Witness Name: Lisa Ann Walker
Statement No.: 1
Exhibits: 4
Dated: 25/03/24

THIRLWALL INQUIRY

WITNESS STATEMENT OF LISA ANN WALKER

I, Lisa Ann Walker, will say as follows:-

1. I qualified as a nursery nurse in 1990 to 2000. I did all my training/qualifications whilst working at the Playpen Nursery.

2. My qualifications are NVQ level 1, 2 and 3 in childcare which I did through Deeside College. My banding is currently band 4 since 2008 - present when I started working in the NNU (Neonatal Unit) at the Countess of Chester Hospital.

3. My employment details are as follows:
   - My first job was at the Playpen day nursery in Mold, Flintshire from 1990 to 2007. I was a nursery nurse in the baby room with up to 4 babies in my care.
   - My second job was at the Countess of Chester Hospital where I was a health care assistant on Ward 50 (Haematology Ward) from 2007 to 2008. My job role was to assist the nurses, e.g. with blood pressure and observation and general care of the patients.
   - My third/current job role is a nursery nurse in NNU at the Countess of Chester Hospital which I started in 2008 as a band 4 nursery nurse.

4. My responsibilities as a band 4 nursery nurse have remained the same throughout my career as NNU nursery nurse in the Countess of Chester (2015-2016 included).
   My responsibilities include:
   - Working with others to meet the needs of the neonate and their families
   - Under the direction of the neonatal practitioner to competently provide clinical care in an agreed timely and appropriate manner
   - Under the direction of the practitioner/medical staff participate in the neonatal assessment process by completing appropriate clinical skills
   - Under supervision administers simple oral medication such as vitamins

- Participate in parent education
- Work with other professionals and agencies
- Maintain accurate and timely documentation and report any concerns
- Recognise and respond appropriately to urgent and emergency situations

5. I remember it being very busy and stressful on the unit between 2015 to 2016. We would sometimes miss breaks because it was that busy, staff morale was low because everyone was tired, however I always felt supported and valued. I had no problems with management at the time, the manager would try and help when she could.

6. The relationships between all professionals during 2015 to 2016 is no different to today, everyone supports and helps each other.

7. I had no involvement in the care of Child A, B, G, I and N around the time they collapsed.

8. I have reviewed my previous police statements dated 26 January 2018 **[INQ0000809]**, 13 February 2018 **[INQ0000329]**, 23 July 2018 **[INQ0000066]** and 6 November 2019 **[INQ0000637]** which are attached as my **Exhibits LAW/01**, **LAW/02**, **LAW/03** and **LAW/04** respectively and they are accurate and I have no further information to provide.

9. I do not recall whether Child A's collapse and death was discussed at handover the following day. I was not aware of any meeting or debrief that took place for Child A.

10. I do not recall if Child B's collapse was discussed in handover the following day.

11. Referring back to my January 2018 police statement **[INQ000809]** (**Exhibit LAW/01**) which I stated that an incident had happened with myself and Lucy Letby in regards to me shouting for assistance as a baby was having desaturations (low oxygen levels). Lucy's response to my actions was "Why did you shout for help?" she stated she was fine on her own and could cope with the situation. I found this question very odd and it took me back a bit as in this situation, the more help you have would benefit the baby.

12. After this incident I told the band 6 nurse (Kate Bissell) who was one of the nurses who came to help when I shouted for assistance. I told her I have just been told off by Lucy for shouting for help. I explained to her that I thought it was odd and explained my reasoning for shouting is because I felt the baby needed more help as the baby was taking a while to recover.

13. I am not aware if the events relating to Child G were discussed in handover the following day.

14. Referring back to my November 2019 police statement **[INQ0000637]** (**Exhibit LAW/04**) where I explained that I did a skin patch test on Child I. This entails putting a small amount of grapeseed oil behind the ear to see if a reaction occurs. I would only undertake this if the baby was fit for a test. I do not undertake skin patch tests on babies in ITU (intensive care babies) who can be on ventilators or other respiratory support or, HDU (high dependency babies) who can also be on respiratory support and nutritional fluids. Prior to doing a skin patch test on Child I, I checked with the nurse to ensure the baby was well enough. I also checked the observations and feed charts to see how stable Child I was. This procedure is done with every skin patch carried out. Child I would have been special care at the time for me to undertake a skin patch test.

15. I would have found out about Child I's collapses if I was on the unit at the time, or when I was next on shift. I do not recall when I found out about Child I's collapses.

16. Child I's collapses came as a shock to me as Child I was doing well and getting ready for home.

17. I was not present for any debrief, handover or meeting about Child I's collapses.

18. It is not unusual for a nurse to arrive 15 minutes early for their shift. It is unusual to go straight to a baby, unless they were concerned about the baby and were on shift the previous day and the baby was unwell before they went home.

19. I do not recall if Child N's desaturations and collapse was discussed at handover.

20. I never considered that there might be a link between the unexpected collapses and deaths to Lucy.

21. I have never discussed nor had any views with anyone else in or out of the hospital.

22. I only realised the link between Lucy and the deaths when Lucy was arrested.

23. We were given training on how to report concerns during our induction prior to starting work on the unit (for me this was 2008 when I started working on the NNU). I report any concerns via Datix or by informing my manager or shift leader at the time.

24. I had no concerns or suspicion of the conduct of Lucy. I was not aware of concerns and suspicions of others.

25. I am not sure what discussions or debrief took place between nurses and doctors after a baby's death, as I was never present or asked to be, nor do I expect to be as it is only nurses and doctors who are present.

26. I became aware of the 15 deaths of babies during my police interviews, which came as a shock as I did not realise it was that many. This was extremely high compared to when I began on the unit in 2008. Up until 2015 as far as I can remember there were no deaths up until that point.

27. I thought the increase of deaths on the unit was down to getting sicker babies, I never thought they were ever being harmed by a member of staff.

28. I am not sure if CCTV would have prevented the crimes of Lucy, however any added security measures can be of benefit. The benefits of CCTV would be pin pointing who was in a room at any given time, with any of the babies. CCTV however does come with disadvantages due to parents privacy when caring for their babies e.g. breast feeding.

29. I would recommend that any learnings in general should be fully reviewed and acted upon, although I would say the care given to babies on the unit is of the highest standard and the acts of Lucy should not be associated with other colleagues.

30. I do not have any documents or other information that is relevant to the Inquiry.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: Personal Data

Dated: 25/03/24