

Witness Name:  
Valerie Thomas  
Statement No.: 1  
Exhibits: 7  
Dated: 31/03/2024

## THIRLWALL INQUIRY

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### WITNESS STATEMENT OF VALERIE THOMAS

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I, Valerie Thomas will say as follows: -

1. I qualified as a State Enrolled Nurse in December 1977. I started at The West Cheshire Hospital Maternity Wing in June 1978. I was employed to work on the Postnatal wards looking after mothers and babies. In about 1990 I went to work on the Central Labour Suite at the hospital. I was trained to be a Scrub Nurse in theatre for Caesarean Sections. I applied to work on the Special Care Baby Unit at the hospital on the Bank. I did this until about 1994.
2. I then went to work on Transitional Care which was upstairs on Ward 32 and managed by Ward Midwives. Staff looked after babies who needed care, but did not require neonatal care. It was better for mums not to be separated from their babies.
3. In 2005, the year I became a Level 4 Neo-natal Assistant and was still registered with the Nursing and Midwifery Council, it was decided that Neonatal Management should take over the running of the Unit. It then meant that we worked between Transitional Care and the Neonatal Unit. I worked there until I retired in December 2016. I then went on the nurse bank, Staffing Solutions doing shifts on the Neonatal Unit when needed. I have not worked since 2022.
4. In 2015/16, I worked between Transitional Care and the Neonatal Unit as a Nursery Assistant, looking after babies and their mothers. My main responsibility was providing care for mothers and babies, teaching mothers to care for their baby and helping provide them with the confidence to return home. I did not have and have never undertaken any management responsibilities during 2015/16 or at any other time during my career.

5. The Neonatal Unit Manager and supervision was very good during the years of 2015 and 2016, and we worked well as a team. I had a good working relationship between all grades of staff.
6. In relation, to Child I, I have read through my police witness statement, which I attach as my **Exhibit VT/01 [INQ0000540]**, and wish to add the following points. I had been on annual leave from the 1<sup>st</sup> October to the 22<sup>nd</sup> October 2015. On the 22<sup>nd</sup> October 2015, I had a baby in the Transitional Care Unit which was on the postnatal Ward 32, and a baby downstairs on the Neonatal Unit. I had been on the Transitional Care Unit helping a mother. I entered back into the Unit through what we called the back stairs from Ward 32 to the Neonatal Unit. It has a coded lock. I therefore passed room 4, Nursery 3 and 2. The ward phone was ringing, I could not see anyone else, so I answered the phone, and it was Child I's mother asking for an update on Child I's condition. Nursery 1 is only a few feet away as I entered the doorway Lucy said, 'if that is Child I's mum tell her to come in'. Child I's mother replied, 'I am on my way'. When Child I's parents arrived, they went straight into the Nursery, I cannot remember anything they said at this point. I was asked to ring Dr Gibbs and ask him to come to the Unit as Child I's condition had deteriorated. I cannot remember what Dr Gibbs said on the phone, but he did come the Unit. I cannot remember any debrief.
7. As far as I am aware I have nothing additional to add to my police witness statements that I have been provided with in relation to Child E, F, G, L and N. I attach my statements as **Exhibit VT/02 [INQ0000230]**, **VT/03 [INQ0000912]**, **Exhibit VT/04 [INQ0000625]**, **Exhibit VT/05 [INQ0000333]**, **Exhibit VT/06 [INQ0000911]** and **Exhibit VT/07 [INQ0001262]**.
8. I cannot remember ever attending a formal training on reporting concerns, but I knew I could go and report at any time with my Ward Manager. Usually after a baby's death you would be updated by the shift leader.
9. I did not have any concerns about Lucy Letby while I worked on the Unit, and I did not hear any concerns from anyone else while working on the Unit. I was aware that the Unit was very busy, especially with more complex babies.
10. In general, discussions between nurses and the shift leader would take place informally after the death of a baby during this period (2015/16).

11. I was aware of the increase in the number of deaths but at that time the Neonatal Unit was very busy, with premature babies, and some of which had complex needs.

12. I am not sure if CCTV would have helped to prevent the crimes of Letby and have no further recommendations to make around keeping babies safe in the Neonatal Unit.

13. I do not have any other documents or other information to provide.

#### 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: \_\_\_\_\_

31/3/2024