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

was my first job.

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

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

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

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

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.

A. -- so there's no time limit -- I think it's not a compulsory course, as far as I'm aware, in terms of units across the country but our hospital we do -- we do get sent on it, so --

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

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

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

A. Yeah, it --

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

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

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

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

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

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

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

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

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

Do you have a view about that?

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

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

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

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

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

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

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

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

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

that was very -- it was very busy, but then again there were shifts that were not so busy. I would say it felt like it was a little bit busier around that time. Yeah. But I don't have the official numbers to say, you know, this was --

Q. No, of course, it's a sense, you were working there.

A. Yes.

Q. Manageably so?

A. I think majority of it, yes. I think -- like I said, sometimes you can't predict what comes through the door, so you can have a certain amount of staff on and you could have no admissions from labour ward and manage really well. Whereas you could have a day and it's you -- it's not something you can predict, but you could have a day where you have lots of admissions coming through, and that can sometimes -- I think we always managed really well, because I think as a team we worked really well together, but sometimes that felt like it could be a lot. But I think I could say that honestly would happen anywhere.

It's not something you can predict and it's not something you can staff, you know, in advance. You can't, you know, have lots and lots of staff to think the possibility that there might be lots of babies

coming through when you would be over-staffed 90% the time, so -- but, yeah, I would say majority of the time it was busy but manageable.

Q. And in terms of how well or otherwise the babies were, I'm not asking you about the babies on the indictment, but generally coming through the unit, how was that, what you'd expect in a neonatal unit or -- in your unit or not?

A. Say the beginning bit, the how well they were.

Q. In terms of how well they were or unwell or sick or unsick. Again, just a sense, I know -- I'm not asking you to look at data or numbers, what was your sense, what you would expect coming through a unit or --

A. Yeah.

Q. -- sicker, or what was your sense about it?

A. I would say I think what I expected. I think, again like -- it's hard to say, because obviously this is all hindsight and me looking back on lots -- many years ago now. I think I never -- I never had the feeling that I was thinking this baby shouldn't be here. It was always within our realms of knowledge and care. I would say because we had limits on the gestation --

Q. You were a tier 2, weren't you?

A. We were Level 2, yeah.

Q. So just -- when you say gestation, what did

that mean? What kind of babies were getting?

A. So you might -- don't completely take me at what -- I think it was 27 weeks and above we used to take. It's been a long time but I think it was 27 weeks.

And we would also -- if we had a baby who maybe was vent -- we managed ventilators as well. The staff that had managed ventilators for years and years and years we would manage generally stable ventilators, babies who were not going to be long-term ventilation.

If there was a baby that maybe -- any ITU baby -- I don't know if it was any ITU baby at that time but definitely ones that we were considering were maybe having longer stays on the ventilator or had more intensive care they would be discussed with tertiary units, so a Level 3 unit Consultant. So it would be Consultant-Consultant to manage care and discuss whether they felt that that baby needed to be transferred out or not.

Q. We asked you about the culture and atmosphere on the unit, and at paragraph 4 -- again you say it's eight or nine years ago now, we do appreciate that Ms Taylor, so doing the best that you can, how did you feel the relationships, first of all, within the unit with the ward manager, deputy ward manager were, how was

it working?

A. Yeah, so the ward manager and deputy ward manager I felt were supportive, were approachable and led really well.

Q. And that's Eirian Powell and Yvonne Griffiths, isn't it?

A. Yeah.

Q. Yeah, go on.

A. Yeah, that was my perception at the time. I definitely still agree with that. I feel -- I felt supported and I felt -- yeah, I thought there was a good culture on the unit.

Q. And when you say supported, how did you feel supported by them? What does that mean in practice?

A. Yeah, so they were very visible to us. They were approachable. They would -- so I think the culture on our unit has always been a very supportive one where new members of staff were encouraged to talk to managers, to check in with new staff.

I always felt very welcomed by managers, by the -- Eirian and Yvonne. And I felt -- yeah, I -- yeah, just a general feeling of supported-ness, and I -- yeah, I always felt like -- and not just them, I think the whole team because that culture was -- all the nurses were very approachable and always checking in with me

especially when I was newer, so yeah.
Q. And in terms of the relationships between clinicians and managers, first of all with Eirian Powell and Yvonne Griffiths on the unit, you say they were good; yes?
A. Yeah.
Q. And what about more senior managers, would you know what the relationships were like there between doctors and senior managers or not?
A. Between doctors and senior managers?
Q. Yeah?
A. Between doctors and managers I -- I don't know. They -- the senior managers as a possibly more junior nurse, not senior or management, they weren't very visible to me, so I couldn't comment on the relationships between the doctors and management.
Q. Would you have known who they were? Would you know who Mr Harvey was, Mr Chambers, if you'd seen then them in the corridor?
A. I would know who Tony Chambers was. Otherwise, I don't think so.
Q. And the relationship between nurses and senior managers then, you'd say you didn't really have one, didn't really know them, so nothing either way really to comment on?

A. No, I would say from my perspective as a Band 5/sort of Band 6 nurse, I -- yeah, there was -- there was just no visibility really that was -- yeah, they were probably around on the unit but they weren't really known -- made known to us. They weren't introduced. They didn't introduce themselves to us. I don't remember them being very visible --
Q. So your --
A. -- as a nurse.
Q. As a nurse, okay. But your direct managers were Eirian and Yvonne, you say they were relationships with them?
A. They were, yeah.
Q. You comment on the relationship between the NNU nurses and midwives, and you say that that communication by the midwives was poor, which caused strange relationships -- strained relationships, sorry. Could you expand on that for us, please?
A. Yeah, I -- again, this is from my perspective. As a more junior nurse, I felt that I was very much overlooked by midwives and not respected in the same way, and that came across in their communication. I felt intimidated by them. I would say now my perception of that is different, and whether that is because things have changed or because I'm more senior,

I don't know. But, yes, I --
Q. How's it changed? The perception -- when you say a perception changed, your impression of what it was like back then or you've got different relationships with midwives now?
A. So I would say I have different relationships with midwives now.
Q. Mm-hm.
A. I don't think it's perfect still, but I think back then there was a notable -- I would say I felt intimidated to go and talk to -- mostly the senior midwives or the Consultant obstetric doctors I would feel intimidated to talk to them.
Q. We know from parents who have given evidence that they were dependent sometimes on midwives for getting down to see their newborns because there was a process to get through there --
A. Yeah.
Q. -- and they'd had surgery and in some cases needed assistance. If you felt that, do you think it might have been difficult for them to ask for help or assistance, or they may have felt intimidated or not? Do you think it was because you were a nurse?
A. Yeah --
Q. I'm just interested in that communication

generally.
A. I mean, I don't feel like I can comment on how they would feel. I think, from feedback that I've had from parents about midwives, the care has always been positive mostly. So I think that probably isn't the case. But I don't -- I don't know if I could comment on that from a different perspective.
Q. You say the relationships between doctors and nurses on the unit, on the NNU, were good. Can you expand on that?
A. Yeah, I -- I think, yeah, they worked -- we worked well together. I think that we had good communication. I think -- yeah, I particularly didn't feel like there was any concerns with the communication at all. I think -- I think as a team we're quite approachable, and I think that reflected in the relationships we had with doctors.
Q. So you didn't find that the Consultants were dismissive of you or in any way you could speak to them about things?
A. No, no.
Q. Did you find they pushed your views aside in any way and their views were best about things?
A. No, quite -- quite the opposite, really. I think I always felt listened to by the Consultants,

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

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

A. Yeah. I did, yeah.

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

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

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

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

experience of looking after Baby A and what happened subsequently?

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

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

Q. And what happened subsequently?

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

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

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

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

desaturate. Lucy was standing by the incubator.

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

Yes, and then --

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

A. Yeah.

Q. And sadly we know what followed.

A. Yeah.

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

A. It was very unexpected.

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

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

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

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

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

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

A. Mm-hm.

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

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

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

A. Yes.

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

A. So my personal experience was I found it

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

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

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

A. Yeah.

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

The last message:

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

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

Colleague says:

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

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

And we go to page 7:

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

Your colleague says:

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

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

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

That's Liverpool Women's Hospital, presumably:

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

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

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

A. No, not at that time, no.

Q. So she says:

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

Your colleague says:

"Ok ..."

And your colleague says:

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

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

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

Says your colleague:

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

If we go down again. Stop there, please.

Again from Letby, message 31363:

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

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

If we go down two more messages:

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

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

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

Q. Around the time of the criminal trial?

A. Yeah, the criminal trial.

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

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

there was a more junior member of staff that needed supporting.

Q. And you were the Band 6?

A. I was the Band 6. I wasn't in charge, but I was the Band 6.

Q. So you had to go back in that next day?

A. In theory, yes. And I think I probably agreed to go in there and say -- and I -- that's -- I can't remember this but this is -- I -- the only thing I can think, reading from these, was I agreed to go in there because that was the most reasonable choice with the staffing and the babies that were on the unit.

Q. But if you'd your own way and that wasn't required you'd clearly not --

A. I wouldn't have.

Q. -- have done that?

A. No. And sometimes -- you know, it can depend on the babies that are in there as well. Sometimes you can get babies that aren't intensive care in there, so that may not have been -- I mean, I think -- but, out of choice, no, I know I definitely wouldn't have expressed a want to go in there.

Q. And was that anything that Letby had discussed, the suggestion at Liverpool Women's Hospital, that she went straight back to the same cots? Was that

ever discussed with you at the time or subsequently?

A. I don't remember that being discussed.

Q. Have you ever heard of that as a way of getting over or dealing with trauma?

A. No.

Q. If -- if -- I'm not suggesting that was the case, I'm just saying the assertion that that was the way of dealing with it?

A. No, I've never heard --

Q. Have you heard of that since?

A. No. I think -- I mean, Liverpool Women's is a very different unit and they have a lot more babies, and they have a lot sicker babies, so it's definitely a -- you know, probably -- well, it definitely happens there a lot more.

So I think the staff would be involved in it a lot more. But, I mean, it's still my personal view if you -- that a death is a traumatic event for everybody and really, really upsetting, and I think it's still my view, and I wouldn't change that, that if you go through something like that that actually ideally a break from that situation is the best.

Q. And standing back from that communication, it is a request to go back to Nursery 1, isn't it --

A. (Nods).

Q. -- which we pick up again later on in relation to Letby? I'll come to that now -- shall we move on to Child C?

A. Yes.

Q. So if you look at Child C, paragraph 18 of your statement, you tell us when you were first called to Child C's cot. What was the situation -- and if you look at your statement there at paragraph 18/19, what did you see, what did you observe with Child C?

A. Sorry, could you repeat that I didn't quite hear that.

Q. Yeah, when you -- when you went to Child C at the resuscitation, what did you observe? You tell us at paragraphs 18 and 19.

A. Yeah, so, there was -- there's a -- I can't remember exactly who was in the room, and I know this was discussed -- this has been discussed previously. What I do remember is Lucy was in the room. What I can't recall is whether -- when I arrived in the room what I can't recall is whether Sophie was already there or came in after me. She was --

Q. What band was she, Sophie?

A. She was a Band 5.

Q. Right, so the same as Louis you --

A. She was the one --

Q. -- and you're the most senior.

A. -- caring for the baby.

Q. So Sophie's caring for the baby, Letby is there, what do you observe? You described the use of a piece of equipment that you were surprised by.

A. Yeah, she -- so, again, my memory of the specific events is, you know, not great any more.

I remember -- but I do remember her using a Guedel airway, which is an airway adjunct, which if you are struggling to inflate the chest, inflate the lungs with inflation breaths or ventilation breaths that can help open the airway to assist that.

Q. So it's a piece of equipment that's usually used, what, had by doctors or --

A. It can be used by doctors or nurses. It's something we get training in using, but very rarely get to use.

Q. Have you ever used it?

A. No.

Q. At that stage you're there more senior than the other two, and is it usual that somebody more junior is using a piece of equipment that you've never used or wouldn't use?

A. I mean, not -- I -- I -- no. And I think that's what struck me about that situation was that she

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

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

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

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

A. No.

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

A. Yeah.

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

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

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

A. Yeah.

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

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

You nod, so is that your recollection?

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

Q. Yes.

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

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

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

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

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

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

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

A. Yes.

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

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

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

A. (Nods).

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

Q. You move on at paragraph 27 of your statement

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

A. What nursery he was moved to?

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

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

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

A. Mm-hm.

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

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

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

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

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

said to Lucy Letby:

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

And you recalled Lucy saying closer to the time:

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

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

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

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

Q. And what happened subsequently?

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

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

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

A. I don't remember.

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

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

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

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

A. Yeah.

Q. -- but what would you describe --

A. So, yeah --

Q. -- the manner?

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

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

A. Yes.

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

A. Yes, it did.

Q. It did?

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

A. (Nods).

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

A. Which comments --

Q. The comments --

A. -- specifically?

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

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

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

Q. Compassionate?

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

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

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

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

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

happening?

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

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

A. Yeah --

Q. -- concern about an individual.

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

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

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

What was it about her that --

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

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

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

A. Yeah.

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

A. Yeah.

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

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

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

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

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

A. Yeah.

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

A. Yeah.

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

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

career --

Q. At that stage --

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

Q. -- yeah.

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

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

A. Yeah.

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

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

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

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

A. I don't know because that's -- that is a really hard question, because I think if you took all away -- all this that's happened in the last few years and put me back in that situation, I still don't -- I still think I would probably wouldn't pick it up because -- well, I don't know. I think ...

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

A. Yeah.

Q. -- with experience.

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

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

A. Yeah.

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

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

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

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

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

Q. And everyone knew that?

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

Q. Sure, easy --

A. -- so --

Q. Exactly.

A. -- it's easily --

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

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

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

A. (Nods).

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

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

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

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

A. I don't think so, no.

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

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

"Hi everyone."

It is an email from Eirian Powell:

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

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

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

Did you see that at the time?

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

Q. What did you make of that?

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

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

Was that this one?:

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

Three months, sorry, that's my eyesight.

And so you see the email there.

A. (Nods).

Q. Did you see that one?

A. Yes.

Q. So what did you make of that one?

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

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

A. No, not that I remember.

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

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

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

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

Did you receive that?

A. Yes.

Q. And what did you understand when you received that?

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

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

Q. She didn't come back to --

A. -- physically to work.

Q. -- work, did she?

A. No. Yeah.

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

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

Q. No.

A. -- as far as I remember.

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

A. Not that I can remember.

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

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

Q. Did you --

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

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

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

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

that point and weren't having --

A. Yeah.

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

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

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

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

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

Q. Understood.

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

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

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

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

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

Q. Checks and balances?

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

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

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

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

A. Thank you.

LADY JUSTICE THIRLWALL: Mr Baker.

Questions from MR BAKER

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

A. (Nods).

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

A. Yes.

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

A. Definitely not.

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

A. No.

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

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

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

A. (Nods).

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

A. Yes.

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

Were you present when that happened?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Sorry, I'm highlight differences?

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

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

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

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

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

Q. You've explained that really clearly.

A. Is that enough?

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

A. Yes.

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

A. Yes.

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

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

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

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

Q. When you say who was qualified, is that

a Band 6 --

A. Sorry --

Q. -- or a Band 7?

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

Q. Yes, yeah.

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

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

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

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

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

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

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

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

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

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

Can you expand upon that for us?

A. Sorry, can you be more specific?

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

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

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

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

And you also say:

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

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

A. I think -- and I'm sure much of this will have been discussed already -- a lot of what was going on behind the scenes in terms of concerns regarding unexpected deaths and potentially worrying that somebody was responsible, none of that was discussed with us. But I do feel like the divide was a symptom of that, because certainly when I first started I didn't feel that there was a divide. I think as time went on, and probably following Lucy being removed from the unit, there seemed to be this -- a little bit of an atmosphere but I never had any information to know why.

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

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

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

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

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

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

Q. Shall we go to that if that helps?

A. Yeah.

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

A. Yeah.

Q. "... I was redeployed from the unit in July 2016 following serious and distressing allegations."

That one?

A. That was the -- from my memory was the first time I had seen in black and white that there been any accusation. She'd been removed from the unit. We had been told it was for her own well-being and it was going to be a short period, that she had a secondment. One of our other nursing staff also had a secondment. So it didn't seem out of the realms of possibility.

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

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

A. Yeah, just from common sense.

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

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

Q. You're positive --

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

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

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

Q. Yeah.

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

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

A. I don't --

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

A. Not that I can remember.

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

reminded us of from Letby herself to all of you.

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

It suggested:

"Lucy has as agreed to undergo supervision first."

Ie others of you are going to follow and she started on Monday, 18 July.

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

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

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

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

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

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

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

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

A. Mm-hm.

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

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

A. (Nods).

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

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

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

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

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

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

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

A. Yeah.

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

whether you would in fact have supervision?

A. Not that I recall.

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

A. I can't remember.

Q. That can go down, thanks.

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

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

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

A. Yeah.

Q. You were involved with Child A.

A. Yes.

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

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

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

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

and 2 of that.

So we see at the top:

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

Scrolling down you say:

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

She responds:

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

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

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

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

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

"Oh god, he was doing really well when I left. I do hope Child B continues to improve, have they done bloods to check?"

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

A. I don't know.

Q. Okay. Carrying on with the messages:

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

And so it continues. You can see that.

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

She says:

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

And then the next bundle one message she says:

"Yes they had time together & got some nice little

mementos when they are ready to take them. Fingers crossed."

You will have appreciated this was a mother who lost her baby after 24 hours -- or within 24 hours and had managed to touch him once, once on the tummy in the incubator, and this message comes to you. First of all, you didn't invite that message, did you?

A. No.

Q. Are you okay?

A. Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Okay, 11 and 12?

Q. Yes, thanks.

A. Yeah:

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

"This collapse was unexpected in my opinion,

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

Q. You turned on lights. Why did you turn on lights?

A. Because I couldn't see.

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

A. No.

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

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

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

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

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

A. Not that I can recall.

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

A. No.

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

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

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

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

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

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

When did the suspicions develop then, in your mind?

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

Q. Had they taken statements from you before she

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

A. Yeah.

Q. -- then you learnt she was arrested?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. (Nods).

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

A. Yeah. Yes. Yeah, sorry.

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

A. Is that paragraph 20?

Q. Yes.

A. I'll just having a little read.

Q. You heard the monitor sounding.

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

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

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

Nursery 1 I was just outside, and I can't recall what alerted me to go into the room, I either heard a cry, I heard the monitor go. I'm not sure which one it was but I knew that I needed to go into the room.

She was very unsettled, exhibited a large and relentless cry. I've said that:

"I attempted to settle her with a dummy and sucrose; when that didn't work, I repositioned her on to her tummy. Following this, she stopped crying, stopped breathing and became dusky in colour. I shouted for help, and Lucy Letby arrived to provide help. We positioned Child I on her back ..."

And began resus measures.

Q. And you were involved in the aftercare, weren't, you for Child I? Can you tell us about that, and we know Letby insisted with that because you'd never done before? Did she tell you she had?

A. And I knew that she had because I knew that she's lost a patient before, more than one, and I knew that she -- I knew that she delivered that because generally whoever is responsible for the care of that baby then delivers the aftercare.

Q. And you were actually on -- you were designated for that baby --

A. Yeah.

Q. -- not her --

A. Yeah.

Q. -- but because she had done this before, did she want to do that and assist with that?

A. Yeah.

Q. So although you're the designated nurse, she wants to assist she does assist --

A. (Nods).

Q. -- with that?

A. Mm-hm. Yeah.

Q. Again, looking back, and maybe at the time, what did you think about that, her wishing to assist with that?

A. I thought she was being helpful. I would expect that from any colleague. I have never -- there is the pastoral side, the emotional support, but there's also a lot of paperwork and things that have to be done when a child dies, and I was just aware that I hadn't done it before, I was really worried about not doing it right, so I just wanted that guidance from somebody. And I didn't specifically ask Lucy, I asked just the staff that were there if somebody could help me.

Since then I've -- I think within the trial there was information that she'd gone into the room without me and discussed things with parents that then upset them,

and I had no idea that that was happening at the time, so I didn't have an opinion when it was happening.

Q. Because you didn't know it was being done like that?

A. No.

Q. You thought she was helping you not taking it over really?

A. Yeah.

Q. You say at paragraph 22:

"Child I's collapses and subsequent death were unexpected events in my opinion. Despite her medical history prior to this point, she presented as a stable baby."

You said that you knew that at the time as well and there was a debrief, wasn't there, following on from that?

A. Yeah.

Q. If we go to INQ0000429, page 1543. We see here it looks as though it's between yourself, Lucy Letby, Dr Gibbs, who was present at the resuscitation, and the chaplain.

A. Yeah.

Q. And we look there we see:

"Discussed briefly overall cause of illness since prem delivery."

And then:

"Discussed episodes of sudden cardio respiratory deteriorations the week before death, then again at time of death seemed fine and stable prior to the episode of sudden collapse."

So right close to the event Dr Gibbs, yourselves acknowledging that came from nowhere, sudden and unexpected collapse.

A. (Nods).

Q. At the bottom, it a reference to nursing staff -- quite difficult to read this -- but nursing staff --

A. Yes.

Q. -- felt ...

LADY JUSTICE THIRLWALL: "... resuscitations were well run."

MS LANGDALE: Yeah:

"... must have been due to ..."

Actually let's go to the next paragraph:

"Nursing staff felt resuscitations ..."

A. "... were well run."

Q. "... were well run."

Do you remember that discussion now?

A. Barely. I knew that we had a debrief. I didn't really get any information from it.

Q. And it look likes John Kingsley, the reverend has said that:

"Someone will come to talk to parents whether or not a child has already been baptised."

A. Yeah.

Q. There seemed, amongst all the deaths that we are looking at in the context of the Inquiry, references to baptism --

A. Mm-hm.

Q. -- and would they like babies baptised. Was that something you all had training in or discussions about when that should be raised, how that should be raised, if it should be raised?

A. Yeah, so -- I can't remember the nature of the training at the time but we get regular updates about what support can we provide to parents, and it's -- a big part of that has always been: are they of a religious denomination? Would they appreciate having a baptism? Having a christening? Regardless, even if they are not religious, would they appreciate a blessing? And that comes from parent feedback, from charities -- bereavement charities where parents have said that would have helped to be offered that at the time and be offered that maybe when their child was sick and not after the fact when their child has already

passed.

Q. If it is a sudden deterioration or a sudden death, I suppose you may not have asked about those preferences in any event at all, mightn't you?

A. No, I -- no, and that's -- you are so focused -- rightly or wrongly, you're so focused on helping that patient and giving them what they need and the emergency at the time, you don't really think about things like baptism. I know that Child I had been baptised and that had been following the initial episode before she was transferred out where I think she was not quite stable but there was a time period where that was thought of by somebody.

I think it just didn't cross our minds to offer that again. So John Kingsley very rightly said, "I'm happy to come. I can come again. There is no limit there is no restrictions."

Q. And dealing with managing bereavement generally, were there other options of support or care or assistance that you were trained about or discussed that people might want in that hour or time of need?

A. No. I feel the bereavement care in general in neonates was very poor at the time. We -- we did what we could, but we're not -- although you can -- you can attend study days and you can get training, there wasn't

a lot of resource to have somebody specifically who could provide that support. We have it now.

Q. What do you have now?

A. We have bereavement links on the unit, nursing staff who help deliver training, help liaise with parent advisory boards. We have a bereavement midwife whose sole -- her job is to provide bereavement support to families, and sometimes she will be involved before the baby is even born if there is knowledge that the baby might not survive or they might have severe health problems.

We on the unit now have well-being practitioners that come to the unit twice a week who can deliver counselling whether the baby is in hospital, whether they've gone home, whether they've lost a baby. And they can also assess and signpost and refer parents to further support if necessary. None of that was available at the time.

Q. And it sounds like the fact that you hadn't dealt with it before and you were unsure of your own position, let alone supporting somebody in a deeply distressing position --

A. Yeah.

Q. We've had evidence from at least one parent that they were given a leaflet, and leaflets how

effective can they be in these circumstances compared with a real person, what's your view about that?

A. I agree. I think things like leaflets and booklets it's very impersonal, and this is a very sensitive and personal subject. There are some fantastic charities such as SANDS that have been set up by grandparents or parents who have been bereaved who provide a lot of that literature from experience. But we cannot just depend on goodwill and charitable causes to provide this support. It should be integral to the healthcare that we provide. It should be a continuation of the neonatal care, and I think only recently has that been properly recognised, and even so it's having the funding.

We in neonates work in a certain area where we expect that sometimes outside of this period babies will pass away unfortunately for many reasons. So we're acutely aware of what these families go through. And at the time, not being able to provide that support was so difficult because we would know what they need but we just had no funding and no staff to provide that.

I think recently, and publicly, that has been more recognised and there are more conversations about the neonatal period, things like maternity and paternity leave, things like bereavement care because it's a very

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

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

A. It's --

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

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

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

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

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

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

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

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

Q. You were invited as part of the Royal College

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

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

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

Q. You did --

A. -- when I answered --

Q. -- apologies.

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

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

A. Yeah.

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

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

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

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

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

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

A. Yeah --

Q. -- not Planned Care, is it?

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

Q. It looks as though here:

"Normally a positive environment but been very difficult. "

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

A. Sorry, okay.

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

A. Yeah.

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

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

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

Q. Fair enough. Okay.

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

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

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

A. Yes.

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

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

Q. If we look at the bottom of that paragraph 2:

"Only thing we need is a unit debrief [underlined]."

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

A. Yeah. I've put:

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

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

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

Q. Thank you, the document can go down.

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

A. Of course.

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

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

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

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

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

Q. A management plan --

A. Yes.

Q. -- where you're going?

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

Q. You also say:

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

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

A. Yes.

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

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

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

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

Q. Annual leave?

A. Yes.

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

A. No.

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

A. Not out loud, and not to me.

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

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

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

A. No.

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

in September 2015, she'd seen:

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

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

A. No.

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

A. No.

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

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

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

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

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

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

A. Yes.

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

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

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

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

We have training on radicalisation and spotting

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

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

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

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

A. Unexpected.

Q. -- that were significant.

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

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

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

A. Yes.

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

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

A. I can't remember.

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

A. Yes.

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

A. Yes, yeah.

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

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

Q. You do say in your statement at paragraph 41:

"Due to working on the unit as a student nurse, I knew the average death rate had previously been much lower. I was worried about this increase, especially as they all seemed to be unexpected or sudden -- and there was no explanation ..."

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

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

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

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

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

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

A. Yes.

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

A. (Nods).

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

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

A. Yes.

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

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

Do you recognise anything like that?

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

Q. Right.

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

Q. This suggestion is:

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

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

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

How was it?

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

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

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

Q. You say finally on reflections:

"I don't think the crimes of Letby would have been prevented if there had been CCTV present."

A. Yes.

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

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

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

That's not for me to decide.

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

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

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

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

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

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

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

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

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

A. Yes.

Q. Who has access to it?

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

Q. How's that changed?

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

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

MS LANGDALE: Thank you very much, Ms Hudson.

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

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

A. Thank you.

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

A. Thank you very much.

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

(1.07 pm)

(The luncheon adjournment)

(2.10.00 pm)

LADY JUSTICE THIRLWALL: Yes, Ms Lyons.

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

LADY JUSTICE THIRLWALL: Yes.

KATHRYN PERCIVAL-CALDERBANK (sworn)

Questions by MS LYONS

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

A. My name is Kathryn Lesley Percival-Calderbank.

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

A. Yes.

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

A. Yes.

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

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

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

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

I think I got my dates slightly wrong.
Q. Were you aware around the time of your training to become a midwife of the case of Beverley Allitt?
A. Yes.
Q. And so you were aware that insulin could be used as a drug to harm babies?
A. Yes.
Q. After you qualified as a midwife, in your witness statement at paragraph 5, you say that you took up a position as a midwife on the neonatal ward; is that correct?
A. That's correct, yes.
Q. And at some stage you were no longer a midwife on the neonatal ward and you became a nurse --
A. Yes.
Q. -- on neonates. So can you just explain that transition?
A. When the NMC decided that you had to keep with dual training, you had to do so many hours in one qualification and the other I couldn't adhere to the full qualification as a midwife because I wasn't practising on a labour ward to fulfil that requirement. So I -- I kept my registration for nursing and not midwifery.

Q. And that was in 2013?
A. I can't remember what date that really was.
Q. In paragraph 6 of your statement you say you became a senior neonatal practitioner at the Band 6 level in 2013 is what I inferred from your statement, but if you don't remember.
A. Yeah, because I did extra qualifying cases towards it as well, towards getting that -- that qualification. So I'd done my -- what was known as the 405, which was part of the looking after neonates, and then I then did my R23, which is a -- an advanced training to further my position.
Q. And are you still employed as a neonatal nurse on the -- at the -- on the neonatal unit at the Countess of Chester Hospital?
A. Yes.
Q. I would like to move now to some questions about how the unit was in 2015/2016 and your relationships with your fellow staff members.
At paragraphs 26 and 69 of your statement, you describe the working environment on the neonatal unit during the period that we're concerned about, 2015 to 2016, as very busy and particularly stressful for the nursing staff.
Can you -- can you tell us why that was? In

your -- in your view why that was?
A. Because we were -- we had a lot of babies -- intensive care babies and there was a lot of work to do for the amount of babies towards the staff. Even though we were BAPM compliant it was still very busy.
Q. Busy but manageable?
A. At the time -- most of the time it was manageable but at times it wasn't because of the requirements of taking babies from the maternity unit that were unable -- that mothers weren't able to be transferred out in utero or because the mothers had come in and delivered, and the babies then needed further care with -- with us, so we were indebted to take that -- the care of the baby over for them. The care of the baby to ensure its safe -- it's -- help it -- help the baby out.
Q. And what about medical cover, did you feel at the time that there was adequate medical cover, enough doctors -- junior doctors, middle-grade doctors, Consultants on the neonatal unit at that time?
A. Yes. I -- the only difference was that they had to cover an awful lot of -- they weren't just for neonates -- looking after neonates, they were looking after the -- any babies that were born on labour ward and also the paediatric. At times they were also

covering the paediatric ward and -- and A&E at times as well.
Q. But if you needed a doctor on the neonatal unit, would they come if you called them?
A. Yes, we would bleep them and they would answer the bleep and come to us.
Q. And I'm going to ask you some questions now about Datix reporting. Now, I think by 2015 you would have been employed on the neonatal unit for about I think 22 years or around then.
A. Yeah.
Q. So you've probably seen different systems come and go?
A. (Nods).
Q. Do you remember when the Datix incident reporting system was introduced?
A. I -- I can't -- can't recall the dates, no.
Q. And you explain very helpfully at paragraph 29 of your statement how it was used, and if I understood your evidence correctly, there are two scenarios. I think you say in response to a specific concern, and you give an example, closure of the ward due to acuity or lack of staff or admissions above the allocated number of beds, and the second scenario is if a mistake was made in the clinical care of a baby, for example

a drug administration error.
A. Mm-hm.
Q. Would you or any of your nursing colleagues complete a Datix form if a baby suddenly and unexpectedly collapsed and died?
A. No, we wouldn't have done that. It would have probably been left to the medical staff to complete that.
Q. And would there be a discussion -- so if a baby has to be -- had -- was being resuscitated and the resuscitation was unsuccessful and the baby sadly died and you have the nurses in the room and you have the doctors in the room, how would the conversation go, in terms of who's deciding to fill out the Datix form? In practice, how did it work?
A. It was just understood that the doctors would complete that -- that side of it.
Q. Understood, by whom?
A. By -- by the nurses.
Q. And what was your understanding about if a baby suddenly collapsed unexpectedly, needed to be resuscitated but did not die, so recovered --
A. Then --
Q. -- would a Datix form be --
A. It should have been --

Q. -- filled out in that situation?
A. It should have been, yes.
Q. And, again, would that be the responsibility of the doctors to do or the nurses --
A. As far as I'm --
Q. -- or a joint responsibility?
A. As far as I'm concerned, yes.
Q. As far as you're concerned it would be the --
A. The doctors' responsibility.
Q. Now, if I can turn now to your roles and responsibilities in the neonatal unit during 2015 to 2016. You set these out at paragraphs 7 to 21 of your witness statement. I would like to ask you some questions about your role as a shift leader.
A. Mm-hm.
Q. Now, you were a shift leader between 2015 and 2016, and are you still a shift leader?
A. Yes.
Q. And how often would you work as a shift leader? Because it's an additional -- you know, you have additional responsibilities when you work as a shift leader so --
A. It was -- tended to be allocated throughout all the Band 6s who were -- who were working that it was -- that we all covered the shifts and had an equal

opportunity to cover the shifts.
Q. So was it monthly, or weekly?
A. I think it was trying to be done -- be done on a monthly basis. But sometimes that might alter depending on staffing and if somebody's not feeling well that they couldn't take the responsibility of being a shift leader, then one of the other Band 6s would take that shift over.
Q. And one of your responsibilities as a shift leader, I think you say at paragraph 8 of your statement, was that you were:
"... responsible for coordinating shifts and for allocating duties to junior members of the team and ensuring patient safety."
Now, can you explain, what was the process between June 2015 and June 2016 for allocating nurses to babies?
A. It tended to be the shift leader who allocated for the next shift on. So if you were on nights you would allocate for the day shift looking at the acuity of the ward and what -- what staff you had on that -- coming on to that day shift or that night shift, and then you would also look at who had been caring for the babies previously, so if they'd worked the day before, then you would -- for continuity of care, then you would then perhaps give that person that baby again so that

there would be continuity for the parents and for the baby.
Q. What about -- did you take into consideration any welfare concerns that you may have had for the nurse, for example if the nurse had experienced a bereavement in the previous shift, would you --
A. Yes.
Q. Would that play a part in your decision-making?
A. Yes, that would have done as well.
I had on occasions moved staff -- staff not to be in an intensive care setting and put them outside in the outside nurseries so that they weren't -- to help with their mental well-being and so that they could not be put in that stressful situation again.
Q. And is that something that you would do of your own volition or is that something a nurse might request.
A. Both. I would do both if I -- if I was able to.
Q. And by outside nurseries, can you explain what you mean by that, please?
A. The -- we would have intensive care nurseries and then we would have high dependency nurseries, and then there would be -- in the unit, as it was, there

were two special care nurseries, and so the intensive care were the babies that might need ventilating or additional support with their breathing. High dependency they didn't need as much support but still needed more specialised care. And then the outside nurseries the special care babies were the babies that were -- had maybe gone past all those intensive and high dependency and were getting ready towards going home, really, so they were -- you were trying to get them to feed and to grow so that they were big enough and well enough to be able to go home with the support of the -- with the parents in being supported as well.

Q. And how was the allocation communicated to the nurses?

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

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

A. Yes.

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

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

Q. And would that be during the handover?

A. It would just be just -- just beforehand over, yes.

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

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

Q. Provided by the shift leader?

A. Yes.

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

A. Most of the time, yes.

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

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

Q. And senior would be a Band 6 nurse?

A. Yes.

Q. Turning now to relationships between staff.

You've told us that -- in your statement at paragraph 6 that Eirian Powell was your manager.

A. Yes.

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

A. Yes.

Q. -- the neonatal unit.

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

A. Yes.

Q. And how was your relationship with her?

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

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

A. Yes.

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

A. Yes.

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

A. It wasn't just one, it could be -- it was just little, little things that you -- we noticed -- I noticed. It wasn't -- they just -- they seemed to -- if they were able to go into the office they were able to -- to -- if they wanted to go on certain study days or something like that they were able to get it, whereas other people might not have been able to.

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

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

Q. And why do you think that?

A. I don't know. I don't know.

Q. Well, what gave you that impression?

A. It was just --

Q. Did she say so?

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

compassionate nurse.
Q. Do you think others picked up on what you picked up, that she liked Letby a lot?
A. I don't know.
Q. So it wasn't something that was discussed on the unit?
A. No.
Q. Looking back, do you think Eirian Powell's positive attitude towards Letby might have affected how she would have responded to any concerns about her?
A. I don't know, it might have done.
Q. If you had had any concerns about Letby, would you have felt comfortable raising them with Eirian Powell?
A. Yes, and I did. On an occasion I did raise my concerns because after --
Q. Let's talk about that now. So can you tell us about that occasion, please.
A. Yes, it was I had been asked by Eirian Powell to try and not put Lucy Letby into the intensive care nursery --
Q. So can you just pause there, can you tell us when that happened?
A. I -- I can't -- I can't know the exact dates. I know it was --

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

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

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

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

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

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

Q. And what was --

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

Q. What was Eirian Powell's reaction?

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

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

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

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

Q. For that week?

A. Yes.

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

A. Mm-hm.

Q. What did you mean by that?

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

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

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

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

Q. So you worked well together --

A. Yes.

Q. -- with the midwives?

A. (Nods).

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

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

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

A. Yes.

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

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

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

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

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

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

A. Yes --

Q. Yes.

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

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

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

A. Mm-hm.

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

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

care that we could give at the time but it wasn't as good as we could have given I think at times.

Q. So what did you think would happen once you completed the Datix form? How did in your mind did you think that would get up to senior management and cause some --

A. I know that --

Q. -- sort of response or change?

A. I know at the moment it would -- it goes to a Datix meeting and then it's -- it's looked at there and then it's progressed further, but I don't know what the process was in 2015 and 2016.

Q. But you didn't feel the process was working?

A. No.

Q. You describe the visibility of senior management before and after Letby was removed from the neonatal unit in your statement. How did senior managers become more visible after Letby had been removed, which is what you say?

A. They would visit every day after -- after Letby was -- was moved. And especially when she was first taken in for questioning, we were aware of them coming to see how we were, but other than that --

Q. Who would visit every day?

A. It would depend on who the managers were. At

one point I think it was Karen Rees came. Occasionally the chief exec would come who was --

Q. Tony Chambers?

A. -- tony Chambers.

Q. Ian Harvey?

A. Sorry?

Q. Did Ian Harvey visit the NNU?

A. Very infrequently. But not on a -- not on a very regular basis, though.

Q. What about Alison Kelly?

A. And Alison would come on a regular basis as well.

Q. Before or after Letby was removed?

A. I felt it was after she was removed.

Q. I would like to ask you now some questions about Child D.

A. Mm-hm.

Q. You deal with this in your statement at paragraph 38. You may want to turn it up.

Now, we can see from your police statement, which you don't need to look at, that you worked the night shift on 22 of -- well, on 21 to 22 June 2015. And you tell us in your police statement that at around 1.30 in the morning you became aware that Child D collapsed.

Do you have any independent recollection of the

collapse?

A. Other than what is written in my police statement?

Q. So in your police statement you describe that Child D had become mottled over her trunk and legs, and you say:

"I have seen babies in the past with discolouration from circulation issues or from sepsis but on this occasion it looked unusual and we did not know what was causing it at the time. Discolouration later disappeared and she became a normal colour again."

Do you recall any discussions at the time about Child D's skin discolouration with either the nurses or the doctors who attended the resuscitation?

A. Yes. It would have been whoever was there at the time we would be discussing it because it was -- was so unusual because of this mosaic red, mosaic rash that appeared on the baby.

Q. So you weren't alone in thinking it was unusual?

A. No.

Q. And were you aware that Child A and Child B had displayed an unusual rash or skin discolouration?

A. No.

Q. Now, you tell us at paragraph 42 of your

statement that:

"On the NNU we expect babies to survive. Some have increased risk factors ..."

And you go through those risk factors:

"Child D did not appear to fit any of those concerns as far as I was aware."

So is it fair to say that Child D's death was a shock for you?

A. Yes.

Q. And were there any discussions on the unit about how unexpected Child D's death was?

A. Yes, I think there was at the time of the death. We weren't expecting that to have happened, to have occurred.

Q. And earlier in the month of June, we know that Child A had died on 8 June and Child B had collapsed on 9 and 10 June. Now, you worked the shift -- the night shift I think it was, is that correct, when Child B collapsed?

A. I don't know. I can't remember.

Q. Okay. And then -- well, were you aware that Child B had collapsed and had to be resuscitated?

A. No.

Q. Were you aware that Child C had collapsed and died?

A. We were aware that there had been a collapse but I -- I wasn't -- I don't think I ever looked after Child C.

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

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

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

I take it you were not involved in those conversations?

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

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

Were you aware that some of the Registrars were

concerned about the three neonatal deaths?

A. No.

Q. All three deaths were unexpected and we know, at least in the case of Child A, Child B and Child D, that there were an unusual rash or skin discolouration.

A. Mm-hm.

Q. Do you recall any conversations about these deaths?

A. No.

Q. A few weeks after Child D died, on 4 August Child E died. So by August, so from 8 June to 4 August, four babies had died. Do you recall any conversations in the unit about these deaths?

A. I don't recall any -- any conversations about them, no.

Q. Do you recall an atmosphere of worry or concern?

A. I -- I can remember myself because I think I'd had a period of absence and then came on and had enquired after one of the babies where -- had it gone home? Had it been discharged home? Had it gone somewhere else? And then to be told that the baby had actually collapsed and died, that was a surprise. And then to -- then you ask -- you always ask, "Oh, which -- which person was involved when they died, you know, how

are they?" Because you worry about -- about people who've had to deal with it.

And then when I was told it was -- that Nurse Letby had been -- had been involved with it, there was thinking -- there was concerns and I can remember saying to one of my colleagues, "If somebody's not careful, they're going to think there's something untoward happening here because it's not" -- you know, because you start worrying about your colleagues' well-being and things like that, but you also start worrying, what are we missing? What's -- what are we not seeing here? Why -- why is this occurring?

Q. Do you remember when that conversation was?

A. I don't know when it was, the conversation, and I don't know who I -- I spoke to at the time. But I just remember exclaiming.

Q. And what did you mean when you said "something untoward", were you referring to incompetence or deliberate harm or something else?

A. Just because it was -- it -- you know, I'd been there a long time and in the period of the time before this -- these -- these four deaths, I'd never known to have that many deaths in such a short period of time. I'd been there, you know, for -- you know, over -- over 10 years by then, and in that are period of

the 10 years prior I'd not dealt with as many deaths before that.

Q. So you -- just based on what you've just said it sounds like maybe you'd this conversation after the three or four deaths, do you think?

A. I -- I think -- I don't know how many deaths it was, I just know that I'd had a period of absence, I'd come back on, and then when I exclaimed that -- you know, finding out that another baby had died, that I was worried -- that there was a worry.

Q. Do you remember when your period of absence was?

A. I don't know whether it was -- that I'd had a holiday and then came on -- back after a couple of weeks.

Q. But your nursing colleagues were updating you as to what had happened?

A. Yeah, because you would come on and you'd look on the board and say, "Oh, so and so, did that baby go home? Did that one go home?" Because you spent a lot of time with -- with parents or with the babies if they'd been on the unit for a while -- a long time, so you would always sort of like look at -- look at a board and scan where -- and ask -- you know, knowing if the baby was going to be well enough to go home within

a short period of time you would ask about it.

Q. I want to ask you about an incident which we heard evidence about from Dr Rachel Lambie. She described an occasion when she walked into the neonatal unit, and I think she might have been in the intensive care room, and she found there were some nurses huddled over a computer and they were going through the staff rota, and the reason they were going through the staff rota is because they were trying to enquire, investigate as to who might have been on duty when the recent events had occurred.

Now, she thinks this happened before she left the hospital in September 2015, and she remembers a nurse saying words to the effect that, you know, "It would be awful, but we are just checking", something along those lines.

Were you, were you part of that conversation?

A. Not as far as I'm aware, no.

Q. Were you involved in sort of looking at the staff rota just to try and find out if this was --

A. Was the staff rota on a computer.

Q. It was -- that was her recollection.

A. We never -- our staff rotas were not computerised by that period of time. They -- they were all on paper.

Q. Right. But you don't know anything about that?

A. No.

Q. Okay. So I'm going to ask you now some questions about Child N.

A. Right.

Q. So Child N -- you set out your involvement in Child N's care at paragraph 48 of your statement, and on the night shift of 14 to 15 June you say that you were the shift leader. Were you aware -- you don't say so in your statement -- were you aware that Child N's parents were expecting him to be discharged and taken home on 15 June 2016?

A. I think there had been talk about it, yes, as far as I can recollect.

Q. And Child N was in Nursery 3?

A. Yes.

Q. And you've already explained that that's the sort of feed and grow nursery.

A. Mm-hm.

Q. And you say in your statement that -- at paragraph 48 -- that Letby arrived about 15 minutes early for her shift.

A. (Nods).

Q. For the day shift of 15 June. Had you done

the staff allocation already?

A. Yes.

Q. And had you allocated Letby to Child N?

A. Yes, because she had had the child the day before and so because they were getting ready for home I thought it would be -- there would be a continuity and all the -- all the talk of the baby going home there would be all the continuity of getting all the discharge papers together ready for the baby to go home so that all the notes and discharge letters would be done by her.

Q. So Letby's shift would have started at 7.30; is that correct?

A. Yes.

Q. And she arrived at 7.15. Would she have been aware that she had been allocated Child N at 7.15?

A. I think she'd -- she'd requested, if she was able to, would she be able to have the baby to the shift before or to the nurse who was looking after her -- after the baby -- or after him.

Q. But not to you?

A. I think it had been spoken to me about it as well.

Q. So when she arrived 15 minutes early she knew that Child N would be her allocated baby for that shift?

A. I don't think she did know at that time.

Q. But she had requested it?

A. But she had requested it if she was able to.

Q. Now, we -- you say that at around 7.15 -- well, firstly, Jennifer Jones-Key was the designated nurse.

A. Yes.

Q. And in her witness statement at paragraphs 9 to 10 she said that Letby came into Nursery 3 at 7.15 am to have a chat with her, and she said Child N started to desaturate and was mottled all over and was blue in colour, Letby responded and commenced resuscitation using the Neopuff. Then she called for assistance. Is that when you became involved?

A. Yes.

Q. Can you tell us what happened from that point?

A. I -- well, I wasn't -- I don't think I -- I'd been informed because I was at the desk and she shouted for help, but I don't know whether I went in or Belinda Simcock went in to -- to assist because she was around, and the baby was then brought -- the doctors were called and the baby was brought out and put into Nursery 1.

Q. And what happened next?

A. And then I was still sorting out ready for the

shift for the day -- the day shift coming on, so the baby was in Nursery 1, the doctors and Nurse Letby, Belinda Simcock and Jennifer Jones were -- were in there dealing with the baby.

Q. And did Child N's collapse concern you, surprise you?

A. Yes. Well, it -- overnight the baby had -- was not acting as well as he should do. We'd actually called out the doctors in the night and monitored -- put a monitor on the baby of his saturations because Jennifer Jones was concerned about it and had been speaking with Belinda and the course of events, so the doctors had been informed in the night and had come and had -- we put the baby nil by mouth I believe and we'd screened the baby and put IV fluids. So -- and given IV antibiotics --

Q. But no decision --

A. -- which is a course of action.

Q. Sorry, but no decision had been made during your shift to move Child N into --

A. Not at that time --

Q. -- another nursery?

A. -- no, we -- because we still had monitor -- were able to monitor the baby and we -- and because Jennifer was staying in the room with the baby we were

happy for the baby to stay there at that -- that moment.

Q. Were you aware that Dr Brearey and Eirian Powell were taking a particular interest at this point in time in any sudden and unexpected deteriorations in a baby on the unit?

A. No.

Q. Did you speak to Eirian Powell about Child N's collapse and the fact that he had to be moved to Nursery 1 and wouldn't be discharged?

A. Not that I can remember, no.

Q. So who within the unit would have informed Child N's parents of what happened?

A. I think it would have been -- I -- because I was in the middle of sorting out the next shift they were coming on, so it I don't know whether one of the team who were looking -- with the baby at the time were going to inform them or -- I don't know whether one of the doctors were going to. I don't know whether it was actually ever mentioned at the time unfortunately.

Q. And do you remember Eirian Powell coming to find you to ask you about this incident?

A. No. She might have done but I can't -- I can't remember if she -- if I did.

Q. We're going to move now to Child O. You talk about your involvement in his care from

paragraph 52 of your witness statement. You were the designated nurse for Child O on the night shift of 23 to 24 June 2016 following Child O's death; is that correct?

A. Yes.

Q. And how did you feel on learning that Child O had died? What was your reaction?

A. I was very surprised because that baby -- because he was -- he was one of three and they were all very well babies, born in good condition, and so it was -- we were -- wasn't expecting the baby to become unwell and to have died.

Q. And you returned to work the following night shift.

A. Yes.

Q. And you were informed that Child P had died, and what was your reaction, and what was the atmosphere like on the unit?

A. I think we were stunned by the -- the react -- by that happening because in the event of the -- the first Baby O dying, the baby -- the other two had been -- were screened and started on antibiotics as a precautionary thing because we were -- just to see if there was something that was being missed.

And the babies were -- were not acting -- were -- were okay really that -- the night before. There had

been an episode where we'd -- I think it -- where we'd -- one of them we'd stopped the feeds for a short time because he wasn't absorbing the feeds as well, so we just stopped the feeds for a bit and we got him observed by the doctors, and the doctors had checked the baby over, but because we'd already put the anti -- the baby already had antibiotics and had been screened during the day shift, we were not as -- that as concerned as we -- we would have been otherwise.

Q. You mention in your statement at paragraph 62 that there were discussions happening between the nursing staff who were working the night shift, so the shift you were on --

A. Yes.

Q. -- and the -- and the Consultants involved in the day shift. What were those discussions about? What was being said?

A. I think we were just concerned that we were -- we were missing something, that there were -- that was there something that -- a congenital infection or something that had been -- that was a congenital abnormality that had been missed, or there was something that was causing -- you know, for one of them to be -- to have died and then for the other two -- you know, to be screened and that second triplet being -- having to

be screened -- going -- becoming unwell the next day.
Q. Did anyone suggest that the deaths might be unnatural?
A. I don't know. I think we were just -- we were just wondering what -- because, as far as we -- we were concerned, we were doing everything that we would have normally done with babies that were -- were acting as if they have got infections.
Q. And by this stage, was there any talk on the unit about Letby's involvement in the deaths of Child O and Child P because she was caring for them and any of the previous -- were people starting to look back and talk and wonder, and speculate?
A. I don't know. I don't know. I think we were just so busy with doing things that we were -- we were just focusing on what we were doing at the time. There might have been thoughts by other members of staff but it wasn't spoken out loud.
Q. And having previously thought yourself that maybe -- you know, people might think something untoward was happening, did that thought come back to you with greater intensity?
A. There was a -- I -- I think I did have a niggle, if I'm -- if I'm honest, but I didn't -- but then I thought we were -- because they weren't intensive

care babies, they were special care babies, it somehow didn't -- didn't equate really.
Q. So the niggle, is that like a gut feeling?
A. Yeah. Or a concern really.
Q. And what was -- what was your -- sort of what was your concern at that point that you wouldn't perhaps tell anyone?
A. That may be, you know -- but then none of us had ever -- most people who go into nursing or to the medical profession are not there to harm. They're there to care and heal and protect and support. They're not there -- so it's completely alien to most nurses to ever think about that you would want to harm, especially a baby.
Q. But you had a niggle?
A. There was just -- there was concerns, yes.
Q. I'd like to take you now to a document on the screen. The reference is IN0002879, page 81. So we're going to fast-forward now, Mrs Percival-Calderbank, to -- so the -- Child O and Child P had died on 23 and 24 June 2016, and then on 15 July 2016 this email was sent by Yvonne Griffiths to the nurses in the neonatal unit.
Do you recall receiving this email and reading it at the time?

A. No.
Q. Do you recall this being discussed?
A. No.
Q. The fact that Letby was volunteering to be the first person to undergo clinical supervision within the team?
LADY JUSTICE THIRLWALL: Are we looking at the right document?
A. Actually, I think that's --
MS LYONS: INQ -- I'll read out the reference again INQ0002879, page 91. Sorry about that. There we are.
I'll give you a moment to read that. (Pause).
Do you remember receiving this email --
A. Yes.
Q. -- at the time? Sorry about that.
And was there any discussion in the unit about having to undergo clinical supervision?
A. I think at times we -- it was felt that maybe we -- there was a talk about going to a different hospital to get -- look at different things how they do it and how to just keep us updated really and things like that and if there was -- but there had been a talk about it, yes.
Q. And was anybody objecting to being -- going -- undergoing clinical supervision?

A. I don't think so, no, not as far as I'm aware.
Q. And then it's the same document reference but it's a different page. It's now page 75. So a few weeks later. I'll give you a moment to read it.
(Pause).
Having received an email a bit earlier about the undergoing --
A. Yes.
Q. -- being the first person to undergo clinical supervision and now receiving an email a couple of weeks later about her going on secondment, what did you think at the time? Did you think this was unusual?
A. Because we'd already got a member of staff already -- who'd gone on secondment, so we didn't think it anything --
Q. So you didn't question it?
A. No. No.
Q. And the last document I would like to take you to -- sorry, before I take you to the last document, paragraph 66 of your statement. If we could go there, please. You say that Tony Chambers told staff at a meeting to be nice to Letby on her return to the unit.
Can you tell us a bit more about this meeting?
A. We were all -- a lot of the staff were taken into a room and he took us -- took us by surprise by him

saying that we had to be nice to -- to nurse -- to Lucy because none of us had ever been horrible to her, we -- we were unaware that -- we just knew she'd been on secondment, she wasn't communicating with many people, she only communicated with a certain amount of people, So we -- which at times she could -- she could not speak with people, so we didn't think anything. But to be told that we had to be nice to her because she was coming back, well, we wouldn't have been anything else. That's not in our nature -- nobody was ever horrible to her.

Q. What did he say the purpose of the meeting was?

A. Just to explain that she was going to be coming back to the unit.

Q. Did he mention an investigation, did he mention anything?

A. No, we weren't -- no. Because I think we'd had a -- I think the QCQ had come in and investigated the unit, and they had been happy with what, everything that had gone on, from what I can recollect --

Q. I think might that have been the RCPCH.

A. -- but it's just it's -- there's -- there was so much going on at the time and it's -- so --

Q. So this meeting happened after they came to --

it? What did you think about it?

A. Because we weren't -- we weren't informed about anything, we -- the fact that we didn't know what these allegations had been and so we were -- and so we were a bit -- a bit stunned by it all really, because we -- we just were still under the impression she'd been on secondment.

Q. Had Eirian Powell or Yvonne Griffiths said anything to the team -- the nursing team after this email had been sent?

A. Not as far as I'm aware, no. I don't -- I can't remember being informed about anything.

MS LYONS: My Lady, I have about 10 minutes more of questioning. Should I continue?

LADY JUSTICE THIRLWALL: Yes, please.

MS LYONS: Yes.

Were you concerned about Letby returning to the unit after you received that email?

A. I think -- I think we were all -- I think we just -- we thought that she would need some support and supervision for her to be able to -- for her to come back for her own -- for herself really.

Q. Had you noticed any change in the unit whilst she'd been away in terms of number of collapses and unexpected deaths?

A. I think so, yeah.

Q. -- inspect? And was there any chatter, any discussion after this meeting about what Tony Chambers had said?

A. I think we just -- it was just the fact that, well, why wouldn't we be nice to her? You know, we were -- it wasn't -- we just thought that she'd been on secondment and that she'd come back into the unit because she'd been there for a while that she just needed to gain her confidence and the competence back, and so we just -- I think we were just a bit, well, really?

Q. So during the period that she was on secondment, there was no discussion about Letby and the unexpected deaths that had occurred on the unit?

A. No.

Q. And no one had made a link at that stage, you say?

A. No, we'd not been -- we'd not -- we'd been kept in the dark completely over everything.

Q. Last document. It's INQ0058624, page 1. (Pause).

Do you recall receiving this email at the time?

A. I vaguely remember, yes.

Q. And what were your thoughts when you received

A. Yeah, that -- I mean there had been -- there had been changes made by the network and things so we -- certain gestational babies were being transferred out, but also that we had noticed that the number of collapses and deaths and things had -- had gone down drastically as well.

Q. So when you got that email, did your sort of niggle come back?

A. I think -- I think everybody was concerned that she needed support if she was coming back, yes.

Q. Was anyone concerned about the babies on the unit?

A. I don't know. I don't know. Because not long after that, I think things -- everything changed again after that so she never actually returned to the unit.

Q. You tell us at paragraph 5 of your statement that you felt that Letby had involved -- had been involved with many of the collapses and deaths. What did that make you think at the time?

A. It was only after -- when the investigation -- the police investigation we had to look back at stuff for our own -- own statements, that it sort of raised concerns and issues that, you know, there was -- that you were becoming more aware that there was a -- there seemed to be a pattern.

Q. And I'd like to ask you briefly now -- moving on to another topic -- just about debriefs and what was your recollection of debriefs and support following death of a baby back in 2015/16?

A. I know there were -- there were debriefs but I don't know whether it was actually very often with the nursing team involved. I think it's more that the medical team seemed to have the debrief rather than the nursing team.

If it was a scribbled note in the diary saying that there was going to be a team -- a debrief or if a member of the nursing staff had said, "Is there going to be one?" Then it was -- it was then deemed that we were invited. But if you were busy or you couldn't get to them that -- they weren't altered to accommodate anyone, really.

Q. And what's the process now, because you still work at the hospital --

A. I do.

Q. -- so is it a different debriefing process?

A. Yeah, there's more -- we try and organise now with a -- an email is sent out to the team that were involved and anybody -- and everyone is involved in it from Band 4s up to the Consultant in that, so --

Q. Are they compulsory?

A. They're not compulsory, but it's whether -- if you wish to go, but there would be opportunities as well afterwards to speak with -- with other members if you needed to as well. And also we now have -- there's more support with counselling as well.

Q. And you say at paragraph 67 of your statement that you had not received any formal training on how to raise suspicions or concerns other than speaking with your manager.

Were you aware of any other channel or route for raising concerns about a member of staff at the time?

A. Other than going -- you know, going to your manager or to other managers, matrons and that, not --

Q. And what about now?

A. -- not really. There is more -- there is a little bit more concerns and more open -- and that we've -- there's a freedom to speak and there's more being put within the hospital for everybody, so now there is more opportunities to be able to -- to mention these to people.

Q. So if you had a concern today about a fellow member of staff that they were harming babies on the unit, would you know where to go?

A. Yes.

Q. What to do?

A. Yes.

Q. My last question is, what do you think would keep babies safe in hospital from the events that occurred in 2015 and '16?

A. I think we need a more robust way -- policies so that if -- and communications so that if people have these concerns -- without -- without singling out people we need something that's more robust, a policy that can be passed down so that -- to raise these concerns rather than everybody kept in the dark really.

Q. Do you think they should be raised internally or externally, anonymously?

A. I suppose it would have -- internally first but then if it needed to, then externally.

Q. And anonymously or not?

A. Sorry?

Q. Anonymously or not?

A. It would probably have to be anonymously at the start because -- in case -- so nobody is singled out or -- you know, there needs to be a place where somebody needs to be able to say it in a safe space, to -- to mention that, that they have these concerns.

MS LYONS: Thank you, I have no further questions for you. My Lady, do you have any questions?

LADY JUSTICE THIRLWALL: Are there any other

questions.

MS LYONS: No, there aren't.

LADY JUSTICE THIRLWALL: No. Thank you.

Is the plan to change the layout of the room now?

MS LYONS: Yes. Please can we have a break now and then they're going to reconfigure the room and then we have two more witnesses after Mrs Percival-Calderbank.

LADY JUSTICE THIRLWALL: Thank you.

Thank you very much indeed, Mrs Percival-Calderbank. You will be free to go when the room has been sorted out.

How long do we need to move the screens?

MS LYONS: 15 minutes, please.

LADY JUSTICE THIRLWALL: Good. We will start just after half past 3.

(3.17 pm)

(A short break)

(3.34 pm)

LADY JUSTICE THIRLWALL: Ms Lyons.

MS LYONS: My Lady, may Kate Bissell be sworn in.

KATE BISSELL (affirmed)

LADY JUSTICE THIRLWALL: Do sit down.

Questions by MS LYONS

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

A. Katie Anne Bissell.
Q. Ms Bissell you were sent a questionnaire by the Inquiry which you returned dated 19 March 2024. Do you have it in front of you?
A. Yes, I do.
Q. And are your responses to the questionnaire true to the best of your knowledge and belief?
A. Yes, they are.
Q. Ms Bissell, we're going to go very briefly through your career. You qualified as a children's nurse in 2007; is that correct?
A. That's right.
Q. Between 2007 and 2009 you worked as a Band 5 nurse at Alder Hey Children's Hospital in the paediatric intensive care unit.
A. (Nods).
Q. In 2009 you commenced employment as a Band 5 nurse on the neonatal unit at the Countess of Chester Hospital; is that right?
A. That's right.
Q. In 2014 having obtained further qualifications you were elevated to a Band 6 role.
A. That's right.
Q. Six years later, in 2020, you left the Countess of Chester Hospital to become a health visitor.

A. (Nods).
Q. And this year, 2024, you returned to the neonatal unit.
A. That's right.
Q. And you currently work part-time as a Band 6 nurse on the neonatal unit and part-time as a health visitor; is that right?
A. That's right.
Q. I'd like to focus now on the period that this Inquiry is concerned with, June 2016 to -- June 2015 to June 2016 when you were working on the neonatal unit.
We understand from your responses to the questionnaire that this period on the neonatal unit was very busy and stressful for nurses. Can you explain why that was?
A. We were a Level 2 unit and we were just -- we were busy all the time. We just felt like we were at capacity most shifts. We had -- we were supposed to have sort of two Band 6 nurses and some Band 5 nurses and then nursery nurses on the shift but felt at times we didn't run at full capacity and that we were short-staffed, so there were obviously just a lot of pressure to deliver care during that time.
Q. We've heard evidence earlier today that it was busy but manageable. Would you agree with that?

A. I think some shifts were a lot busier than others. I think often staff would work through break times and lunch times. So I think some shifts it was very busy. We'd often stayed behind after a shift to write up notes that we hadn't had a chance to do in the daytime.
And then other shifts were manageable. So I guess that it was sort of peaks and troughs really during that time.
Q. And you also -- I think you said -- in your witness statement to the police at page 2, paragraph 2, you said doctors:
"Were and still are in short supply, so we couldn't always get the support we needed as soon as we needed it. Like everyone on the NHS they're under immense pressure and cover a number of units, departments within the Countess of Chester Hospital."
A. (Nods).
Q. During 2015 to 2016, were you concerned about the lack of doctor presence on the NNU?
A. Not -- not the presence. I just think sometimes on a night shift obviously doctors are covering paediatrics, as we say, obstetrics, A&E, so sometimes maybe if they were stuck over in the A&E department and we'd bleeped them for some support then

there would obviously be a little bit of a delay while they were finishing in A&E before they came over to the neonatal unit. That wasn't all the time. In those instances then we might have to go sort of above and maybe ask for a Consultant to come in.
Yeah.
Q. But if you called them they came -- they came to the unit eventually; is that what you're saying?
A. Yes, yes.
Q. I'd like to turn now to relationships on the neonatal unit starting with the NNU manager, Eirian Powell. In your response to the questionnaire, you said you felt supported by her and you also say that there were staff appraisals, and those staff appraisals you said could have -- you could raise -- you could raise issues outside of your control which may impact on your performance.
So did Eirian Powell conduct those staff appraisals with the nurses on the unit?
A. Eirian -- it wasn't always Eirian, sometimes it's the assistant manager --
Q. Yvonne Griffiths?
A. -- Yvonne Griffiths or the practice nurse, Yvonne Farmer.
Q. And what was your understanding as to the

purpose of these staff appraisals?
A. As an annual update just to make sure that we were up to date with our training, for managers to feedback to us how we were performing, whether they felt there was any improvement needed within our practice or any areas that we would need further training in. It would be kind of an open forum for us to discuss whether we would like to do further training. And then also, you know, any issues that you felt sort of impacted on your care as a nurse for the patients.
Q. If you had any concerns about patient care, patient safety, would you have used this opportunity to raise those concerns or would you raise them separately?
A. I think I probably would raise them separately. I wouldn't wait -- because it was an annual review, if you had concerns about care, I wouldn't have waited until the appraisal to raise that. You know, I'd raise that earlier as the concerns arose.
Q. And you found the environment within the NNU supportive; is that correct?
A. I did. I worked there for 11 years before I left to do my health visitor training and I felt during that time -- although it was busy, I felt, you know, there was a lot of opportunities for learning and development and education. I felt I was supported

through that, you know, from the managers and from the practice development nurse. And I just -- yeah, I just felt I'd always -- I was continually sort of training and developing as a nurse, so I felt that it was a good place to work. I felt supported by my colleagues and I enjoyed it. You know, I really enjoyed my job.
Q. And how would you describe the relationship between the neonatal nurses and the doctors?
A. I think generally good. You know, we generally worked well together. I mean, you know, stress -- you have stressful shifts when may be, you know, people are under a lot of pressure or maybe there's the odd sharp word spoken to one another, but, you know, when everyone's under that much pressure that can be expected. But generally most people got on well with each other and were supportive.
Q. So when you say at your paragraph 4 of your questionnaire that relationships between the nurses and the doctors could be strained, you meant there may be a cross word in the heat of the moment?
A. I meant strained as, you know, in a -- yeah, like a resuscitation or, you know, as a situation where it's sort of highly stressful obviously there's a lot of anxiety and a lot of pressure on people. So I meant strained as in now and again people might have --

I don't know, maybe not speak to people as kindly as they -- as they would have done but generally I think, you know, after that people probably apologise or, you know, generally relationships were -- were okay.
Q. What about relationships with midwives, how was that?
A. I think they was a little bit more strained. I do feel there was probably sometimes sort of difficult relationships. It's hard because they -- everyone's got their own agenda, haven't they, when they're dealing with babies and -- and mums, so I feel sometimes they had their agenda and we had our agenda and communication wasn't always as good as it could be maybe.
Q. So as a shift leader were there occasions when you'd to communicate with midwives?
A. Yes.
Q. And how would that work?
A. We'd often have to go on to labour -- on to labour ward and just -- just explain whether we were open or closed as a unit, sort of how many intensive care babies we'd have at that time, and then the midwives would have to sort of explain to us whether they had any impending deliveries, preterm deliveries, and it was just to try and co-ordinate care that day, make sure that we had enough space for babies to come on

to the unit if they needed it, and whether we'd enough staffing and appropriately trained staff to deal with any impending deliveries.
Q. And were you usually able to find a resolution?
A. Generally, yes. And if not, then obviously that would be discussed with -- with the manager or with the doctors at the time and they'd liaise at a higher level with the obstetric team.
Q. Did you have much involvement with any of the senior management team at the hospital, so above your ward manager, so above, Eirian Powell?
A. No.
Q. Would they visit the NNU at all?
A. Not really, no.
Q. Would you know what they looked like?
A. I knew their faces but we didn't often see them on the unit, no.
Q. You tell us at page 3 of your -- page 3, paragraph 9 of your response to the questionnaire that initially you were not worried about the increase in the number of baby deaths on the NNU and thought that the unit was simply going through an unfortunate time; is that fair?
A. Yes.

Q. Were you aware at the time of the unexpected deaths of Child A, C and D in June 2015? So these are three deaths that occurred within a short space of time in the month of June 2015.

A. I can't remember specifics, sorry.

Q. Were you aware of a time in 2015 where there seemed to have been a cluster of unexpected deaths?

A. Yes, I felt like we -- yeah, I do feel like we'd had an increase to previous years and, as I say, I just felt that we were just having a really awful time.

Q. And was there any discussion on the unit about -- about these unexpected deaths, or did they go along the lines of what you just said, it's just an unfortunate time, it will pass?

A. Yeah, I think it was more of, you know, this is -- this is awful for everybody and it's -- it's an awful time that we're going through hoping that it would -- it would get better, you know.

Q. And then we heard evidence from Dr Rachel Lambie about an occasion when she went to the neonatal unit and she said she was walking through the intensive care unit and she came upon nursing staff in a small huddle in the corner, over the computer, and she said she asked them what they were doing, and one of the

nurses replied that they were going through the rota just to make sure there wasn't somebody who was on "for all of them", I think -- I'm not sure what that was a reference to but maybe the recent events, and Dr Lambie gave oral evidence that she recalled the nurse saying something along the lines of "It's an awful thing to think but we're just looking."

Were you involved in that huddle around the computer? Does that ring any bells?

A. No, I wasn't involved in that, and I don't recall that -- looking at an off -- an off-duty on the computer, did she say?

Q. Well, I think her evidence is that "They were in a small huddle in the corner over the computer and they said they were looking at the rota", do you know anything about that incident?

A. No.

Q. So by the end of 2015, in addition to the deaths of Child A, C and D, Child E had also died on 4 August, and Child I had died in October. Were you aware of those deaths, the latter two, or not specifically?

A. I would -- I can't remember specifically.

Q. Could we, please, have on the screen INQ0017399. Sorry 7339.

So these appear to be notes made by a CQC inspector, Care Quality Commission inspector, during their inspection of the hospital. They're dated 4 March 2016, and if we look at attendees, your name is listed next to Yvonne Griffiths.

Do you recall speaking to the CQC in March 2016?

A. I have -- I have a vague memory of, yeah, chatting with them. I don't remember the details, sorry.

Q. Was it just you and Yvonne Griffiths and the inspector, or was anyone else present, do you remember?

A. I can't remember at the time but I assume, from looking at this, it was just myself and Yvonne and the inspector.

Q. The notes are very difficult to read.

A. Yeah.

Q. But if we look at the summary section at the bottom of page 96, it's the last box, it looks like some of the topics that you covered were staffing, parental feedback, complaints, Pseudomonas, news, vision, fluid balance, care, metrics, plan assessment, executive team support, fundraising events.

Does any of that ring a bell to you?

A. I mean, only -- I used to carry out the care metrics, so I used to do audits on the unit relating to

whether pain assessments were carried out, whether paperwork was up to date, hand washing audits and things is like that, so I can assume that that's what that is alluding to.

Q. So a number of topics were covered. Do you remember whether either you or Yvonne Griffiths mentioned the unexpected deaths that had occurred in 2015 at this meeting?

A. I don't -- I didn't -- I don't -- I can't remember whether Yvonne did, no.

Q. Did you mention it?

A. I didn't, no.

Q. Do you know why you didn't mention it?

A. No, I don't, sorry.

Q. You were asked in your questionnaire whether you had any concerns or were aware of concerns of others about Letby's conduct, and you responded by describing an incident at page 3, paragraph 7. Do you want to just turn that up. So you've described the incident here, but would you -- would you be able to tell us about it?

A. So I was working in a non-clinical role on the unit and I heard a shout for help from Nursery 3, so I went to help and, as I entered the nursery, Lisa -- nursery nurse Lisa was on the right-hand side and there was a baby with Lucy Letby on the left-hand side and the

baby was desaturating -- I can't recall the name of the baby or who the baby was, sorry, but the baby was desaturating and obviously needed some help, so I aspirated the nasogastric tube that the baby had in situ, and then I gave oxygen via a Neopuff to help increase the saturations, and then another nurse came to help, and then another doctor. And then eventually the baby looked like he or she was recovering. And then the other nurse and the doctor who were actually on shift at the time then took the baby into Nursery 1 and took over the care of that baby.

Q. And I don't think you say in your questionnaire, but do you remember which nursery this baby was in?

A. It was in Nursery 3.

Q. It was Nursery 3. So a desaturation of a baby in Nursery 3 and a transfer to Nursery 1 --

A. Yes.

Q. -- would that have been a sort of significant event for a baby in Nursery 3?

A. I think the baby would -- yeah, would have been moved into Nursery 1 for more closer monitoring just to make sure that that didn't happen again.

Q. And after this incident, you were -- I think Lisa Walker came to speak to you, didn't she?

A. Yeah, it was just -- yeah, just very briefly afterwards she just -- she said was concerned that she'd asked Lucy if she needed some help and Lucy said, no, she was okay. But Lisa -- Lisa couldn't help herself because she was in the middle of a feed, she couldn't leave her baby, so Lisa was obviously concerned that -- she felt the baby needed help but Lucy hadn't actually asked for help herself.

Q. And did she say anything about how -- what Lucy said to her after the child had been transferred to Nursery 1? Did she say anything to her about calling for help?

A. I think I remember she said something about she felt like she'd been told off by her, I think.

Q. And at this stage Lucy was a Band 5 nurse; is that correct?

A. Yes.

Q. So would you have expected a Band 5 nurse to call for help if a baby is desaturating or collapsing?

A. I think any nurse, no matter what band you are, should shout for help if they feel a baby is compromised and needs further assistance.

Q. Do you remember whether -- do you have any idea when this incident happened?

A. I can't remember, I'm sorry.

Q. Do you think it happened during the time frame June 2015 to June 2016?

A. I can't remember, I'm sorry.

Q. Do you remember whether you discussed this incident with either Yvonne Griffiths or Eirian Powell afterwards?

A. No, I didn't.

Q. You tell us at paragraph 9, page 3 of your questionnaire, that once you heard that Child O and Child P had died you were very shocked, and what were you -- did you have any concerns at this stage about either their deaths or the deaths of the unexpected deaths that had been happening, after death of Child O and Child P?

A. I was just -- I was very surprised that they had passed away.

Q. Did that surprise lead you to be concerned about what was happening?

LADY JUSTICE THIRLWALL: We can take a moment. It's probably best to continue if you can, rather than stopping, but if you want a break just say.

A. Sorry. Just that I'd attended their delivery and they were -- seemed well, needed some intervention but were seemingly doing really well. So I think I'd attended their delivery but only looked after them for

one shift, and I didn't look after them again, but I was surprised to hear that they'd passed away.

I didn't know why, I -- I didn't know how they -- you know, what had happened and why they had passed away but it just struck me as odd that they had been so well and then they passed away.

Q. In the questionnaire we asked you whether you had any concerns or suspicions about the conduct of Lucy Letby while you worked on the NNU, and your reply was:

"Not until two of the three triplets had died and Lucy was moved off the unit to work in a non-clinical role."

A. (Nods).

Q. So at that stage, after the death of the Child O and death of Child P, what were you thinking? What were your concerns at that stage?

A. I just wondered what had happened. We were obviously told when -- they gave a reason why Lucy was moved off the unit, and that was to -- to a secondment but it just didn't seem to fit. I don't know, it just didn't seem right.

Q. Let's --

A. It just seemed strange to me that somebody would be moved off clinical -- you know, from a clinical

area to move -- and moved to work in a non-clinical area. That ...

Q. I'm going to pull up the email about Lucy's move, but prior it that I'm going to pull up another email that hopefully you've seen. Please can INQ0002879, page 91, be brought up.

So before Letby was moved from the unit, this email was sent by Yvonne Griffiths about undertaking a period of clinical supervision. Do you recall receiving this, reading it at the time?

A. I can't remember seeing it at the time.

Q. Was there any discussion about the NNU nurses having to undergo clinical supervision? Do you recall that?

A. I can't remember. I can't remember, it was so long ago.

Q. Can I -- it's the same document reference but it's page 75. Can we, please, bring that one up.

So this is what you were referring to a moment ago when the staff were informed that Letby would be seconded to the risk and patient safety office. Do you remember receiving that email or hearing this news at the time?

A. I remember hearing -- I can't remember reading the email but I can remember hearing that that was the

reason that she had been taken off -- away from the clinical area.

Q. And what was your feeling at the time? Did you think this was a genuine reason or did you think something else?

A. It didn't really make sense to me, but I just had to go with what we were told from -- from the management. So ...

Q. And when you say it didn't make sense to you, in what way didn't it make sense to you? I know it's really hard to put into words but it would help.

A. That I know Lucy liked to worked clinically, so I think for her to be to -- move away from the clinical area into a different area I was just quite surprised at that.

Q. And were you the only one who was quite surprised by that?

A. I don't know.

Q. Did you have any chats or discussions with your colleagues about this email or about this news that she would be seconded?

A. I mean, maybe we were wondering if there were other reasons why she'd been moved but I don't -- I can't recall properly.

Q. Can you, please, put up INQ0058624, please.

So August you got the email -- or in fact Letby was already on her secondment when that email was sent, and now fast-forward to January 2017, and this email was sent by Letby. Do you -- do you recall receiving this, reading this at the time?

A. Vaguely, yes, yes.

Q. And what were your thoughts on receiving it? What did you think?

A. Just --

Q. Sorry, go ahead.

A. No. I mean, it's awful. Just I remember thinking it's awful to -- to be -- have allegations like that against you, but then she never back to the unit, so it just all --

Q. What did you think the allegations related to?

A. Related to probably -- they were related to the higher incidence of deaths --

Q. Is that what you thought at the time?

A. -- that were occurring. Possibly, yes.

Q. Is that what you were told?

A. We were never -- we were never told anything, other than -- I felt like the nursing staff were never really told why -- what was happening. We were just told that she was removed from -- from the unit, she went to the risk and safety department, and then

obviously we had this email to say that there were allegations made against her. So it kind of fitted that obviously she was moved at the time and then obviously allegations had been made, so it --

Q. Did you have any understanding as to who was making the allegations?

A. No.

Q. Did you have any understanding as to precisely what the allegations were?

A. No.

Q. Were you concerned about Letby coming back on to the unit?

A. I can't -- I can't remember what I thought at the time. I don't know. She never did come back.

Q. Had you been in touch with her while she had been off the unit?

A. No, I don't -- I was a colleague of Lucy's but I didn't -- I wasn't friends outside of work with her, so I wouldn't have communicated with her outside of work.

Q. You say you had no -- in your questionnaire at page 2, paragraph 5 -- that you had no specific training regarding reporting concerns of fellow members of staff. What would you have done in 2015/2016 if you did have concerns that a nurse was harming babies on the unit?

A. In the first instance, you would go to your manager and speak to her about it and then --

Q. Speak to?

A. The manager. The unit manager, yeah.

Q. Would you do anything else?

A. Well, I think you'd have -- you'd be led -- hopefully, you'd be led by the manager, wouldn't you, then of how -- how you would report it. I mean, I know we've talked about safeguarding before but I think our training for safeguarding is more -- we've always thought of it as safeguarding babies and families on the unit rather than safeguarding staff.

But, you know, obviously if I'd have seen think malpractice then I would have reported that to maybe the clinician -- the doctors at the time or definitely the manager and hopefully that would have been escalated.

Q. So you returned to the unit this year.

A. (Nods).

Q. And is there a different process that existed before on -- or what is the process for reporting concerns about a fellow member of staff, is there a process?

A. I don't think there's any other process other than you're encouraged to fill out Datix -- Datixes or -- it depends how serious it, does doesn't it?

Obviously if it's --

Q. And when you returned in 2024, did you have any safeguarding training or any additional training that covered this issue of harm from fellow members of staff?

A. No.

Q. And when did you start in 2024?

A. January 2024.

Q. You say that -- at page 3, paragraph 9, you refer to the need for managers to take concerns seriously when they're raised with them and to take appropriate action.

And I just want to clarify with you. Did you raise any specific concerns with managers or senior managers at the hospital?

A. No, but that was talking about what -- on reflection what has happened and, I mean, obviously as nursing staff we didn't know that concerns were being raised from the doctors and above --

Q. So you're referring to doctors --

A. -- so obviously it's -- on reflection it's referring to that, you know, that --

Q. To the doctors' concerns?

A. Yeah.

Q. And what do you think -- this is my last

question -- what do you think would keep babies safe in hospital from the events that occurred?

A. It's really hard -- really hard to say, isn't it? But, you know, obviously training, like you said, about people reporting. I know there's talk of CCTV on units. I don't know whether that would be something that -- that would help. It's a difficult environment, isn't it, to have CCTV in place when you've got mothers and doing kangaroo care and breastfeeding and things like that? But ... I don't know if that's something that made parents feel safer leaving their babies in the care of neonatal unit, then maybe that's something that could be looked at.

In Chester we do now encourage, you know, every cot side has a bed for the parents to stay, so we do encourage parents to stay as often -- you know, as often they as they want and -- or as often as they can. So I -- and just encouraging transparency, really, so that people feel they can raise issues and that they'll be listened to.

MS LYONS: Thank you. I have no further questions.

A. Okay.

MS LYONS: My Lady, there are no other questions unless you have any.

LADY JUSTICE THIRLWALL: Thank you very much

indeed, Ms Bissell, you are free to go.

MS LYONS: The next witness is Elizabeth Marshall.

LADY JUSTICE THIRLWALL: Good afternoon, Ms Marshall, you're just about to be asked to take the oath.

ELIZABETH MARSHALL (sworn)

LADY JUSTICE THIRLWALL: Do sit down.

Questions by MS LYONS

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

A. Elizabeth Marshall.

Q. Ms Marshall, you were sent a questionnaire by the Inquiry, which you completed. It's dated 18 April 2024. Are your responses to the questionnaire true to the best of your knowledge and belief?

A. Could you speak up a bit, sorry?

Q. Sure, yes, I can.

A. Thank you.

Q. Are your responses to the questionnaire that was sent to you true to the best of your knowledge and belief?

A. Yes, they are.

Q. You have been employed by the Countess of Chester Hospital since 2004 initially as a healthcare assistant on the postnatal ward and the labour ward; is

that correct?
A. That's correct.
Q. By 2005, you were working as a neonatal assistant on the NNU; is that correct?
A. Yes.
Q. Can you tell us, please, the difference between a neonatal assistant and a neonatal practitioner or a senior neonatal practitioner?
A. A neonatal assistant is Band 4. We're not trained specifically as the trained neonatal nurses are, so we have -- some of us have a base training of what used to be called nursery nurse, and also it's learning on the job, and very much training and -- within the actual neonatal unit and externally as well.
Q. And between 2015 and 2016, there was a change to your role; is that correct? Were you now working across the neonatal unit and the transitional care unit?
A. Yes, I did work in transitional care as well previously but it sort of varied really dependent upon workload on the neonatal unit.
Q. And can you just explain what the transitional care unit is?
A. Transitional care is between neonatal unit care and ward care, so for those babies who might need extra support with feeding or be premature, or for some

reason need further support with feeding or -- so it just meant mum and baby could be together, and if they didn't need any respiratory support or monitoring of any sort then we could hopefully accommodate them under that umbrella of transitional care.
Q. And where was that unit located?
A. Normally on the ward -- in the postnatal ward.
Q. Now, I'd like to ask you about relationships within the unit in 2015 to 2016 starting with your managers. How would you describe your relationship with your managers Yvonne Griffiths and Eirian Powell?
A. In retrospect, I felt my personal relationship with them was -- was good. I had quite a lot of personal stuff going on and they were very supportive throughout, and it did occur sort of the 2015/2016 time as well.
Q. What about with your nursing colleagues, the Band 6 nurses, the Band 5 nurses, the other Band 4 nurses?
A. Generally I think our sort of relationships were pretty good. I think there's a -- always a variety of people you feel are colleagues rather than -- or people you're particularly close to and it's that sort of variable with the people you work, so ...
Q. And just -- you worked -- can you just tell us

which nurseries you worked in?
A. Sorry?
Q. Which nurseries on the unit did you tend to work in?
A. It tended to be 3 and 4, occasionally Nursery 2. But less -- less so Nursery 1 because that would be ITU and HDU.
Q. Did you have much involvement with midwives at the hospital?
A. Occasionally. Occasionally sort of going through to labour ward or transferring babies back up to postnatal ward.
Q. And how would you describe that relationship?
A. I think it's better now than it used to be. Potentially I think it was more them and us, but now I think it's a lot more integrated -- sorry, I'm not answering the question, am I?
LADY JUSTICE THIRLWALL: We can probably guess but (inaudible).
A. Yes.
MS LYONS: And what about relationships with doctors, did you have much involvement with the doctors on the unit?
A. Not a lot. It would tend -- I mean, we -- we had our own workload, but decisions would tend to go

between the doctors and the trained nurses. So would be around on ward round or if they're there, you know, but --
Q. So if you had any concerns about a baby in Nursery 3 or 4, who would you direct those concerns to?
A. Initially the shift leader and then if it needed escalating they would do that.
Q. At paragraph 6 of your questionnaire you were asked if you had any concerns or suspicions about Letby's conduct while you worked on the unit. And I'd like to ask you about the second paragraph underneath that question, where you said:
"After the death of the first five babies, I thought about how Lucy Letby was involved in the care of all those five babies. I know it is circumstantial but that was my recollection at the time. Also, despite having a horrendous shift, Lucy Letby [was] always happy and almost requested to go back to Nursery 1 with Intensive Care babies and wanted to be with all the sicker babies. I recall other members of staff stating that Lucy Letby wanted to be in Nursery 1 and that was what I found odd. I can't recall the names of staff who spoke about this. Surely in my view, after a horrific experience, you would want to be out of the scene to regroup and reflect."

I'd like to sort of unpack that response.
Can you -- when you say "the first five babies", are you talking about the babies in June that died, the three babies in June that died or -- what is your sort of -- your reference point? What are your first -- I'm not sure what you mean by "first five".
A. I think I'm referring to the first five deaths that I was actually on shift for. I struggle --
Q. Was this in 2015 or 2016 or some other time?
A. I struggle to give a timeline. It was -- it was probably the first five deaths at all -- you know, that -- that were -- sorry, I feel it was the first actual five deaths that occurred.
Q. So the unexpected death of Child A, Child C, Child D, Child E and Child I, is that what you think?
A. I think so.
Q. Given you worked in the outside nurseries or nurseries 3 and 4, and occasionally 2, how did you become aware of Letby's involvement in these unexpected deaths?
A. Generally if there was a trauma situation going on, for example in Nursery 1, then the trained staff would move into help with that situation and the Band 4s would be monitoring the outside nurseries ensuring babies are fed and observations are done, so

keeping everything else going, so were -- the actual physical unit then was quite compact, so it was very easy to become aware that there was a major event going on.
Q. So if I just understood your response correctly, you became aware by seeing her; is that what you're saying?
A. By what, sorry?
Q. By seeing Letby there and involved in these deaths?
A. Seeing?
Q. Letby on shift when these babies died. Is that how you knew she was involved?
A. Oh, knew Lucy was involved? It was my impression that she was always in -- yes, she was always involved with what was going on when there was a major collapse.
Q. How did you form that impression?
A. How did I?
Q. How did you come to think that?
A. I think it was my observation.
Q. Were there any discussions taking place on the unit between the nurses about the unexpected deaths and/or collapses and Letby during this time?
A. Not that I recall.

Q. Did you share your thoughts with anybody on the unit?
A. Initially, no. I think I just kept my thoughts to myself because I was an untrained member of staff and maybe just felt that it wasn't appropriate to say or --
Q. How did you know that Letby always wanted to get back into Nursery 1?
A. That was something I was aware through -- then through conversations I'd heard at a latter time, not specifically at that time in 2015.
Q. Do you know when you became aware of that?
A. Not specifically, no.
Q. Was there anything about Letby's demeanour, conduct, anything she said that you recall that struck you at the time?
A. She was quite a closed individual, maybe quite superior, I think liked being in amongst the higher grade staff.
Q. Did you work with her?
A. Pardon?
Q. Did you sometimes work in the same nursery?
A. I don't really recall working -- actually working alongside her. I've worked many shifts with her, but not specifically with her, because it was quite

rare that she was in the outside nurseries.
Q. And during this period, you say the first five deaths and -- were you getting concerned?
A. Yes. I do recall having that thought of I suppose Lucy was the one common factor who had been on shift, but that was just my thought.
Q. Did there ever come a point where you sort of articulated that thought with your manager -- shared your concern --
A. No.
Q. -- with your manager?
A. Regrettably no. But I think it's quite a leap to have a thought about something and then to take that leap to think: what if harm's being done?
Q. Did you share it with anyone else on the unit?
A. Pardon?
Q. Did you share your feeling, your thinking with anyone else on the unit?
A. No.
Q. I'd like to take you to three emails. The first email the reference is INQ0002879, page 91, please.
Do you recall receiving this email?
A. I don't recall.
Q. Do you recall any discussion about staff

undergoing clinical supervision?
A. I really struggle to recall any of the -- this -- this email and any sort of discussions that went around that.
Q. Do you recall when Letby was taken off the unit?
A. Vaguely, yes.
Q. And do you recall any discussion either with your nursing colleagues or with your managers about the reason she had been removed from the unit?
A. No. I -- I remember that she was placed in a non-clinical role but not really specifically why that was being done.
Q. So if we just stay on that document but go to page 75, please, this is another email that you might have received. Do you remember receiving that or having a discussion about that?
A. Not really, no. Again, a vague -- a very vague memory, but not -- not specifically, no.
Q. So when you got the third email, assuming you got it -- so this is INQ0058624 -- do you recall receiving that email?
A. No.
Q. Do you recall being told that Letby would be returning to the unit?

A. I -- yes, I do remember conversations of the fact that she was due to come back.
Q. And do you think it was around this time, January 2017, or it's just hard to --
A. Possibly, yes.
Q. And what were your feelings about that -- given you had made a correlation in your mind that you hadn't shared, how were you feeling about her return to the unit?
A. I really struggle to recall my -- my sort of feelings about it. I think having had that thought initially of the fact that I felt, you know, there was that correlation between Lucy being on the first -- involved with the first five deaths, I don't think I'd gone much beyond that. So, therefore, not necessarily relating harm being done to Lucy.
Q. So you had made an association but that's where it ended; is that correct?
A. At that time, yes.
Q. But you were still concerned about the association?
A. Yes.
Q. And in 2016, there were further deaths, and we've heard about obviously the death of Child O and Child P., had you associated her with those deaths as

well, or were you unaware of her involvement?
A. I find it hard to remember. Yeah, I just find it very hard to remember.
Q. I'd just like to go to something you said earlier. You formed the view that Letby liked being in amongst the higher grade staff, so I guess the Band 6 nurses. What gave you that impression?
A. Just from my observations being at work and I know she had a friend or two that were senior nurses, so that's --
Q. How did you know these senior nurses were her friends?
A. Because they spent time outside of work together and did quite a lot of things together outside of work.
Q. And how did you know that?
A. Because it was just -- that was just general knowledge.
Q. Were you aware about how to raise concerns about a fellow member of staff at this time?
A. I think I would have spoken to my manager had I had -- you know had I -- yeah.
Q. Did you have a good relationship with her?
A. Yes -- yeah, I feel I used to have a good relationship with her.

Q. But you still didn't feel you could share what you were feeling back in 2015 with her?
A. Possibly. Again, I think as -- as a untrained member of staff I -- I don't know if I'd have felt -- not felt it right to say anything, but felt it appropriate, you know, yeah.
Q. And if you were to suspect a member of staff today, someone you were -- a colleague that you worked with was harming babies, what would you do?
A. I'd speak to my manager.
Q. And are things different now than they were in 2015/2016 --
A. Yeah, I think so.
Q. -- which would make it easier for you to speak with her?
A. I think so. I think there's a lot more -- there's a lot less segregation between, sorry, manager and doctor, and I think it's encouraged -- being encouraged to speak up is --
Q. And how are they -- like, how do they -- how are they encouraging staff to speak up? Can you think of an example?
A. The managers?
Q. Yes.
A. Just by their approach and the way they are

with the staff. I think they make us feel -- well, make me feel that if I did have any issues, concerns that I could approach them confidentially and speak to them.

Q. So this is what they're saying on the unit to staff, so that's why you know you could, is that right? Is that what you're saying?

A. Currently?

Q. Currently.

A. Yeah, I would feel that it would be -- I would feel more able to go and speak to management now if I had concerns.

MS LYONS: Thank you. My Lady, I have no further questions for Ms Marshall and I don't think anyone else does.

LADY JUSTICE THIRLWALL: No other questions. Thank you very much indeed, Ms Lyons.

Ms Marshall, thank you very much indeed for coming to give your evidence. You are free to go now.

And that concludes the evidence for this afternoon.

MS LANGDALE: That concludes the evidence for today, my Lady.

LADY JUSTICE THIRLWALL: Very good. And for the week. So we will rise now and reconvene on Monday morning at 10 o'clock.

(The Inquiry adjourned until 10.00 am,

on Monday, 14 October 2024)

I N D E X