THIRLWALL INQUIRY

WITNESS STATEMENT OF SHELLEY ANNE TOMLINS

I, Shelley Anne Tomlins, will say as follows: -

Personal details

1. My full name is Shelley Anne Tomlins.

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

2. My qualifications and the years I achieved them are as follows:
   - Bachelor of Nursing (honours) degree from the University of Manchester in 2010
   - Introduction to Neonatal Nursing in 2012
   - Nursing Mentorship in 2013
   - Intensive Care of the Newborn (405) in 2015
   - High Frequency Oscillation and Nitric Oxide in 2016
   - Intravenous Cannulation in 2018

3. Whilst nursing in the United Kingdom I was always employed at band 5. The nursing positions I've held from October 2015 onwards have all been in Australia, where the classification of nursing grades is different. In Australia I was grade 2.

4. My employment history is as follows:
   - Registered Nurse, Paediatric Intensive Care Unit, Royal Manchester Children's Hospital, September 2010 - April 2011

- Registered Nurse, Neonatal Unit (NNU), Countess of Chester Hospital, April 2011 – October 2015 (with a 6-month career break in 2014)
- Registered Nurse, Neonatal Intensive Care Unit, Royal Children's Hospital, Melbourne, November 2015 – May 2016
- Registered Nurse, Neonatal Intensive Care Unit, Mercy Hospital for Women, Melbourne, May 2016 – September 2019 and January 2020 – February 2021
- Registered Nurse, Neonatal Intensive Care Unit, Monash Children's Hospital, Melbourne, June 2020 – February 2021
- Registered Nurse, Paediatric Ward, Northwest Regional Hospital, Tasmania, October 2021 – January 2023
- Lifeguard, Smithton Wellbeing Indoor Recreation and Leisure, Tasmania, October 2022 – December 2023
- Lifeguard, Clarence Aquatic Centre, Tasmania, August 2023 – Present

5. In the United Kingdom I commenced employment with the nursing agency Pulse, and worked a small number of shifts as a registered nurse on the Neonatal Unit at Arrowe Park Hospital. However, I'm unable to recall precisely what year this was. It was either 2014 or 2015. In Australia I have been employed by several nursing agencies (also as a registered nurse), but I don't believe I worked any shifts under their employment, therefore I haven't listed them as part of my employment history. I haven't worked as a registered nurse since January 2023.

6. In 2015 my duty and responsibility on the neonatal unit was to care for the babies. This involved a range of different duties at the start of each shift including: receiving handover, checking emergency equipment, medication charts and fluid requirements, checking intravenous fluid and medication infusions were calculated correctly and within date, observing the baby at handover, checking ventilation/CPAP/Optiflow settings, checking the position of endotracheal tubes and auscultating air entry, and checking any intravenous or intraarterial cannulation sites. During a shift I was responsible for: vital sign observation and documentation at the required frequency, observation and documentation of any breathing support equipment, observation of intravenous and/or intraarterial sites, documentation of hourly infusion quantities and

site pressures, correct and safe phototherapy administration if required, feeding my patients via bottle, cup, assisted breast feeding or nasogastric/orogastric tubes, checking the position of feeding tubes via aspiration and pH testing of the stomach contents.

7. In addition, I was also responsible for the preparation and administration of medications, including checking the correct dose was prescribed and double checking with a second nurse, communication about the patients with doctors, other nurses and the wider multidisciplinary team, communicating and supporting parents and families of the babies, documenting nursing notes at several points throughout every shift, and assisting parents to have cuddles with their babies. In addition, I was also required to adhere to strict infection control precautions, perform regular hand washing and hand sanitisation, attend deliveries of expected and unexpected sick and/or preterm infants, assist doctors to stabilise infants at delivery, transfer to the NNU and commence care, which could involve assisting with intubation and/or cannulation. I also took blood samples from babies via heel prick, ran blood gases and administered blood products as prescribed. It was the role of nurses to carry out several checks on a night shift such as checking the resuscitation trolley and the intensive care bedspaces, which I frequently did. I never had any managerial responsibilities when working on the NNU and I left the Trust in October 2015.

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

8. I recall having a good relationship with my manager and deputy manager in 2015. I remember them being friendly, supportive and approachable. In my opinion the quality of the management was good on the NNU, but I'm not sure about the quality of the supervision. New starters and less experienced nurses cared for the special care babies that were more stable, however I don't think care was directly supervised by a more experienced nurse unless they were learning a new clinical skill. The same applied to more experienced nurses; most care would have been done independently unless they were practicing something unfamiliar, or the task required a second checker or extra pair of hands. It was a small unit with very frequent coming and going happening from each nursery room, however everyone had their own workload and nurses sometimes carried out care with no other staff members present in the room.

9. I don't think nurses were 'thrown in the deep end' on the NNU. I found it to be quite a protected environment where new starters cared for special care level babies, under the guidance of the nurse in charge. As their experience and confidence grew, nurses would gradually begin to care for babies with more complex needs, again under guidance from more experienced nurses.

10. As far as I can recall, the support of nurses during 2015 was good. The NNU had a relatively small team of nursing staff (and nursery nurses), where many of us knew several of our colleagues well, we organised regular social events outside of work and I remember the unit feeling friendly and inclusive. I believe the management staff were supportive to us and nurses also supported each other.

11. I can't recall any information regarding the relationship between clinicians and managers, or the relationship between midwives and managers in 2015. In terms of the relationship between nurses and managers, I only know what my own experiences were. I had a good relationship with my manager and deputy manager and can't recall having any issues with either of them, during any of the years I worked for the Trust. I don't know what the relationship was like between doctors and midwives, however I remember the relationship between doctors and nurses generally being good. We had a small team of consultants, most of which had worked on the NNU for a long time and were well known to us. The registrars and senior house officers (SHOs) rotated every few months, and I recall being on friendly terms with many of them throughout my time on the NNU, which was probably the case in 2015.

Child E, Child F, Child G, Child H, Child I

12. I can confirm that as requested, I have reviewed the five statements I gave to the police regarding Children E, F, G, H and I. I attach these statements as my **Exbibit SAT/01 [INQ0000231]**, **Exhibit SAT/02 [INQ0001023]**, **Exhibit SAT/03 [INQ0000344]**, **SAT/04 [INQ0000529]** and **Exhibit SAT/05 [INQ0000905]**. These statements are accurate and I do not wish to add anything to them.

13. I believe that I first found out about the death of Child E on the 4th August 2015, during handover that morning (07:30 – 08:00). I likely heard the news first during the group handover we received from the nurse in charge, however I only remember discussing it in nursery one when I took a more detailed handover. The only nurse I can clearly

remember being there was Nurse W, although I have a vague memory of Lucy Letby also being there. It is possible that Caroline Burgess (Oakley) and Jo Williams were there too. I don't recall anything that was said about Child E's death.

14. The only discussion I can specifically recall having regarding Child E's death, was when Doctor ZA and I sat down with the parents later in the day on the 4th August. I can see from my police statement that we talked about Child E not requiring a post mortem, however I don't actually recall this detail myself. I vaguely recall discussing Necrotising Enterocolitis as the cause of death. I remember the parents wanting to have Child F transferred I&S but don't recall anything else that we discussed. Throughout the shift I probably had other conversations with the parents, however I can't remember what was said. I am also sure that I would have discussed Child E with other staff members throughout the day, as I needed to complete the necessary paperwork following his death. Again, I can't remember exactly who I spoke to or what was discussed, except I do recall sitting in the management office whilst working through a checklist of tasks, and I believe that Yvonne Farmer was working in there too. It is likely that I asked for her assistance at some points in my shift.

15. I don't remember attending any debrief or meeting regarding Child E's death.

16. In regards to whether I had any other discussions about Child E's death, I recall informing my Mum after my shift had finished that I had cared for a deceased baby that day, and that it was the first time I had ever done it. I can't recall most of what I discussed with her, although I was always very careful to maintain confidentiality when talking about anything that happened at work. I think I talked to her about having gone to the mortuary and it is likely that I would have mentioned that Child E was a twin. However, I can't be sure of anything else I talked about.

17. I can't remember the handover I received for Child F on the morning of the 5th August 2015, neither can I recall whether I was surprised by Child F's low blood sugars that day. I also can't remember if I was surprised when Child F's blood sugars rose after the TPN had been paused.

18. I can't remember discussing Child F's blood sugar with anyone during the shift, except perhaps with Dr Ravi Jayaram later on in the day. I have a vague memory of him being there, so it's possible I discussed the persistent hypoglycaemia with him. However, I am quite sure that I would have discussed the low sugars with the nurse in charge and

the doctors managing Child F's care, as we tried to correct the problem. It's likely that I discussed each new blood sugar, as I would have needed to get instruction on the plan of care (when to take the next glucose level, for example). I don't recall the handover of Child F from my day shift to the night shift staff and I also don't recall any informal discussions, meetings or debriefs regarding Child F's persistent hypoglycaemia.

19. I can't recall how I found out that Child G had collapsed on the 7th September 2015, however as I worked a night shift from 7-8th September, I probably found out either during handover or later on in the shift. I would have found out from a colleague but I don't remember whom. I also can't recall how I found out that Child G had been transferred to another hospital after her collapse, it was also probably word of mouth from a colleague.

20. I don't recall any specific discussions, debriefs or meetings happening after Child G's collapse on the 7th September. I only have vague memories of hearing other staff members discussing what happened.

21. I recall speaking to Nurse W about Child G's apnoea and desaturation that happened on the 21st September 2015. I don't recall exactly what was said or if there was anyone else who was part of the conversation. I do remember Nurse W being upset and crying.

22. I don't remember attending any meetings or debriefs regarding Child G's 21st September 2015 collapse.

23. I don't have any memory of the handover of Child H from the day shift to the night shift, on 26th September 2015. I also can't remember whether I discussed with anyone about my view of Child H's 00:55 desaturation on the 27th September 2015 being inexplicable. For a serious collapse like this one was, involving a desaturation, chest compressions and medications needing to be given, another nurse or nurses would have been present and assisting. It is probable that we discussed what could be causing the desaturation as we tried to fix it, but I am not sure.

24. I can't remember the handover to the day shift on the morning of the 27th September 2015. I can see from my notes that Child H was transferred to Arrowe Park Hospital before the day shift commenced, so care of her would not have needed to be handed over. However, it is likely that the events of the night shift were mentioned to the day

staff, although I don't know for sure. I therefore don't know whether the 00:55 desaturation was discussed.

25. I don't recall having any informal discussions, meetings or debriefs about Child H's collapses. I don't know whether any occurred that I wasn't present for.

26. I don't recall if, when or how I became aware of Child I's collapses on 30th September 2015, therefore I am unable to comment on whether I would have found it surprising, or whether I discussed the collapses with anyone else. I also don't remember attending any informal discussions, meetings or debriefs about Child I's collapse on the 30th September 2015.

27. I don't remember anything that was said as I was receiving handover from Letby on the 14th October 2015, however I clearly remember Child I having a cardiac arrest as we were standing at the bedside looking at her. I recall snippets of what was said during the resuscitation that followed. I recall Dr Matthew Neame saying that he was worried, and either Mum or Dad agreeing and saying they were too. I recall Dr Neame asking staff the question 'any thoughts?'. I also remember Dad being on the phone to someone and informing them that we had a heart rate.

28. I first found out that Child I died when I was on a work social gathering, some time in July 2016. I had left the unit a few months prior, and asked ex-colleague Ailsa Simpson what the outcome had been for Child I. However, I didn't find out the specific date that she died until I was reviewing her notes for a police statement. I'm unsure exactly when this was, but as my statement was given in 2019, it's likely to have been some time that year. As far as I was concerned, the death of Child I was an unexpected event.

29. I left the NNU a few days prior to Child I's death, so did not attend any informal discussions or debriefs about her death.

30. I remember noticing that Letby had been on shift for all the deaths that had happened (including Child E), but I can't remember if I ever thought there was anything suspicious about it at the time. I can't remember if I also noticed that she had been on shift for all the collapses not resulting in a death though (including the collapses of Children F, G, H and I).

31. Regarding whether I discussed my views on Letby with anyone else, I think I discussed with my Mum that Letby had been there for all the deaths, and that I had not been present for any of them. Unfortunately, I can't remember when I talked about this. I also can't remember if I discussed it with anyone else.

32. I'm not completely sure when I realised that people had made a link between Letby and the collapses and deaths on the NNU. I have a vague memory from when I still worked there, of colleagues mentioning that there had been another collapse and that Letby had again been the nurse caring for the baby. I first found out that she had been removed from the NNU after concerns were raised, when I was at a staff social gathering in July 2016.

Concerns or suspicions

33. I don't remember ever having any training on how to report concerns about other staff members.

34. I remember noticing that Letby always seemed to be on shift when deaths occurred, however I can't remember for sure whether I ever thought anything was suspicious about it back in 2015, or whether I only started suspecting her after I knew she was being investigated.

35. I recall hearing that Dr Ravi Jayaram had noticed Letby's presence for all the deaths and collapses, and that she had been removed from the NNU to a non-clinical role. I got this knowledge from ex-colleagues at a social gathering in July 2016. I don't think I was aware of anyone else having any suspicions or concerns about Letby's conduct.

36. I can't remember whether there were always formal or informal debriefs between doctors and nurses after the death of a baby. I think they were sometimes arranged (and I think they were ran by the Consultant), however I don't recall attending any. Between nurses I'm sure there were always informal discussions that happened after major incidents, but I don't think nurses held their own formal debriefs.

37. I was aware of the increase in deaths on the NNU whilst I still worked there during 2015. I probably thought it was a coincidence that we'd had so many very sick babies during a short time frame, some of which died or nearly died, when deaths were usually

infrequent. I probably thought it was just the way things happened to turn out. It must have played on my mind at the time, as I can remember dreaming about an emergency situation.

Reflections

38. I am undecided whether having the babies monitored by CCTV could have prevented the crimes of Letby. On the one hand, it could have prevented any harm coming to any baby by deterring her entirely. It also could have prevented some of her later crimes, as perhaps once the medical team started to suspect Letby, she may have been either deterred by knowing she was being monitored or caught via the CCTV. Some of her crimes such as injecting insulin into TPN bags, and failing to act or request help when a baby was 'crashing' would have been detectable by CCTV. However, some of the ways in which she murdered or attempted to murder the babies were by using equipment that nurses handled all the time, and by doing things which were very similar to routine tasks. What I'm referring to here is when she used feeding tubes to overfeed the babies or insert air, and intravenous lines to inject air. On camera these actions might be indistinguishable from routine and correct procedures. For instance, it might not be possible to tell from CCTV whether a syringe has air or clear fluid in it, or whether a baby is receiving more milk than their usual feed amount. These crimes may have been detectable later on, once the CCTV was scrutinised closely and people had an idea what they were looking for. By that point, it would have been too late to catch her in the act and therefore too late to prevent harm happening to the babies. Overall though, I do feel that perhaps the presence of CCTV might have been enough of a deterrent and therefore could have prevented Letby's crimes.

39. I think the Inquiry should make recommendations about the ways in which members of staff can voice concerns they have about other staff members. The procedure for doing this should be straightforward, dealt with much more quickly than it was for Letby, take the concerns of the whistleblower(s) seriously, and should put the safety of the babies as a priority rather than the feelings of staff members. I am sure there are ways to deal with serious concerns that are fair and sensitive to the staff member, whilst also making patient safety the top priority. There should be no red tape to get through, and never any hesitation or delay in contacting the police.

Request for documents

40. I do not possess any documents or further information that could assist with 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 SHELLEY A TWINS

Dated: 01/04/2024