Thirlwall Inquiry

THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE – MIDWIVES

Name: Deborah Moore
Role as per Countess of Chester 2015-2016 Staff List: Midwife
Enclosed documents: Witness statement dated 21 February 2018 (INQ0001011)

Questionnaire

Midwifery career and employment at the Countess of Chester Hospital ("the hospital")

1. Please provide a short summary of your midwifery career. This summary should include at least the following information:

    a. when you qualified as a midwife, including the educational institute or awarding body;
    b. your midwifery qualifications, including your midwifery band from 2015 to the present;
    c. details of your previous and current employment.

I am a Band 6 Midwife currently working in the maternity unit at The Countess of Chester Hospital. I qualified as a midwife in October 2004 following successfully completing a 3 year degree at Liverpool John Moores University. All of my placements during the degree were based at The Liverpool Women's Hospital. After qualifying as a Midwife I continued to work at the Liverpool Women's Hospital until September/October 2009 when I worked for a company called 1-2-1 midwives which is a private company who aimed to provide the same service for expectant parents as the NHS. I worked for them for 6 months to help set up the business.

In April 2010 I began working at The Countess of Chester Hospital and have worked on the antenatal/postnatal ward, labour ward, community and antenatal clinic. I am registered on the Nursing & Midwifery Council where I hold registration number I&S

2. Did you have any management responsibilities of any kind within the Countess of Chester hospital between 2015 and 2016?

I did not hold any managerial roles at The Countess of Chester Hospital between 2015-2016.

The culture and atmosphere on the NNU at the hospital in 2015-2016

3. Please explain the extent to which you carried out work on/in connection with the neonatal unit (the "**NNU**") between 2015 and 2016, or any other situation in which you worked alongside nurses or clinicians based in the NNU.

My only interface with the NNU between 2015 - 2016 was to take handover of babies returning to the postnatal ward or perhaps taking a patient to visit her baby on NNU.

4. How would you describe the quality of the management, supervision and/or support of midwives who carried out work on/in connection with the NNU between June 2015 and June 2016?

As a midwife I have never worked on the NNU, all my practice was on The Maternity Ward. As most of the interface with staff on the NNU was handover of babies supervision/management or support was never required in my situation. I was aware that supervision/management or support was available from Shift Leaders or Ward Manager if required.

5. How would you describe the relationships between: (i) clinicians and managers; (ii) nurses, midwives and managers; and (iii) between medical professionals (doctors, nurses, midwives and others) at the hospital between June 2015 and June 2016?

We regularly have Multidisciplinary meetings and debriefs following unexpected situations or high risk cases. These meetings would involve, Matrons, Consultants, Registrars, Shift Leaders, Midwives and Neonatal Nurses (if a baby was involved)

6. How would you describe the culture on the NNU between June 2015 and June 2016? Please feel able to compare it (for good or bad) with your experience elsewhere.

I didn't work on the NNU between June 2015 - June 2016 and have never worked on the NNU. However, my relationship on the maternity ward with the Multidisciplinary Team was good, I felt I was supported and listened to by the Consultants, Doctors, shift leaders and management team.

Concerns or suspicions

7. Were you given any training on how to report concerns about fellow members of staff? When? If so, how were any concerns to be reported?

Yes, I have had training and am aware of processes such as Datix incident reporting and Whistleblowing. Please see below training completed relevant to reporting concerns about fellow members of staff:

- Datix Incident reporting is part of the Corporate and Local Induction which I completed – April 2010
- Recording clinical observations & escalating abnormal records competency – May 2010
- Conflict Resolution Training - April 2014
- Equality, Diversity & Human Rights - July 2014
- Safeguarding Children Level 3 - August 2014
- Preventing Radicalisation – November 2014

From what I can remember any concerns to be reported between 2015 onwards where to be reported as always through Datix Incident Reporting or if this was not suitable or feasible to do so, there was the option to use The Freedom to Speak Policy (I am not sure whether it was called this at the time) and report to a higher ranking person.

8. Did you have any concerns or suspicions about the conduct of Lucy Letby ("**Letby**") while you worked as a midwife in connection with the NNU? If so, what were your concerns or suspicions, and did you raise them with anyone, either formally or informally?

No.

9. Were you aware of any suspicions or concerns *of others* about the conduct of Letby and, if so, when and how did you become aware of those concerns?

It was only brought to my attention through media coverage.

10. Were you ever aware or worried about the increase in the number of deaths on the NNU? If so, when was this and what did you think?

I was aware there were increasing numbers of babies dying, as a midwife on the postnatal ward we deal with the grieving parents. Unfortunately I can not recall exactly when I became aware

11. What discussion was there (formal or otherwise) with or between midwives after the death of a baby at the hospital?

Following the death of a baby on The Maternity Ward, a debrief would take place involving the members of staff involved to reflect on the events and offer support to the members of staff involved. A 72 hr review would also take place, this is a Multidisciplinary Team including, Consultants, Doctors, Midwives.

12. How were deaths on the NNU investigated? Did midwives participate in any investigation? If so, how? If not, why not?

I am unsure how the deaths of the babies on the NNU were investigated, I personally did not participate in any investigation apart from a police statement I was asked to write involving a baby that was transferred to the NNU following a premature delivery – this baby was part of the Lucy Letby inquiry that was admitted to the NNU. As Midwives do not work on the NNU I would not expect midwives to participate in investigations.

13. When did you first hear it being said that Letby was present at the time of unexpected collapses and deaths of babies on the NNU? Please explain your answer and provide dates if possible.

I only heard through the media when it was public knowledge following her arrest, I am unsure of these dates.

Reflections

14. Do you think if the babies had been monitored by CCTV the crimes of Letby could have been prevented?

CCTV maybe a positive move for parents to regain confidence at The Countess of Chester. However, this could also have an adverse affect for staff, they may feel nervous knowing they are being watched which could lead to mistakes.

15. What recommendations do you think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff?

One recommendation maybe to enquire and interview members of staff regularly see if there have been any changes in their personal life?

Any other matters

16. Is there any other evidence which you are able to give from your knowledge and experience which is of relevance to the work of the Inquiry?

No.

17. Please review your previous statements attached. Do you consider that these are accurate or is there anything in them that you would wish to amend? If so, please provide details.

I have reviewed my previous Police statement dated 21/02/2018 which is accurate.

Signed: Personal Data

Full Name: DEBORAH MOORE

Dated: 15/3/24