Thirlwall Inquiry

THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE – MIDWIVES

Name: Stephanie Terry
Role: Midwife
Enclosed documents: No documents provided

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 qualified as a midwife in September 2011 from the University of Chester with a BSc (Hons) in Midwifery. Once qualified I started working for Ashford and St Peters Hospital in Chertsey, Surrey as a band 5 rotational midwife working on the antenatal and postnatal ward and the labour suite in April 2012. I did my preceptorship there and subsequently obtained a band 6 after one year in the same job role. In April 2014 I moved trust, to the Countess of Chester Hospital as a band 6 rotational midwife, working between the labour suite and the antenatal and postnatal ward. I left the Countess of Chester Hospital in September 2016 to work for the trust I still work at now- West Suffolk Hospital in Bury St Edmunds. I was a community midwife band 6 for the first six years, then later a continuity of care midwife and I now work as a band 6 clinical educator midwife since June 2021 (currently on I&S).

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

No.

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.

As a registered midwife, we can work in conjunction with the neonatal team as part of our role; from memory, I cannot remember any specifics.

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?

The question is not specific to my role as a rotational midwife, not having worked on the NNU.

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?

The question is not specific to my role as a rotational midwife, not having worked on the NNU.

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.

My role did not encapsulate what it was like to work on the NNU, as I did not work there.

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?

From memory, I was not given any specific training on how to report concerns regarding other members of staff, however, I was aware to report incidents via the 'Datix' system (which is an online incident reporting system).

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?

I have no memory of Lucy Letby.

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?

No, I have no recollection of that.

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?

From memory, I believe I first heard it on the news. At the time I didn't have any specific concerns given that the NNU's care for poorly babies.

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

From memory, I cannot remember any discussions had between midwives following baby deaths on the NNU.

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

Between 2015-2016 I was not involved in any 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 was not involved in any discussions, nor did I have any knowledge of any discussions had about Letby being present at the time of unexpected collapses of babies or the deaths of babies on NNU.

Reflections

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

Possibly CCTV could be used as an aid to safeguard staff and the public if it cannot be obstructed.

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

As a clinical educator for student midwives, I feel that the inquiry should investigate the practical element of when students study to become nurses. In my experience, behavioural or personal attributes can be difficult to 'fail' a student on, this, in my opinion, needs to change. We need to ensure that students are safe to be working with vulnerable babies and people, going back to basics with recruitment and education.

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.

Signed: _ Personal Data

Full Name: Stephanie Blenkhorn (Previously Terry)

Dated: 11/03/2024