated Child N at 7.15?

17 **A.** I think she'd -- she'd requested, if she was
 18 able to, would she be able to have the baby to the shift
 19 before or to the nurse who was looking after her --
 20 after the baby -- or after him.

21 **Q.** But not to you?

22 **A.** I think it had been spoken to me about it as
 23 well.

24 **Q.** So when she arrived 15 minutes early she knew
 25 that Child N would be her allocated baby for that shift?

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1 **Q.** Right. But you don't know anything about
 2 that?

3 **A.** No.

4 **Q.** Okay. So I'm going to ask you now some
 5 questions about Child N.

6 **A.** Right.

7 **Q.** So Child N -- you set out your involvement in
 8 Child N's care at paragraph 48 of your statement, and on
 9 the night shift of 14 to 15 June you say that you were
 10 the shift leader. Were you aware -- you don't say so in
 11 your statement -- were you aware that Child N's parents
 12 were expecting him to be discharged and taken home on
 13 15 June 2016?

14 **A.** I think there had been talk about it, yes, as
 15 far as I can recollect.

16 **Q.** And Child N was in Nursery 3?

17 **A.** Yes.

18 **Q.** And you've already explained that that's the
 19 sort of feed and grow nursery.

20 **A.** Mm-hm.

21 **Q.** And you say in your statement that -- at
 22 paragraph 48 -- that Letby arrived about 15 minutes
 23 early for her shift.

24 **A.** (Nods).

25 **Q.** For the day shift of 15 June. Had you done

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1 **A.** I don't think she did know at that time.

2 **Q.** But she had requested it?

3 **A.** But she had requested it if she was able to.

4 **Q.** Now, we -- you say that at around 7.15 --
 5 well, firstly, Jennifer Jones-Key was the designated
 6 nurse.

7 **A.** Yes.

8 **Q.** And in her witness statement at paragraphs 9
 9 to 10 she said that Letby came into Nursery 3 at 7.15 am
 10 to have a chat with her, and she said Child N started to
 11 desaturate and was mottled all over and was blue in
 12 colour, Letby responded and commenced resuscitation
 13 using the Neopuff. Then she called for assistance. Is
 14 that when you became involved?

15 **A.** Yes.

16 **Q.** Can you tell us what happened from that point?

17 **A.** I -- well, I wasn't -- I don't think I -- I'd
 18 been informed because I was at the desk and she shouted
 19 for help, but I don't know whether I went in or
 20 Belinda Simcock went in to -- to assist because she was
 21 around, and the baby was then brought -- the doctors
 22 were called and the baby was brought out and put into
 23 Nursery 1.

24 **Q.** And what happened next?

25 **A.** And then I was still sorting out ready for the

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1 shift for the day -- the day shift coming on, so the
2 baby was in Nursery 1, the doctors and Nurse Letby,
3 Belinda Simcock and Jennifer Jones were -- were in there
4 dealing with the baby.

5 **Q.** And did Child N's collapse concern you,
6 surprise you?

7 **A.** Yes. Well, it -- overnight the baby had --
8 was not acting as well as he should do. We'd actually
9 called out the doctors in the night and monitored -- put
10 a monitor on the baby of his saturations because
11 Jennifer Jones was concerned about it and had been
12 speaking with Belinda and the course of events, so the
13 doctors had been informed in the night and had come and
14 had -- we put the baby nil by mouth I believe and we'd
15 screened the baby and put IV fluids. So -- and given IV
16 antibiotics --

17 **Q.** But no decision --

18 **A.** -- which is a course of action.

19 **Q.** Sorry, but no decision had been made during
20 your shift to move Child N into --

21 **A.** Not at that time --

22 **Q.** -- another nursery?

23 **A.** -- no, we -- because we still had monitor --
24 were able to monitor the baby and we -- and because
25 Jennifer was staying in the room with the baby we were

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1 paragraph 52 of your witness statement. You were the
2 designated nurse for Child O on the night shift of 23 to
3 24 June 2016 following Child O's death; is that correct?

4 **A.** Yes.

5 **Q.** And how did you feel on learning that Child O
6 had died? What was your reaction?

7 **A.** I was very surprised because that baby --
8 because he was -- he was one of three and they were all
9 very well babies, born in good condition, and so it
10 was -- we were -- wasn't expecting the baby to become
11 unwell and to have died.

12 **Q.** And you returned to work the following night
13 shift.

14 **A.** Yes.

15 **Q.** And you were informed that Child P had died,
16 and what was your reaction, and what was the atmosphere
17 like on the unit?

18 **A.** I think we were stunned by the -- the react --
19 by that happening because in the event of the -- the
20 first Baby O dying, the baby -- the other two had
21 been -- were screened and started on antibiotics as
22 a precautionary thing because we were -- just to see if
23 there was something that was being missed.

24 And the babies were -- were not acting -- were --
25 were okay really that -- the night before. There had

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1 happy for the baby to stay there at that -- that moment.

2 **Q.** Were you aware that Dr Brearey and
3 Eirian Powell were taking a particular interest at this
4 point in time in any sudden and unexpected
5 deteriorations in a baby on the unit?

6 **A.** No.

7 **Q.** Did you speak to Eirian Powell about Child N's
8 collapse and the fact that he had to be moved to
9 Nursery 1 and wouldn't be discharged?

10 **A.** Not that I can remember, no.

11 **Q.** So who within the unit would have informed
12 Child N's parents of what happened?

13 **A.** I think it would have been -- I -- because
14 I was in the middle of sorting out the next shift they
15 were coming on, so it I don't know whether one of the
16 team who were looking -- with the baby at the time were
17 going to inform them or -- I don't know whether one of
18 the doctors were going to. I don't know whether it was
19 actually ever mentioned at the time unfortunately.

20 **Q.** And do you remember Eirian Powell coming to
21 find you to ask you about this incident?

22 **A.** No. She might have done but I can't --
23 I can't remember if she -- if I did.

24 **Q.** We're going to move now to Child O.

25 You talk about your involvement in his care from

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1 been an episode where we'd -- I think it -- where
2 we'd -- one of them we'd stopped the feeds for a short
3 time because he wasn't absorbing the feeds as well, so
4 we just stopped the feeds for a bit and we got him
5 observed by the doctors, and the doctors had checked the
6 baby over, but because we'd already put the anti -- the
7 baby already had antibiotics and had been screened
8 during the day shift, we were not as -- that as
9 concerned as we -- we would have been otherwise.

10 **Q.** You mention in your statement at paragraph 62
11 that there were discussions happening between the
12 nursing staff who were working the night shift, so the
13 shift you were on --

14 **A.** Yes.

15 **Q.** -- and the -- and the Consultants involved in
16 the day shift. What were those discussions about? What
17 was being said?

18 **A.** I think we were just concerned that we were --
19 we were missing something, that there were -- that was
20 there something that -- a congenital infection or
21 something that had been -- that was a congenital
22 abnormality that had been missed, or there was something
23 that was causing -- you know, for one of them to be --
24 to have died and then for the other two -- you know, to
25 be screened and that second triplet being -- having to

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1 be screened -- going -- becoming unwell the next day.
 2 **Q.** Did anyone suggest that the deaths might be
 3 unnatural?
 4 **A.** I don't know. I think we were just -- we were
 5 just wondering what -- because, as far as we -- we were
 6 concerned, we were doing everything that we would have
 7 normally done with babies that were -- were acting as if
 8 they have got infections.
 9 **Q.** And by this stage, was there any talk on the
 10 unit about Letby's involvement in the deaths of Child O
 11 and Child P because she was caring for them and any of
 12 the previous -- were people starting to look back and
 13 talk and wonder, and speculate?
 14 **A.** I don't know. I don't know. I think we were
 15 just so busy with doing things that we were -- we were
 16 just focusing on what we were doing at the time. There
 17 might have been thoughts by other members of staff but
 18 it wasn't spoken out loud.
 19 **Q.** And having previously thought yourself that
 20 maybe -- you know, people might think something untoward
 21 was happening, did that thought come back to you with
 22 greater intensity?
 23 **A.** There was a -- I -- I think I did have
 24 a niggle, if I'm -- if I'm honest, but I didn't -- but
 25 then I thought we were -- because they weren't intensive
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1 **A.** No.
 2 **Q.** Do you recall this being discussed?
 3 **A.** No.
 4 **Q.** The fact that Letby was volunteering to be the
 5 first person to undergo clinical supervision within the
 6 team?
 7 **LADY JUSTICE THIRLWALL:** Are we looking at the
 8 right document?
 9 **A.** Actually, I think that's --
 10 **MS LYONS:** INQ -- I'll read out the reference again
 11 INQ0002879, page 91. Sorry about that. There we are.
 12 I'll give you a moment to read that. (Pause).
 13 Do you remember receiving this email --
 14 **A.** Yes.
 15 **Q.** -- at the time? Sorry about that.
 16 And was there any discussion in the unit about
 17 having to undergo clinical supervision?
 18 **A.** I think at times we -- it was felt that maybe
 19 we -- there was a talk about going to a different
 20 hospital to get -- look at different things how they do
 21 it and how to just keep us updated really and things
 22 like that and if there was -- but there had been a talk
 23 about it, yes.
 24 **Q.** And was anybody objecting to being -- going --
 25 undergoing clinical supervision?
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1 care babies, they were special care babies, it somehow
 2 didn't -- didn't equate really.
 3 **Q.** So the niggle, is that like a gut feeling?
 4 **A.** Yeah. Or a concern really.
 5 **Q.** And what was -- what was your -- sort of what
 6 was your concern at that point that you wouldn't perhaps
 7 tell anyone?
 8 **A.** That may be, you know -- but then none of us
 9 had ever -- most people who go into nursing or to the
 10 medical profession are not there to harm. They're there
 11 to care and heal and protect and support. They're not
 12 there -- so it's completely alien to most nurses to ever
 13 think about that you would want to harm, especially
 14 a baby.
 15 **Q.** But you had a niggle?
 16 **A.** There was just -- there was concerns, yes.
 17 **Q.** I'd like to take you now to a document on the
 18 screen. The reference is IN0002879, page 81. So we're
 19 going to fast-forward now, Mrs Percival-Calderbank,
 20 to -- so the -- Child O and Child P had died on 23 and
 21 24 June 2016, and then on 15 July 2016 this email was
 22 sent by Yvonne Griffiths to the nurses in the neonatal
 23 unit.
 24 Do you recall receiving this email and reading it
 25 at the time?
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1 **A.** I don't think so, no, not as far as I'm aware.
 2 **Q.** And then it's the same document reference but
 3 it's a different page. It's now page 75. So a few
 4 weeks later. I'll give you a moment to read it.
 5 (Pause).
 6 Having received an email a bit earlier about the
 7 undergoing --
 8 **A.** Yes.
 9 **Q.** -- being the first person to undergo clinical
 10 supervision and now receiving an email a couple of weeks
 11 later about her going on secondment, what did you think
 12 at the time? Did you think this was unusual?
 13 **A.** Because we'd already got a member of staff
 14 already -- who'd gone on secondment, so we didn't think
 15 it anything --
 16 **Q.** So you didn't question it?
 17 **A.** No. No.
 18 **Q.** And the last document I would like to take you
 19 to -- sorry, before I take you to the last document,
 20 paragraph 66 of your statement. If we could go there,
 21 please. You say that Tony Chambers told staff at
 22 a meeting to be nice to Letby on her return to the unit.
 23 Can you tell us a bit more about this meeting?
 24 **A.** We were all -- a lot of the staff were taken
 25 into a room and he took us -- took us by surprise by him
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1 saying that we had to be nice to -- to nurse -- to Lucy
 2 because none of us had ever been horrible to her, we --
 3 we were unaware that -- we just knew she'd been on
 4 secondment, she wasn't communicating with many people,
 5 she only communicated with a certain amount of people,
 6 So we -- which at times she could -- she could not speak
 7 with people, so we didn't think anything. But to be
 8 told that we had to be nice to her because she was
 9 coming back, well, we wouldn't have been anything else.
 10 That's not in our nature -- nobody was ever horrible to
 11 her.

12 **Q.** What did he say the purpose of the meeting
 13 was?

14 **A.** Just to explain that she was going to be
 15 coming back to the unit.

16 **Q.** Did he mention an investigation, did he
 17 mention anything?

18 **A.** No, we weren't -- no. Because I think we'd
 19 had a -- I think the QCQ had come in and investigated
 20 the unit, and they had been happy with what, everything
 21 that had gone on, from what I can recollect --

22 **Q.** I think might that have been the RCPCH.

23 **A.** -- but it's just it's -- there's -- there was
 24 so much going on at the time and it's -- so --

25 **Q.** So this meeting happened after they came to --
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1 it? What did you think about it?

2 **A.** Because we weren't -- we weren't informed
 3 about anything, we -- the fact that we didn't know what
 4 these allegations had been and so we were -- and so we
 5 were a bit -- a bit stunned by it all really, because
 6 we -- we just were still under the impression she'd been
 7 on secondment.

8 **Q.** Had Eirian Powell or Yvonne Griffiths said
 9 anything to the team -- the nursing team after this
 10 email had been sent?

11 **A.** Not as far as I'm aware, no. I don't --
 12 I can't remember being informed about anything.

13 **MS LYONS:** My Lady, I have about 10 minutes more of
 14 questioning. Should I continue?

15 **LADY JUSTICE THIRLWALL:** Yes, please.

16 **MS LYONS:** Yes.

17 Were you concerned about Letby returning to the
 18 unit after you received that email?

19 **A.** I think -- I think we were all -- I think we
 20 just -- we thought that she would need some support and
 21 supervision for her to be able to -- for her to come
 22 back for her own -- for herself really.

23 **Q.** Had you noticed any change in the unit whilst
 24 she'd been away in terms of number of collapses and
 25 unexpected deaths?

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1 **A.** I think so, yeah.

2 **Q.** -- inspect? And was there any chatter, any
 3 discussion after this meeting about what Tony Chambers
 4 had said?

5 **A.** I think we just -- it was just the fact that,
 6 well, why wouldn't we be nice to her? You know, we
 7 were -- it wasn't -- we just thought that she'd been on
 8 secondment and that she'd come back into the unit
 9 because she'd been there for a while that she just
 10 needed to gain her confidence and the competence back,
 11 and so we just -- I think we were just a bit, well,
 12 really?

13 **Q.** So during the period that she was on
 14 secondment, there was no discussion about Letby and the
 15 unexpected deaths that had occurred on the unit?

16 **A.** No.

17 **Q.** And no one had made a link at that stage, you
 18 say?

19 **A.** No, we'd not been -- we'd not -- we'd been
 20 kept in the dark completely over everything.

21 **Q.** Last document. It's INQ0058624, page 1.

22 (Pause).

23 Do you recall receiving this email at the time?

24 **A.** I vaguely remember, yes.

25 **Q.** And what were your thoughts when you received
 166

1 **A.** Yeah, that -- I mean there had been -- there
 2 had been changes made by the network and things so we --
 3 certain gestational babies were being transferred out,
 4 but also that we had noticed that the number of
 5 collapses and deaths and things had -- had gone down
 6 drastically as well.

7 **Q.** So when you got that email, did your sort of
 8 niggles come back?

9 **A.** I think -- I think everybody was concerned
 10 that she needed support if she was coming back, yes.

11 **Q.** Was anyone concerned about the babies on the
 12 unit?

13 **A.** I don't know. I don't know. Because not long
 14 after that, I think things -- everything changed again
 15 after that so she never actually returned to the unit.

16 **Q.** You tell us at paragraph 5 of your statement
 17 that you felt that Letby had involved -- had been
 18 involved with many of the collapses and deaths. What
 19 did that make you think at the time?

20 **A.** It was only after -- when the investigation --
 21 the police investigation we had to look back at stuff
 22 for our own -- own statements, that it sort of raised
 23 concerns and issues that, you know, there was -- that
 24 you were becoming more aware that there was a -- there
 25 seemed to be a pattern.

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1 Q. And I'd like to ask you briefly now -- moving
 2 on to another topic -- just about debriefs and what was
 3 your recollection of debriefs and support following
 4 death of a baby back in 2015/16?
 5 A. I know there were -- there were debriefs but
 6 I don't know whether it was actually very often with the
 7 nursing team involved. I think it's more that the
 8 medical team seemed to have the debrief rather than the
 9 nursing team.
 10 If it was a scribbled note in the diary saying that
 11 there was going to be a team -- a debrief or if a member
 12 of the nursing staff had said, "Is there going to be
 13 one?" Then it was -- it was then deemed that we were
 14 invited. But if you were busy or you couldn't get to
 15 them that -- they weren't altered to accommodate anyone,
 16 really.
 17 Q. And what's the process now, because you still
 18 work at the hospital --
 19 A. I do.
 20 Q. -- so is it a different debriefing process?
 21 A. Yeah, there's more -- we try and organise now
 22 with a -- an email is sent out to the team that were
 23 involved and anybody -- and everyone is involved in it
 24 from Band 4s up to the Consultant in that, so --
 25 Q. Are they compulsory?

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1 A. Yes.
 2 Q. My last question is, what do you think would
 3 keep babies safe in hospital from the events that
 4 occurred in 2015 and '16?
 5 A. I think we need a more robust way -- policies
 6 so that if -- and communications so that if people have
 7 these concerns -- without -- without singling out people
 8 we need something that's more robust, a policy that can
 9 be passed down so that -- to raise these concerns rather
 10 than everybody kept in the dark really.
 11 Q. Do you think they should be raised internally
 12 or externally, anonymously?
 13 A. I suppose it would have -- internally first
 14 but then if it needed to, then externally.
 15 Q. And anonymously or not?
 16 A. Sorry?
 17 Q. Anonymously or not?
 18 A. It would probably have to be anonymously at
 19 the start because -- in case -- so nobody is singled out
 20 or -- you know, there needs to be a place where somebody
 21 needs to be able to say it in a safe space, to -- to
 22 mention that, that they have these concerns.
 23 MS LYONS: Thank you, I have no further questions
 24 for you. My Lady, do you have any questions?
 25 LADY JUSTICE THIRLWALL: Are there any other

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1 A. They're not compulsory, but it's whether -- if
 2 you wish to go, but there would be opportunities as well
 3 afterwards to speak with -- with other members if you
 4 needed to as well. And also we now have -- there's more
 5 support with counselling as well.
 6 Q. And you say at paragraph 67 of your statement
 7 that you had not received any formal training on how to
 8 raise suspicions or concerns other than speaking with
 9 your manager.
 10 Were you aware of any other channel or route for
 11 raising concerns about a member of staff at the time?
 12 A. Other than going -- you know, going to your
 13 manager or to other managers, matrons and that, not --
 14 Q. And what about now?
 15 A. -- not really. There is more -- there is
 16 a little bit more concerns and more open -- and that
 17 we've -- there's a freedom to speak and there's more
 18 being put within the hospital for everybody, so now
 19 there is more opportunities to be able to -- to mention
 20 these to people.
 21 Q. So if you had a concern today about a fellow
 22 member of staff that they were harming babies on the
 23 unit, would you know where to go?
 24 A. Yes.
 25 Q. What to do?

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1 questions.
 2 MS LYONS: No, there aren't.
 3 LADY JUSTICE THIRLWALL: No. Thank you.
 4 Is the plan to change the layout of the room now?
 5 MS LYONS: Yes. Please can we have a break now and
 6 then they're going to reconfigure the room and then we
 7 have two more witnesses after Mrs Percival-Calderbank.
 8 LADY JUSTICE THIRLWALL: Thank you.
 9 Thank you very much indeed,
 10 Mrs Percival-Calderbank. You will be free to go when
 11 the room has been sorted out.
 12 How long do we need to move the screens?
 13 MS LYONS: 15 minutes, please.
 14 LADY JUSTICE THIRLWALL: Good. We will start just
 15 after half past 3.
 16 (3.17 pm)
 17 (A short break)
 18 (3.34 pm)
 19 LADY JUSTICE THIRLWALL: Ms Lyons.
 20 MS LYONS: My Lady, may Kate Bissell be sworn in.
 21 KATE BISSELL (affirmed)
 22 LADY JUSTICE THIRLWALL: Do sit down.
 23 Questions by MS LYONS
 24 MS LYONS: Can we begin, please, with your full
 25 name.

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1 A. Katie Anne Bissell.
 2 Q. Ms Bissell you were sent a questionnaire by
 3 the Inquiry which you returned dated 19 March 2024. Do
 4 you have it in front of you?
 5 A. Yes, I do.
 6 Q. And are your responses to the questionnaire
 7 true to the best of your knowledge and belief?
 8 A. Yes, they are.
 9 Q. Ms Bissell, we're going to go very briefly
 10 through your career. You qualified as a children's
 11 nurse in 2007; is that correct?
 12 A. That's right.
 13 Q. Between 2007 and 2009 you worked as a Band 5
 14 nurse at Alder Hey Children's Hospital in the paediatric
 15 intensive care unit.
 16 A. (Nods).
 17 Q. In 2009 you commenced employment as a Band 5
 18 nurse on the neonatal unit at the Countess of Chester
 19 Hospital; is that right?
 20 A. That's right.
 21 Q. In 2014 having obtained further qualifications
 22 you were elevated to a Band 6 role.
 23 A. That's right.
 24 Q. Six years later, in 2020, you left the
 25 Countess of Chester Hospital to become a health visitor.

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1 A. I think some shifts were a lot busier than
 2 others. I think often staff would work through break
 3 times and lunch times. So I think some shifts it was
 4 very busy. We'd often stayed behind after a shift to
 5 write up notes that we hadn't had a chance to do in the
 6 daytime.
 7 And then other shifts were manageable. So I guess
 8 that it was sort of peaks and troughs really during that
 9 time.
 10 Q. And you also -- I think you said -- in your
 11 witness statement to the police at page 2, paragraph 2,
 12 you said doctors:
 13 "Were and still are in short supply, so we couldn't
 14 always get the support we needed as soon as we needed
 15 it. Like everyone on the NHS they're under immense
 16 pressure and cover a number of units, departments within
 17 the Countess of Chester Hospital."
 18 A. (Nods).
 19 Q. During 2015 to 2016, were you concerned about
 20 the lack of doctor presence on the NNU?
 21 A. Not -- not the presence. I just think
 22 sometimes on a night shift obviously doctors are
 23 covering paediatrics, as we say, obstetrics, A&E, so
 24 sometimes maybe if they were stuck over in the A&E
 25 department and we'd bleeped them for some support then

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1 A. (Nods).
 2 Q. And this year, 2024, you returned to the
 3 neonatal unit.
 4 A. That's right.
 5 Q. And you currently work part-time as a Band 6
 6 nurse on the neonatal unit and part-time as a health
 7 visitor; is that right?
 8 A. That's right.
 9 Q. I'd like to focus now on the period that this
 10 Inquiry is concerned with, June 2016 to -- June 2015
 11 to June 2016 when you were working on the neonatal unit.
 12 We understand from your responses to the
 13 questionnaire that this period on the neonatal unit was
 14 very busy and stressful for nurses. Can you explain why
 15 that was?
 16 A. We were a Level 2 unit and we were just -- we
 17 were busy all the time. We just felt like we were at
 18 capacity most shifts. We had -- we were supposed to
 19 have sort of two Band 6 nurses and some Band 5 nurses
 20 and then nursery nurses on the shift but felt at times
 21 we didn't run at full capacity and that we were
 22 short-staffed, so there were obviously just a lot of
 23 pressure to deliver care during that time.
 24 Q. We've heard evidence earlier today that it was
 25 busy but manageable. Would you agree with that?

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1 there would obviously be a little bit of a delay while
 2 they were finishing in A&E before they came over to the
 3 neonatal unit. That wasn't all the time. In those
 4 instances then we might have to go sort of above and
 5 maybe ask for a Consultant to come in.
 6 Yeah.
 7 Q. But if you called them they came -- they came
 8 to the unit eventually; is that what you're saying?
 9 A. Yes, yes.
 10 Q. I'd like to turn now to relationships on the
 11 neonatal unit starting with the NNU manager,
 12 Eirian Powell. In your response to the questionnaire,
 13 you said you felt supported by her and you also say that
 14 there were staff appraisals, and those staff appraisals
 15 you said could have -- you could raise -- you could
 16 raise issues outside of your control which may impact on
 17 your performance.
 18 So did Eirian Powell conduct those staff appraisals
 19 with the nurses on the unit?
 20 A. Eirian -- it wasn't always Eirian, sometimes
 21 it's the assistant manager --
 22 Q. Yvonne Griffiths?
 23 A. -- Yvonne Griffiths or the practice nurse,
 24 Yvonne Farmer.
 25 Q. And what was your understanding as to the

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1 purpose of these staff appraisals?

2 **A.** As an annual update just to make sure that we
3 were up to date with our training, for managers to
4 feedback to us how we were performing, whether they felt
5 there was any improvement needed within our practice or
6 any areas that we would need further training in. It
7 would be kind of an open forum for us to discuss whether
8 we would like to do further training. And then also,
9 you know, any issues that you felt sort of impacted on
10 your care as a nurse for the patients.

11 **Q.** If you had any concerns about patient care,
12 patient safety, would you have used this opportunity to
13 raise those concerns or would you raise them separately?

14 **A.** I think I probably would raise them
15 separately. I wouldn't wait -- because it was an annual
16 review, if you had concerns about care, I wouldn't have
17 waited until the appraisal to raise that. You know, I'd
18 raise that earlier as the concerns arose.

19 **Q.** And you found the environment within the NNU
20 supportive; is that correct?

21 **A.** I did. I worked there for 11 years before
22 I left to do my health visitor training and I felt
23 during that time -- although it was busy, I felt, you
24 know, there was a lot of opportunities for learning and
25 development and education. I felt I was supported

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1 I don't know, maybe not speak to people as kindly as
2 they -- as they would have done but generally I think,
3 you know, after that people probably apologise or, you
4 know, generally relationships were -- were okay.

5 **Q.** What about relationships with midwives, how
6 was that?

7 **A.** I think they was a little bit more strained.
8 I do feel there was probably sometimes sort of difficult
9 relationships. It's hard because they -- everyone's got
10 their own agenda, haven't they, when they're dealing
11 with babies and -- and mums, so I feel sometimes they
12 had their agenda and we had our agenda and communication
13 wasn't always as good as it could be maybe.

14 **Q.** So as a shift leader were there occasions when
15 you'd to communicate with midwives?

16 **A.** Yes.

17 **Q.** And how would that work?

18 **A.** We'd often have to go on to labour -- on to
19 labour ward and just -- just explain whether we were
20 open or closed as a unit, sort of how many intensive
21 care babies we'd have at that time, and then the
22 midwives would have to sort of explain to us whether
23 they had any impending deliveries, preterm deliveries,
24 and it was just to try and co-ordinate care that day,
25 make sure that we had enough space for babies to come on

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1 through that, you know, from the managers and from the
2 practice development nurse. And I just -- yeah, I just
3 felt I'd always -- I was continually sort of training
4 and developing as a nurse, so I felt that it was a good
5 place to work. I felt supported by my colleagues and
6 I enjoyed it. You know, I really enjoyed my job.

7 **Q.** And how would you describe the relationship
8 between the neonatal nurses and the doctors?

9 **A.** I think generally good. You know, we
10 generally worked well together. I mean, you know,
11 stress -- you have stressful shifts when may be, you
12 know, people are under a lot of pressure or maybe
13 there's the odd sharp word spoken to one another, but,
14 you know, when everyone's under that much pressure that
15 can be expected. But generally most people got on well
16 with each other and were supportive.

17 **Q.** So when you say at your paragraph 4 of your
18 questionnaire that relationships between the nurses and
19 the doctors could be strained, you meant there may be
20 a cross word in the heat of the moment?

21 **A.** I meant strained as, you know, in a -- yeah,
22 like a resuscitation or, you know, as a situation where
23 it's sort of highly stressful obviously there's a lot of
24 anxiety and a lot of pressure on people. So I meant
25 strained as in now and again people might have --

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1 to the unit if they needed it, and whether we'd enough
2 staffing and appropriately trained staff to deal with
3 any impending deliveries.

4 **Q.** And were you usually able to find
5 a resolution?

6 **A.** Generally, yes. And if not, then obviously
7 that would be discussed with -- with the manager or with
8 the doctors at the time and they'd liaise at a higher
9 level with the obstetric team.

10 **Q.** Did you have much involvement with any of the
11 senior management team at the hospital, so above your
12 ward manager, so above, Eirian Powell?

13 **A.** No.

14 **Q.** Would they visit the NNU at all?

15 **A.** Not really, no.

16 **Q.** Would you know what they looked like?

17 **A.** I knew their faces but we didn't often see
18 them on the unit, no.

19 **Q.** You tell us at page 3 of your -- page 3,
20 paragraph 9 of your response to the questionnaire that
21 initially you were not worried about the increase in the
22 number of baby deaths on the NNU and thought that the
23 unit was simply going through an unfortunate time; is
24 that fair?

25 **A.** Yes.

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1 Q. Were you aware at the time of the unexpected
2 deaths of Child A, C and D in June 2015? So these are
3 three deaths that occurred within a short space of time
4 in the month of June 2015.

5 A. I can't remember specifics, sorry.

6 Q. Were you aware of a time in 2015 where there
7 seemed to have been a cluster of unexpected deaths?

8 A. Yes, I felt like we -- yeah, I do feel like
9 we'd had an increase to previous years and, as I say,
10 I just felt that we were just having a really awful
11 time.

12 Q. And was there any discussion on the unit
13 about -- about these unexpected deaths, or did they go
14 along the lines of what you just said, it's just an
15 unfortunate time, it will pass?

16 A. Yeah, I think it was more of, you know, this
17 is -- this is awful for everybody and it's -- it's an
18 awful time that we're going through hoping that it
19 would -- it would get better, you know.

20 Q. And then we heard evidence from
21 Dr Rachel Lambie about an occasion when she went to the
22 neonatal unit and she said she was walking through the
23 intensive care unit and she came upon nursing staff in
24 a small huddle in the corner, over the computer, and she
25 said she asked them what they were doing, and one of the

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1 So these appear to be notes made by a CQC
2 inspector, Care Quality Commission inspector, during
3 their inspection of the hospital. They're dated
4 4 March 2016, and if we look at attendees, your name is
5 listed next to Yvonne Griffiths.

6 Do you recall speaking to the CQC in March 2016?

7 A. I have -- I have a vague memory of, yeah,
8 chatting with them. I don't remember the details,
9 sorry.

10 Q. Was it just you and Yvonne Griffiths and the
11 inspector, or was anyone else present, do you remember?

12 A. I can't remember at the time but I assume,
13 from looking at this, it was just myself and Yvonne and
14 the inspector.

15 Q. The notes are very difficult to read.

16 A. Yeah.

17 Q. But if we look at the summary section at the
18 bottom of page 96, it's the last box, it looks like some
19 of the topics that you covered were staffing, parental
20 feedback, complaints, Pseudomonas, news, vision, fluid
21 balance, care, metrics, plan assessment, executive team
22 support, fundraising events.

23 Does any of that ring a bell to you?

24 A. I mean, only -- I used to carry out the care
25 metrics, so I used to do audits on the unit relating to

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1 nurses replied that they were going through the rota
2 just to make sure there wasn't somebody who was on "for
3 all of them", I think -- I'm not sure what that was
4 a reference to but maybe the recent events, and
5 Dr Lambie gave oral evidence that she recalled the nurse
6 saying something along the lines of "It's an awful thing
7 to think but we're just looking."

8 Were you involved in that huddle around the
9 computer? Does that ring any bells?

10 A. No, I wasn't involved in that, and I don't
11 recall that -- looking at an off -- an off-duty on the
12 computer, did she say?

13 Q. Well, I think her evidence is that "They were
14 in a small huddle in the corner over the computer and
15 they said they were looking at the rota", do you know
16 anything about that incident?

17 A. No.

18 Q. So by the end of 2015, in addition to the
19 deaths of Child A, C and D, Child E had also died on
20 4 August, and Child I had died in October. Were you
21 aware of those deaths, the latter two, or not
22 specifically?

23 A. I would -- I can't remember specifically.

24 Q. Could we, please, have on the screen
25 INQ0017399. Sorry 7339.

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1 whether pain assessments were carried out, whether
2 paperwork was up to date, hand washing audits and things
3 is like that, so I can assume that that's what that is
4 alluding to.

5 Q. So a number of topics were covered. Do you
6 remember whether either you or Yvonne Griffiths
7 mentioned the unexpected deaths that had occurred in
8 2015 at this meeting?

9 A. I don't -- I didn't -- I don't -- I can't
10 remember whether Yvonne did, no.

11 Q. Did you mention it?

12 A. I didn't, no.

13 Q. Do you know why you didn't mention it?

14 A. No, I don't, sorry.

15 Q. You were asked in your questionnaire whether
16 you had any concerns or were aware of concerns of others
17 about Letby's conduct, and you responded by describing
18 an incident at page 3, paragraph 7. Do you want to just
19 turn that up. So you've described the incident here,
20 but would you -- would you be able to tell us about it?

21 A. So I was working in a non-clinical role on the
22 unit and I heard a shout for help from Nursery 3, so
23 I went to help and, as I entered the nursery, Lisa --
24 nursery nurse Lisa was on the right-hand side and there
25 was a baby with Lucy Letby on the left-hand side and the

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1 baby was desaturating -- I can't recall the name of the
2 baby or who the baby was, sorry, but the baby was
3 desaturating and obviously needed some help, so
4 I aspirated the nasogastric tube that the baby had in
5 situ, and then I gave oxygen via a Neopuff to help
6 increase the saturations, and then another nurse came to
7 help, and then another doctor. And then eventually the
8 baby looked like he or she was recovering. And then the
9 other nurse and the doctor who were actually on shift at
10 the time then took the baby into Nursery 1 and took over
11 the care of that baby.

12 **Q.** And I don't think you say in your
13 questionnaire, but do you remember which nursery this
14 baby was in?

15 **A.** It was in Nursery 3.

16 **Q.** It was Nursery 3. So a desaturation of a baby
17 in Nursery 3 and a transfer to Nursery 1 --

18 **A.** Yes.

19 **Q.** -- would that have been a sort of significant
20 event for a baby in Nursery 3?

21 **A.** I think the baby would -- yeah, would have
22 been moved into Nursery 1 for more closer monitoring
23 just to make sure that that didn't happen again.

24 **Q.** And after this incident, you were -- I think
25 Lisa Walker came to speak to you, didn't she?

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1 **Q.** Do you think it happened during the time frame
2 June 2015 to June 2016?

3 **A.** I can't remember, I'm sorry.

4 **Q.** Do you remember whether you discussed this
5 incident with either Yvonne Griffiths or Eirian Powell
6 afterwards?

7 **A.** No, I didn't.

8 **Q.** You tell us at paragraph 9, page 3 of your
9 questionnaire, that once you heard that Child O and
10 Child P had died you were very shocked, and what were
11 you -- did you have any concerns at this stage about
12 either their deaths or the deaths of the unexpected
13 deaths that had been happening, after death of Child O
14 and Child P?

15 **A.** I was just -- I was very surprised that they
16 had passed away.

17 **Q.** Did that surprise lead you to be concerned
18 about what was happening?

19 **LADY JUSTICE THIRLWALL:** We can take a moment.
20 It's probably best to continue if you can, rather than
21 stopping, but if you want a break just say.

22 **A.** Sorry. Just that I'd attended their delivery
23 and they were -- seemed well, needed some intervention
24 but were seemingly doing really well. So I think I'd
25 attended their delivery but only looked after them for

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1 **A.** Yeah, it was just -- yeah, just very briefly
2 afterwards she just -- she said was concerned that she'd
3 asked Lucy if she needed some help and Lucy said, no,
4 she was okay. But Lisa -- Lisa couldn't help herself
5 because she was in the middle of a feed, she couldn't
6 leave her baby, so Lisa was obviously concerned that --
7 she felt the baby needed help but Lucy hadn't actually
8 asked for help herself.

9 **Q.** And did she say anything about how -- what
10 Lucy said to her after the child had been transferred to
11 Nursery 1? Did she say anything to her about calling
12 for help?

13 **A.** I think I remember she said something about
14 she felt like she'd been told off by her, I think.

15 **Q.** And at this stage Lucy was a Band 5 nurse; is
16 that correct?

17 **A.** Yes.

18 **Q.** So would you have expected a Band 5 nurse to
19 call for help if a baby is desaturating or collapsing?

20 **A.** I think any nurse, no matter what band you
21 are, should shout for help if they feel a baby is
22 compromised and needs further assistance.

23 **Q.** Do you remember whether -- do you have any
24 idea when this incident happened?

25 **A.** I can't remember, I'm sorry.

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1 one shift, and I didn't look after them again, but I was
2 surprised to hear that they'd passed away.

3 I didn't know why, I -- I didn't know how they --
4 you know, what had happened and why they had passed away
5 but it just struck me as odd that they had been so well
6 and then they passed away.

7 **Q.** In the questionnaire we asked you whether you
8 had any concerns or suspicions about the conduct of
9 Lucy Letby while you worked on the NNU, and your reply
10 was:

11 "Not until two of the three triplets had died and
12 Lucy was moved off the unit to work in a non-clinical
13 role."

14 **A.** (Nods).

15 **Q.** So at that stage, after the death of the
16 Child O and death of Child P, what were you thinking?
17 What were your concerns at that stage?

18 **A.** I just wondered what had happened. We were
19 obviously told when -- they gave a reason why Lucy was
20 moved off the unit, and that was to -- to a secondment
21 but it just didn't seem to fit. I don't know, it just
22 didn't seem right.

23 **Q.** Let's --

24 **A.** It just seemed strange to me that somebody
25 would be moved off clinical -- you know, from a clinical

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1 area to move -- and moved to work in a non-clinical
2 area. That ...

3 **Q.** I'm going to pull up the email about Lucy's
4 move, but prior it that I'm going to pull up another
5 email that hopefully you've seen. Please can
6 INQ0002879, page 91, be brought up.

7 So before Letby was moved from the unit, this email
8 was sent by Yvonne Griffiths about undertaking a period
9 of clinical supervision. Do you recall receiving this,
10 reading it at the time?

11 **A.** I can't remember seeing it at the time.

12 **Q.** Was there any discussion about the NNU nurses
13 having to undergo clinical supervision? Do you recall
14 that?

15 **A.** I can't remember. I can't remember, it was so
16 long ago.

17 **Q.** Can I -- it's the same document reference but
18 it's page 75. Can we, please, bring that one up.

19 So this is what you were referring to a moment ago
20 when the staff were informed that Letby would be
21 seconded to the risk and patient safety office. Do you
22 remember receiving that email or hearing this news at
23 the time?

24 **A.** I remember hearing -- I can't remember reading
25 the email but I can remember hearing that that was the

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1 So August you got the email -- or in fact Letby was
2 already on her secondment when that email was sent, and
3 now fast-forward to January 2017, and this email was
4 sent by Letby. Do you -- do you recall receiving this,
5 reading this at the time?

6 **A.** Vaguely, yes, yes.

7 **Q.** And what were your thoughts on receiving it?
8 What did you think?

9 **A.** Just --

10 **Q.** Sorry, go ahead.

11 **A.** No. I mean, it's awful. Just I remember
12 thinking it's awful to -- to be -- have allegations like
13 that against you, but then she never back to the unit,
14 so it just all --

15 **Q.** What did you think the allegations related to?

16 **A.** Related to probably -- they were related to
17 the higher incidence of deaths --

18 **Q.** Is that what you thought at the time?

19 **A.** -- that were occurring. Possibly, yes.

20 **Q.** Is that what you were told?

21 **A.** We were never -- we were never told anything,
22 other than -- I felt like the nursing staff were never
23 really told why -- what was happening. We were just
24 told that she was removed from -- from the unit, she
25 went to the risk and safety department, and then

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1 reason that she had been taken off -- away from the
2 clinical area.

3 **Q.** And what was your feeling at the time? Did
4 you think this was a genuine reason or did you think
5 something else?

6 **A.** It didn't really make sense to me, but I just
7 had to go with what we were told from -- from the
8 management. So ...

9 **Q.** And when you say it didn't make sense to you,
10 in what way didn't it make sense to you? I know it's
11 really hard to put into words but it would help.

12 **A.** That I know Lucy liked to worked clinically,
13 so I think for her to be to -- move away from the
14 clinical area into a different area I was just quite
15 surprised at that.

16 **Q.** And were you the only one who was quite
17 surprised by that?

18 **A.** I don't know.

19 **Q.** Did you have any chats or discussions with
20 your colleagues about this email or about this news that
21 she would be seconded?

22 **A.** I mean, maybe we were wondering if there were
23 other reasons why she'd been moved but I don't --
24 I can't recall properly.

25 **Q.** Can you, please, put up INQ0058624, please.

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1 obviously we had this email to say that there were
2 allegations made against her. So it kind of fitted that
3 obviously she was moved at the time and then obviously
4 allegations had been made, so it --

5 **Q.** Did you have any understanding as to who was
6 making the allegations?

7 **A.** No.

8 **Q.** Did you have any understanding as to precisely
9 what the allegations were?

10 **A.** No.

11 **Q.** Were you concerned about Letby coming back on
12 to the unit?

13 **A.** I can't -- I can't remember what I thought at
14 the time. I don't know. She never did come back.

15 **Q.** Had you been in touch with her while she had
16 been off the unit?

17 **A.** No, I don't -- I was a colleague of Lucy's but
18 I didn't -- I wasn't friends outside of work with her,
19 so I wouldn't have communicated with her outside of
20 work.

21 **Q.** You say you had no -- in your questionnaire at
22 page 2, paragraph 5 -- that you had no specific training
23 regarding reporting concerns of fellow members of staff.
24 What would you have done in 2015/2016 if you did have
25 concerns that a nurse was harming babies on the unit?

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1 A. In the first instance, you would go to your
2 manager and speak to her about it and then --
3 Q. Speak to?
4 A. The manager. The unit manager, yeah.
5 Q. Would you do anything else?
6 A. Well, I think you'd have -- you'd be led --
7 hopefully, you'd be led by the manager, wouldn't you,
8 then of how -- how you would report it. I mean, I know
9 we've talked about safeguarding before but I think our
10 training for safeguarding is more -- we've always
11 thought of it as safeguarding babies and families on the
12 unit rather than safeguarding staff.

13 But, you know, obviously if I'd have seen think
14 malpractice then I would have reported that to maybe the
15 clinician -- the doctors at the time or definitely the
16 manager and hopefully that would have been escalated.

17 Q. So you returned to the unit this year.

18 A. (Nods).

19 Q. And is there a different process that existed
20 before on -- or what is the process for reporting
21 concerns about a fellow member of staff, is there
22 a process?

23 A. I don't think there's any other process other
24 than you're encouraged to fill out Datix -- Datixes
25 or -- it depends how serious it, does doesn't it?

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1 question -- what do you think would keep babies safe in
2 hospital from the events that occurred?

3 A. It's really hard -- really hard to say, isn't
4 it? But, you know, obviously training, like you said,
5 about people reporting. I know there's talk of CCTV on
6 units. I don't know whether that would be something
7 that -- that would help. It's a difficult environment,
8 isn't it, to have CCTV in place when you've got mothers
9 and doing kangaroo care and breastfeeding and things
10 like that? But ... I don't know if that's something
11 that made parents feel safer leaving their babies in the
12 care of neonatal unit, then maybe that's something that
13 could be looked at.

14 In Chester we do now encourage, you know, every cot
15 side has a bed for the parents to stay, so we do
16 encourage parents to stay as often -- you know, as often
17 they as they want and -- or as often as they can. So
18 I -- and just encouraging transparency, really, so that
19 people feel they can raise issues and that they'll be
20 listened to.

21 MS LYONS: Thank you. I have no further questions.

22 A. Okay.

23 MS LYONS: My Lady, there are no other questions
24 unless you have any.

25 LADY JUSTICE THIRLWALL: Thank you very much

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1 Obviously if it's --

2 Q. And when you returned in 2024, did you have
3 any safeguarding training or any additional training
4 that covered this issue of harm from fellow members of
5 staff?

6 A. No.

7 Q. And when did you start in 2024?

8 A. January 2024.

9 Q. You say that -- at page 3, paragraph 9, you
10 refer to the need for managers to take concerns
11 seriously when they're raised with them and to take
12 appropriate action.

13 And I just want to clarify with you. Did you raise
14 any specific concerns with managers or senior managers
15 at the hospital?

16 A. No, but that was talking about what -- on
17 reflection what has happened and, I mean, obviously as
18 nursing staff we didn't know that concerns were being
19 raised from the doctors and above --

20 Q. So you're referring to doctors --

21 A. -- so obviously it's -- on reflection it's

22 referring to that, you know, that --

23 Q. To the doctors' concerns?

24 A. Yeah.

25 Q. And what do you think -- this is my last

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1 indeed, Ms Bissell, you are free to go.

2 MS LYONS: The next witness is Elizabeth Marshall.

3 LADY JUSTICE THIRLWALL: Good afternoon,
4 Ms Marshall, you're just about to be asked to take the
5 oath.

6 ELIZABETH MARSHALL (sworn)

7 LADY JUSTICE THIRLWALL: Do sit down.

8 Questions by MS LYONS

9 MS LYONS: Can we, please, begin with your full
10 name.

11 A. Elizabeth Marshall.

12 Q. Ms Marshall, you were sent a questionnaire by
13 the Inquiry, which you completed. It's dated
14 18 April 2024. Are your responses to the questionnaire
15 true to the best of your knowledge and belief?

16 A. Could you speak up a bit, sorry?

17 Q. Sure, yes, I can.

18 A. Thank you.

19 Q. Are your responses to the questionnaire that
20 was sent to you true to the best of your knowledge and
21 belief?

22 A. Yes, they are.

23 Q. You have been employed by the Countess of
24 Chester Hospital since 2004 initially as a healthcare
25 assistant on the postnatal ward and the labour ward; is

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1 that correct?

2 **A.** That's correct.

3 **Q.** By 2005, you were working as a neonatal
4 assistant on the NNU; is that correct?

5 **A.** Yes.

6 **Q.** Can you tell us, please, the difference
7 between a neonatal assistant and a neonatal practitioner
8 or a senior neonatal practitioner?

9 **A.** A neonatal assistant is Band 4. We're not
10 trained specifically as the trained neonatal nurses are,
11 so we have -- some of us have a base training of what
12 used to be called nursery nurse, and also it's learning
13 on the job, and very much training and -- within the
14 actual neonatal unit and externally as well.

15 **Q.** And between 2015 and 2016, there was a change
16 to your role; is that correct? Were you now working
17 across the neonatal unit and the transitional care unit?

18 **A.** Yes, I did work in transitional care as well
19 previously but it sort of varied really dependent upon
20 workload on the neonatal unit.

21 **Q.** And can you just explain what the transitional
22 care unit is?

23 **A.** Transitional care is between neonatal unit
24 care and ward care, so for those babies who might need
25 extra support with feeding or be premature, or for some

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1 which nurseries you worked in?

2 **A.** Sorry?

3 **Q.** Which nurseries on the unit did you tend to
4 work in?

5 **A.** It tended to be 3 and 4, occasionally
6 Nursery 2. But less -- less so Nursery 1 because that
7 would be ITU and HDU.

8 **Q.** Did you have much involvement with midwives at
9 the hospital?

10 **A.** Occasionally. Occasionally sort of going
11 through to labour ward or transferring babies back up to
12 postnatal ward.

13 **Q.** And how would you describe that relationship?

14 **A.** I think it's better now than it used to be.
15 Potentially I think it was more them and us, but now
16 I think it's a lot more integrated -- sorry, I'm not
17 answering the question, am I?

18 **LADY JUSTICE THIRLWALL:** We can probably guess but
19 (inaudible).

20 **A.** Yes.

21 **MS LYONS:** And what about relationships with
22 doctors, did you have much involvement with the doctors
23 on the unit?

24 **A.** Not a lot. It would tend -- I mean, we -- we
25 had our own workload, but decisions would tend to go

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1 reason need further support with feeding or -- so it

2 just meant mum and baby could be together, and if they
3 didn't need any respiratory support or monitoring of any
4 sort then we could hopefully accommodate them under that
5 umbrella of transitional care.

6 **Q.** And where was that unit located?

7 **A.** Normally on the ward -- in the postnatal ward.

8 **Q.** Now, I'd like to ask you about relationships
9 within the unit in 2015 to 2016 starting with your
10 managers. How would you describe your relationship with
11 your managers Yvonne Griffiths and Eirian Powell?

12 **A.** In retrospect, I felt my personal relationship
13 with them was -- was good. I had quite a lot of
14 personal stuff going on and they were very supportive
15 throughout, and it did occur sort of the 2015/2016 time
16 as well.

17 **Q.** What about with your nursing colleagues, the
18 Band 6 nurses, the Band 5 nurses, the other Band 4
19 nurses?

20 **A.** Generally I think our sort of relationships
21 were pretty good. I think there's a -- always a variety
22 of people you feel are colleagues rather than -- or
23 people you're particularly close to and it's that sort
24 of variable with the people you work, so ...

25 **Q.** And just -- you worked -- can you just tell us

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1 between the doctors and the trained nurses. So would be
2 around on ward round or if they're there, you know,
3 but --

4 **Q.** So if you had any concerns about a baby in
5 Nursery 3 or 4, who would you direct those concerns to?

6 **A.** Initially the shift leader and then if it
7 needed escalating they would do that.

8 **Q.** At paragraph 6 of your questionnaire you were
9 asked if you had any concerns or suspicions about
10 Letby's conduct while you worked on the unit. And I'd
11 like to ask you about the second paragraph underneath
12 that question, where you said:

13 "After the death of the first five babies,
14 I thought about how Lucy Letby was involved in the care
15 of all those five babies. I know it is circumstantial
16 but that was my recollection at the time. Also, despite
17 having a horrendous shift, Lucy Letby [was] always happy
18 and almost requested to go back to Nursery 1 with
19 Intensive Care babies and wanted to be with all the
20 sicker babies. I recall other members of staff stating
21 that Lucy Letby wanted to be in Nursery 1 and that was
22 what I found odd. I can't recall the names of staff who
23 spoke about this. Surely in my view, after a horrific
24 experience, you would want to be out of the scene to
25 regroup and reflect."

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1 I'd like to sort of unpack that response.

2 Can you -- when you say "the first five babies",
3 are you talking about the babies in June that died, the
4 three babies in June that died or -- what is your sort
5 of -- your reference point? What are your first -- I'm
6 not sure what you mean by "first five".

7 **A.** I think I'm referring to the first five deaths
8 that I was actually on shift for. I struggle --

9 **Q.** Was this in 2015 or 2016 or some other time?

10 **A.** I struggle to give a timeline. It was -- it
11 was probably the first five deaths at all -- you know,
12 that -- that were -- sorry, I feel it was the first
13 actual five deaths that occurred.

14 **Q.** So the unexpected death of Child A, Child C,
15 Child D, Child E and Child I, is that what you think?

16 **A.** I think so.

17 **Q.** Given you worked in the outside nurseries or
18 nurseries 3 and 4, and occasionally 2, how did you
19 become aware of Letby's involvement in these unexpected
20 deaths?

21 **A.** Generally if there was a trauma situation
22 going on, for example in Nursery 1, then the trained
23 staff would move into help with that situation and the
24 Band 4s would be monitoring the outside nurseries
25 ensuring babies are fed and observations are done, so

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1 **Q.** Did you share your thoughts with anybody on
2 the unit?

3 **A.** Initially, no. I think I just kept my
4 thoughts to myself because I was an untrained member of
5 staff and maybe just felt that it wasn't appropriate to
6 say or --

7 **Q.** How did you know that Letby always wanted to
8 get back into Nursery 1?

9 **A.** That was something I was aware through -- then
10 through conversations I'd heard at a latter time, not
11 specifically at that time in 2015.

12 **Q.** Do you know when you became aware of that?

13 **A.** Not specifically, no.

14 **Q.** Was there anything about Letby's demeanour,
15 conduct, anything she said that you recall that struck
16 you at the time?

17 **A.** She was quite a closed individual, maybe quite
18 superior, I think liked being in amongst the higher
19 grade staff.

20 **Q.** Did you work with her?

21 **A.** Pardon?

22 **Q.** Did you sometimes work in the same nursery?

23 **A.** I don't really recall working -- actually
24 working alongside her. I've worked many shifts with
25 her, but not specifically with her, because it was quite

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1 keeping everything else going, so were -- the actual
2 physical unit then was quite compact, so it was very
3 easy to become aware that there was a major event going
4 on.

5 **Q.** So if I just understood your response
6 correctly, you became aware by seeing her; is that what
7 you're saying?

8 **A.** By what, sorry?

9 **Q.** By seeing Letby there and involved in these
10 deaths?

11 **A.** Seeing?

12 **Q.** Letby on shift when these babies died. Is
13 that how you knew she was involved?

14 **A.** Oh, knew Lucy was involved? It was my
15 impression that she was always in -- yes, she was always
16 involved with what was going on when there was a major
17 collapse.

18 **Q.** How did you form that impression?

19 **A.** How did I?

20 **Q.** How did you come to think that?

21 **A.** I think it was my observation.

22 **Q.** Were there any discussions taking place on the
23 unit between the nurses about the unexpected deaths
24 and/or collapses and Letby during this time?

25 **A.** Not that I recall.

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1 rare that she was in the outside nurseries.

2 **Q.** And during this period, you say the first
3 five deaths and -- were you getting concerned?

4 **A.** Yes. I do recall having that thought of
5 I suppose Lucy was the one common factor who had been on
6 shift, but that was just my thought.

7 **Q.** Did there ever come a point where you sort of
8 articulated that thought with your manager -- shared
9 your concern --

10 **A.** No.

11 **Q.** -- with your manager?

12 **A.** Regrettably no. But I think it's quite a leap
13 to have a thought about something and then to take that
14 leap to think: what if harm's being done?

15 **Q.** Did you share it with anyone else on the unit?

16 **A.** Pardon?

17 **Q.** Did you share your feeling, your thinking with
18 anyone else on the unit?

19 **A.** No.

20 **Q.** I'd like to take you to three emails. The
21 first email the reference is INQ0002879, page 91,
22 please.

23 Do you recall receiving this email?

24 **A.** I don't recall.

25 **Q.** Do you recall any discussion about staff

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1 undergoing clinical supervision?

2 **A.** I really struggle to recall any of the --
3 this -- this email and any sort of discussions that went
4 around that.

5 **Q.** Do you recall when Letby was taken off the
6 unit?

7 **A.** Vaguely, yes.

8 **Q.** And do you recall any discussion either with
9 your nursing colleagues or with your managers about the
10 reason she had been removed from the unit?

11 **A.** No. I -- I remember that she was placed in
12 a non-clinical role but not really specifically why that
13 was being done.

14 **Q.** So if we just stay on that document but go to
15 page 75, please, this is another email that you might
16 have received. Do you remember receiving that or having
17 a discussion about that?

18 **A.** Not really, no. Again, a vague -- a very
19 vague memory, but not -- not specifically, no.

20 **Q.** So when you got the third email, assuming you
21 got it -- so this is INQ0058624 -- do you recall
22 receiving that email?

23 **A.** No.

24 **Q.** Do you recall being told that Letby would be
25 returning to the unit?

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1 well, or were you unaware of her involvement?

2 **A.** I find it hard to remember. Yeah, I just find
3 it very hard to remember.

4 **Q.** I'd just like to go to something you said
5 earlier. You formed the view that Letby liked being in
6 amongst the higher grade staff, so I guess the Band 6
7 nurses. What gave you that impression?

8 **A.** Just from my observations being at work and
9 I know she had a friend or two that were senior nurses,
10 so that's --

11 **Q.** How did you know these senior nurses were her
12 friends?

13 **A.** Because they spent time outside of work
14 together and did quite a lot of things together outside
15 of work.

16 **Q.** And how did you know that?

17 **A.** Because it was just -- that was just general
18 knowledge.

19 **Q.** Were you aware about how to raise concerns
20 about a fellow member of staff at this time?

21 **A.** I think I would have spoken to my manager had
22 I had -- you know had I -- yeah.

23 **Q.** Did you have a good relationship with her?

24 **A.** Yes -- yeah, I feel I used to have a good
25 relationship with her.

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1 **A.** I -- yes, I do remember conversations of the
2 fact that she was due to come back.

3 **Q.** And do you think it was around this time,
4 January 2017, or it's just hard to --

5 **A.** Possibly, yes.

6 **Q.** And what were your feelings about that --
7 given you had made a correlation in your mind that you
8 hadn't shared, how were you feeling about her return to
9 the unit?

10 **A.** I really struggle to recall my -- my sort of
11 feelings about it. I think having had that thought
12 initially of the fact that I felt, you know, there was
13 that correlation between Lucy being on the first --
14 involved with the first five deaths, I don't think I'd
15 gone much beyond that. So, therefore, not necessarily
16 relating harm being done to Lucy.

17 **Q.** So you had made an association but that's
18 where it ended; is that correct?

19 **A.** At that time, yes.

20 **Q.** But you were still concerned about the
21 association?

22 **A.** Yes.

23 **Q.** And in 2016, there were further deaths, and
24 we've heard about obviously the death of Child O and
25 Child P., had you associated her with those deaths as

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1 **Q.** But you still didn't feel you could share what
2 you were feeling back in 2015 with her?

3 **A.** Possibly. Again, I think as -- as a untrained
4 member of staff I -- I don't know if I'd have felt --
5 not felt it right to say anything, but felt it
6 appropriate, you know, yeah.

7 **Q.** And if you were to suspect a member of staff
8 today, someone you were -- a colleague that you worked
9 with was harming babies, what would you do?

10 **A.** I'd speak to my manager.

11 **Q.** And are things different now than they were in
12 2015/2016 --

13 **A.** Yeah, I think so.

14 **Q.** -- which would make it easier for you to speak
15 with her?

16 **A.** I think so. I think there's a lot more --
17 there's a lot less segregation between, sorry, manager
18 and doctor, and I think it's encouraged -- being
19 encouraged to speak up is --

20 **Q.** And how are they -- like, how do they -- how
21 are they encouraging staff to speak up? Can you think
22 of an example?

23 **A.** The managers?

24 **Q.** Yes.

25 **A.** Just by their approach and the way they are

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on Monday, 14 October 2024)

1 with the staff. I think they make us feel -- well, make 1
 2 me feel that if I did have any issues, concerns that 2
 3 I could approach them confidentially and speak to them. 3
 4 **Q.** So this is what they're saying on the unit to 4
 5 staff, so that's why you know you could, is that right? 5
 6 Is that what you're saying? 6
 7 **A.** Currently? 7
 8 **Q.** Currently. 8
 9 **A.** Yeah, I would feel that it would be -- I would 9
 10 feel more able to go and speak to management now if 10
 11 I had concerns. 11
 12 **MS LYONS:** Thank you. My Lady, I have no further 12
 13 questions for Ms Marshall and I don't think anyone else 13
 14 does. 14
 15 **LADY JUSTICE THIRLWALL:** No other questions. Thank 15
 16 you very much indeed, Ms Lyons. 16
 17 Ms Marshall, thank you very much indeed for coming 17
 18 to give your evidence. You are free to go now. 18
 19 And that concludes the evidence for this afternoon. 19
 20 **MS LANGDALE:** That concludes the evidence for 20
 21 today, my Lady. 21
 22 **LADY JUSTICE THIRLWALL:** Very good. And for the 22
 23 week. So we will rise now and reconvene on Monday 23
 24 morning at 10 o'clock. 24
 25 **(The Inquiry adjourned until 10.00 am,** 25
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