THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE – MIDWIVES

Name: Susan Brookes
Role as per Countess of Chester 2015-2016 Staff List: Midwife
Enclosed documents: Audio recorded witness interview dated 26 March 2019 (INQ0007671)
Witness statement dated 2 April 2019 (INQ0000227)

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;

   I qualified as a Midwife from Chester University in 2008 and started my employment at the Countess of Chester Hospital.

   b. your midwifery qualifications, including your midwifery band from 2015 to the present;

   My Qualification is a Diploma in Higher Education in Midwifery.

   In 2015 I was a Band 6 Midwife, I completed two separate 6th month developmental posts, gaining experience as a Labour Ward Shift Leader in 2015/2016 – prior to securing a permanent Band 7 Labour Ward Shift leader post at interview in 2017.

   c. details of your previous and current employment.

   Current employment – Countess of Chester Hospital – (2008 to Present)
   Previous employment – Cheshire County Council (1987 to 2005)

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

   No, I was employed a Band 6 rotational midwife.

When I did my developmental post gaining experience as a Labour Ward Shift Leader, I was coordinating the labour ward and out of hours and did not have any management responsibility.

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.

   Between 2015 and 2016, as a rotational midwife I would be allocated to work on Central Labour Ward, Antenatal/Postnatal ward and I was also part of a small group of midwives trained to work within the Maternity Day Unit.

   If I was working on Labour Ward and a baby required any care or observation on the Neonatal Unit (NNU) immediately following birth, the baby may have been transferred to the unit by the Neonatal team, I would

complete a Situation, Background, Assessment and Recommendation (SBAR) handover to a member of the NNU team, this is a recognised tool we use in medicine to give a clear and concise handover, and would detail any relevant risk factors from the mothers pregnancy, labour and deliver.

When working on the Postnatal Ward a Nursery Nurse from NNU would be allocated to the wards Transitional Care room. This was a three bedded bay and may include, for example, babies who were slightly premature requiring additional observation, feeding support, temperature monitoring, or phototherapy. As midwife I would be caring for the mother and the Nursery Nurse would be responsible for the care of the baby – in these situations I liaised with the Neonatal Nursery nurse who was caring for baby.

If a baby was being cared for on NNU – Mum may be staying in a single room on the Postnatal Ward. If mum was unable to mobilise independently then a member of ward staff (on occasion a midwife) would transfer mum to the NNU in a wheelchair to feed and spend time with her baby.

At that time any baby on IV antibiotics had to be transferred from the ward to NNU each time their medication was due, as the drug and dose required checking by 2 of their registered nurses.
On occasions that the parents or a member of Neonatal Staff were unable to transfer the baby – they sometimes asked a Midwife or a Midwifery Assistant to take the baby to the unit. I cannot recall if I did this, as during this time period, I had completed 6 months experience as a labour shift leader, then went back to being a band 6 midwife.

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?

I did not work on NNU at all so I cannot comment on the quality of the management, supervision and support.

I had little to do with Neonatal Unit management as I didn't work there, however, I can only recall that staff I encountered were professional and supportive in my limited encounters.

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?

As part of my developmental shift leader role, I regularly liaised with the Neonatal doctors and allocated NNU Shift Leader to inform them of any high-risk women on labour ward whose baby may require NNU care – at or following delivery.

I would also call them to attend any deliveries which required them to be present, for example: Pre-term births, Instrumental Deliveries or Emergency Caesarean Sections.

I do not recall having any personal concerns relating to relationships between the above staff groups. I feel that everyone communicated well with each other and worked as a team as far as I was aware. I only observed people working well as part of multi-disciplinary team. Everyone worked hard as part of a team, knew someone people more than others as when a student worked 2005-2008 as I trained at COCH as well. So older members of staff I knew better.

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 do not recall witnessing or hearing of any examples of poor culture on the NNU. I didn't work on NNU unit and it's a different department and ward. I could go weeks without being in the unit as it was not the unit I worked on.

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?

   Training in how to escalate and report any concerns about fellow staff members was disseminated as part of mandatory study days, via training modules, emails and campaigns (such as the 6 'C's which were the core values of the Hospital at the time: Care, Compassion, Commitment, Courage, Communication and competence).

   The Hospital has always done yearly training days and we still do now, whereby we must complete mandatory training every year within a timescale. There were visible posters on notice boards making sure people knew how to escalate concerns. We now have a freedom to speak up champion but cannot recall whether we had the equivalent during 2015-2016.

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 did not have any concerns or suspicions about Lucy Letby's conduct.
   I didn't know Lucy at all well, I don't recall ever working with Lucy, I may have handed a baby back or handed one to her, but I can't say for certain.

   In my previous interviews, as I mention I was caring in the evening for the mother of a baby (Child E), I took the mother down to the Neo-Natal Unit to say that the baby had deteriorated. We had to wait in the corridor, and I remember being upset and I didn't understand why the mother couldn't go straight into the ward. I questioned a staff member afterwards why the mother couldn't go on the ward. I couldn't recall if this was Lucy that I spoke with. I felt based on the notes that it may have been, but it was a long time ago. I don't recall raising any specific concerns at the time.

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?

   I was unaware of any suspicions or concerns of others in relation to Lucy Letby's conduct.

   I recall that at the end of a Midwifery study day in 2016 our managers informed us that the police had been asked to investigate the high number of baby deaths on the NNU – however, no one was named as being under suspicion.

   I also recall hearing that a Neonatal Nurse had been moved to work in a non-clinical area - I cannot remember who I heard this information from.

   At some time in the following weeks or months – I remember hearing that Lucy Letby had been moved to work in the 'Risk Team' and as a result assumed she was the staff member under suspicion.

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 remember being worried and concerned about the high number of deaths in 2016. This was when I was undertaking my developmental Band 7 Labour Ward Shift Leader role. I was the shift leader on a day shift when two of the three triplets died within a short period of time, I recall hearing that the transport/transfer

team were present when the second baby died and that the parents had requested that the third baby to be transferred to another unit.

I also recall that day that a decision was made to halt any elective Inductions of Labour and not commence any new Inductions at that time. I don't, however, recall who this decision was made by.

I remember feeling incredibly upset and shocked at the recent events and that morale was becoming increasingly low.

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

    If a baby died on Labour Ward during labour or immediately following delivery, a senior review would take place. This would be led by Obstetric Consultants, Midwifery Managers, Neonatal Nurses and Neonatal doctors. The Risk Team and any midwives involved in the care of the woman and baby may have been invited or requested to attend.

    The review would involve a review of pregnancy history, labour and immediate care of the newborn, for example – resuscitation.

    If a midwife raised a concern or needed support following any particular event – we could speak to any of the midwifery management team, a member of the Obstetric Team or our named Supervisor of midwives.

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

    I was not aware how deaths on the NNU were investigated at that time.
    I am unaware of Midwife participation in NNU 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 think that around the time Lucy Letby was moved to work away from the NNU lots of different staff members started to assume she was involved in the investigation but I can't recall specific conversations.

    It was communicated via email to all staff that we must not discuss any events in relation to the live police investigation and to remain respectful to the parents and professionals.

    I think the confirmation of Lucy being present came when she was arrested for the first time – I am unsure of the dates.

Reflections

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

    I would hope that CCTV would be a deterrent and stop anyone planning to commit a crime.

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

    Senior level management should always listen to and act appropriately when any staff member or parent raises any concerns.

    Everyone should be assured that any patient safety or concern relating to care will always be taken seriously and fully investigated.

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, I do not think so.

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 do consider my attached statements to be accurate.

Signed: Personal Data (Previously BROOKES).

Full Name: SUSAN PATRICIA MORTON.

Dated: 20.03.24.