Witness Name: Michelle Turner

Statement No.: 1

Exhibits: MT/1 – MT/26

Dated:15 February 2024

**THIRLWALL INQUIRY**

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**WITNESS STATEMENT OF MICHELLE TURNER**

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I, Michelle Turner, will say as follows:

1. I am the Chief People Officer at Liverpool Women's NHS Foundation Trust (LWH), a role I have held since 2010. I have had a long and varied career within the NHS, working in patient-facing roles and more recently in senior Human Resources positions. In my current role as Chief People Officer, I am responsible for ensuring LWH has a competent, engaged and truly motivated workforce focused on delivering the best possible patient experience. I am also responsible for the Trust's communications and marketing functions.

2. I produce this statement subject to Rule 9 of the Inquiry Rules 2006 and specifically in response to a request from the Rt. Hon. Lady Justice Thirlwall that LWH provide evidence to assist with her ongoing inquiry.

3. Unless otherwise indicated within the body of this statement, the contents relate to the period of time specified within the Rule 9 request, namely the period 2012 to 2016.

## Background

Overview of Liverpool Women's Hospital

4. LWH is a specialist hospital providing a comprehensive range of maternity, neonatology and gynaecological services to women and their babies from across Merseyside, Cheshire and North Wales. During the period October 2012 to June 2016, LWH offered the following services:

- Maternity: LWH was a leading provider of maternity care, delivering over 8,000 babies (including stillbirths and the termination of pregnancies) annually during that time; (2012/13 [8,421], 2013/14 [8,286], 2014/15 [8,456], 2015/16 [8,648]). LWH offered a range of services, including antenatal care, delivery and postnatal care, as well as specialist care for women with high-risk pregnancies.

- Neonatology: LWH's Neonatal Intensive Care Unit (NICU) provided critical care for premature and sick babies. The NICU was one of the largest in the UK, with 48 cots in 2012 reducing to 44 cots in late 2015 and a team of highly specialised staff.

- Gynaecology: LWH offered a wide range of gynaecological services, including diagnostic and treatment services for conditions such as endometriosis, fibroids, recurrent miscarriage and ovarian cysts. The hospital also provided gynaecological cancer care.

5. LWH employed an average of 1,248 WTE (Whole Time Equivalent) staff during the period in question. This included midwives, doctors, nurses and support staff.

6. LWH had a total of 280 beds during this time, this including: 160 maternity beds, 48 (reducing to 44) cots on the neonatal unit, 6 cots in transitional care and 78 gynaecology beds.

Cheshire and Mersey Neonatal Network

7. The Cheshire and Mersey Neonatal Network consisted of 8 neonatal units, with Liverpool Women's Hospital being the largest tertiary level NICU. The cot numbers and designation for each neonatal unit in 2012 and January 2015 are contained within Figures 1.0 and 2.0 below.

| Neonatal Unit | Intensive Care (IC) Cots | High Dependency (HD) Cots | Special Care (SC) Cots | Total Capacity |
|---|---|---|---|---|
| Arrowe Park | 4 | 6 | 14 | **24** |
| Countess of Chester | 3 | 3 | 14 | **16** |
| Leighton | 4 | 4 | 7 | **15** |
| Liverpool Women's | 16 | 12 | 26 | **54** |
| Macclesfield | 0 | 1 | 7 | **8** |
| Ormskirk | 2 | 2 | 8 | **12** |
| Warrington | 3 | 3 | 12 | **18** |
| Whiston | 0 | 2 | 13 | **15** |
| **Total** | **32** | **33** | **101** | **166** |

***Figure 1.0 - Cheshire and Mersey Neonatal Network cot capacity - 2012 (Please see CMNN Annual Report [April 2013] at Exhibit MT/1 [INQ0011622, INQ0011623]).*** *[NB:- The 26 SC cots at LWH included 6 Transitional Care cots; these were cots located with the mother of the baby on the postnatal ward.]*

| Cheshire & Merseyside | Unit Level | IC cots | HD cots | SC cots | Total | TC Cots |
|---|---|---|---|---|---|---|
| Arrowe Park Hospital | NICU | 6 | 8 | 10 | **24** | 4 |
| Countess of Chester Hospital | LNU | 3 | 3 | 10 | **16** | 4 |
| Leighton Hospital | LNU | 3 | 4 | 8 | **15** | 0 |
| Liverpool Women's Hospital* | NICU | 16 | 12 | 20 | **48** | 6 |
| Macclesfield Hospital | LNU | 0 | 1 | 7 | **8** | 0 |
| Warrington Hospital | LNU | 3 | 3 | 12 | **18** | 0 |
| Ormskirk Hospital | LNU | 2 | 2 | 8 | **12** | 0 |
| Whiston Hospital | LNU | 0 | 2 | 13 | **15** | 0 |
| Alder Hey Hospital | Surgical | 0 | 9 | 0 | **9** | 0 |
| **Total** | | **33** | **44** | **88** | **165** | **14** |

***Figure 2.0 – Cheshire and Mersey Neonatal Network cot capacity, January 2015****. [NB:- This data does not include Transitional Care cots. LWH reduced cot numbers to 12 IC, 12 HD & 20 SC from December 2015].*

8. LWH was one of two NICUs in Cheshire and Merseyside. In 2012 to 2015 it was commissioned to care for 16 ICU babies and would accept babies of all gestational ages, including on occasion those from outside of the area, namely from North Wales and the Isle of Man.

9. The care was provided by Consultant Neonatologists all of whom had sub speciality training in neonatal medicine. In 2012 there were 8 Consultants providing 24/7 medical cover to the unit. In January 2015 there were 8 Consultants which increased to 10 in mid-2015. The medical team included Senior House Officers and Registrars along with Advanced Neonatal Nurse Practitioners (ANNPs). These staff were present 24/7.

10. Babies with surgical issues being cared for in the Royal Stoke Hospital would also be referred to LWH. LWH would have also received referrals from elsewhere in the country if the local neonatal services were unable to care for their babies.

11. The NICU at LWH was the designated unit in Cheshire and Merseyside that would care for babies with congenital anomalies including cardiac defects. This is due to LWH being a tertiary centre and the links that are well established with the Alder Hey Children's Hospital (AHCH) that support cardiology, ENT (Ear, Nose & Throat), neurology and other specialities.

12. The NICU at LWH would care for the babies of women who booked their pregnancy at LWH, as well as those whose care was transferred during the pregnancy due to a fetal anomaly that required specialist intervention. The unit would also receive transfers of babies requiring tertiary level and/or specialist surgical or cardiac care from other hospitals in Cheshire and Merseyside and beyond.

13. LWH babies requiring surgical intervention would receive their surgical intervention at AHCH and post-surgery would return to LWH for ongoing care. Babies born with complex cardiac anomalies would be delivered at LWH and transfer to AHCH when appropriate for cardiac surgery.

14. For women in Cheshire and Merseyside with threatened pre-term labour less than 27 weeks who attended another local neonatal unit, their care would be transferred at the earliest possible opportunity to one of the two available NICUs, at LWH or Arrowe Park Hospital (APH), to facilitate delivery. Occasionally, due to cot availability it would be

necessary for the woman and/or her baby to be transferred to a suitable hospital outside of the region for ongoing care.

15. In December 2015, the neonatal unit at LWH reduced the number of NICU cots from 16 to 12 (total from 48 to 44 cots) This was driven by concerns regarding MRSA infection, reduced nurse to ITU cot ratios, reduced activity levels and concerns regarding estate and infection rates. This decision was made in discussion with the Neonatal Network and commissioners. Please see 'Modelling the impact of reducing ITU capacity on NNU at LWH' – as per **Exhibit MT/2 [INQ0011634]**).

Cheshire and Mersey Neonatal Transport Service

16. During the period in question, the Cheshire and Mersey Neonatal Network also had a Neonatal Transport Service. This was funded and managed by the North West Neonatal Operational Delivery Network (NWNODN) but hosted at LWH and supported by staff from LWH and APH.

17. The service was led by a Nurse Consultant who had a team of nurses, ANNPs and medical consultants who supported the rota Monday to Sunday 8.00am – 8.00pm. The Nurse Consultant and nurses all held LWH contracts of employment. The Nurse Consultant worked between LWH and APH. An out of hours service operated Monday to Sunday between 8.00pm – 8:00am and was provided by the neonatal medical, ANNP and/or nursing staff members from LWH and APH.

18. The service provided two types of transport; non-emergency and emergency transfers. Certain non-emergency transfers could be facilitated by a nurse only, for example: Stable special care infants, stable infants requiring outpatient an appointment, high dependency infants who have been stable for 48 hours and infants who have been extubated 24 hours after being electively intubated for surgery and are stable on air.

19. By contrast, a transfer team that included an experienced transport nurse and either a senior medical doctor (registrar or consultant) or a senior ANNP needed to be present for the following emergency transfers: Intensive care babies, babies below 1kg in weight, babies below 28 weeks gestation and less than 48 hours of age, unstable high dependency infants, infants with complex cardiac problems or those that require medication to maintain duct dependent lesions, infants with complex surgical problem and infants with neurological problems that require constant monitoring and treatment to maintain stability.

20. As part of this service, there was a 24/7 perinatal cot bureau. The cot bureau was the first point of contact for all acute antenatal and postnatal referrals and would be responsible for facilitating all administrative and organisational aspects of transfer. During the period in question, the neonatal transport service did not have a dedicated neonatal ambulance.

21. The transport service is now known as Connect North West and has dedicated ambulances. The service is hosted by St Mary's Hospital, Manchester.

Current Neonatal Service within Cheshire and Mersey

22. The NICU at LWH continues to be a tertiary service providing intensive care for the babies of Liverpool and the wider Cheshire and Mersey Network. There have been no changes to cot configuration since December 2015, however the environment and the way we work within it, has been completely changed.

23. The NICU environment has been totally reconfigured with the addition of a new build to extend the floor base, increasing this by 50%. The unit is now made up of 9 clinical rooms and 2 single rooms; rooms 1 - 6 are configured to provide critical care spaces for 24 babies, 4 babies in each room. These rooms can be used to provide either intensive care or high dependency care. Room 7 can provide critical care, however, is currently not counted within the cot base and is used as an extra staff room. Rooms 8, 9 provide low dependency care for 20 babies. The new unit still has 12 intensive care, 12 high dependency and 20 special care cots.

24. The unit has a pharmacy room with swipe access. All drugs are kept in this room, including controlled drugs and drugs requiring refrigeration like insulin, TPN (Total Parenteral Nutrition), Lipid and premade drugs in syringes. The controlled drugs are stored within a locked cupboard and there is only one set of keys on the unit for this cupboard; the keys are allocated on a shift-by-shift basis to one individual. This cupboard meets the standards set nationally for the storage of controlled drugs.

25. There has also been an increase in parental accommodation available both onsite and offsite. There is an expectation within the British Association of Perinatal Medicine (BAPM) Standards that for every intensive care cot there should be one room of parental accommodation available. At LWH we have 14 rooms for parents, which exceeds the standards required. It is important as a unit that embraces FiCare (Family Integrated Care) that we ensure that adequate facilities are available for our families.

26. Before the environmental changes to the unit the medical team would be allocated to work within intensive care, high dependency or low dependency and this would be the same for the junior doctors, nurses and ANNPs. With the move to the new building, LWH introduced the mixed acuity model, meaning babies receiving intensive or high dependency care remain together in one of 6 rooms, only moving to the low dependency room when they are well enough to receive that level of care.

27. From a nursing point of view, we have two groups of nursing staff, those that work the NICU rota spend their time caring for the intensive care and high dependency care babies and a separate low dependency nursing team. A qualified nurse can be asked if necessary to work in any area of the unit. This allows greater exposure for those working in NICU and helps develop confidence, competence, and skill.

28. There continues to be a senior nurse (Band 6/7) co-ordinator on every shift and for the majority of shifts there is a runner nurse who will work between rooms to support with drugs, admission and discharges etc; this is a new post since moving into the new build. The senior nursing structure has also been enhanced with the introduction of a Deputy Head of Nursing.

*Liverpool Neonatal Partnership*

*29.* LWH are working in collaboration with AHCH to improve the provision of service to those babies requiring surgical intervention; this is being developed through the Liverpool Neonatal Partnership (LNP). Both Trusts agreed the appointment of a senior leadership team through competitive process, this comprises of a Neonatal Surgeon (AHCH), a Neonatologist (LWH) and a Head of Nursing. The co-directors report in to the Medical Directors of both Trusts and the Head of Nursing reports to both Chief Nurse Officers (CNOs). The Leadership Team report into the LNP Board that is chaired by the Medical Directors of both Trusts and are supported by the Executive Team on both sites, Specialist Commissioner and the Director for the NWNODN.

*30.* The aim of the LNP is to improve the provision of surgical care for neonates across Liverpool, this will be achieved by reducing transfers of intensive care babies across the city that require surgical intervention, ensuring that there is access to specialist services and teams to provide timely intervention. The LNP will also ensure that appropriate neonatal staff in line with BAPM standards will care for these babies in an appropriate environment on the AHCH site, at all times embracing the FiCare model of care. See

**Exhibit MT/3 [INQ0011641]** - Proposal for the Evolution of the Liverpool Neonatal Partnership, written in 2021.

31. The LNP will also work with the estates team at AHCH to develop and build a new 22 bed neonatal intensive care unit on the Alder Hey site. This will comprise of 8 intensive care cots and 14 high dependency cots. The LNP will have one team working across both sites, this is inclusive of medical teams, nursing teams and Allied Health Professional (including physiotherapists, occupational therapists, speech and language therapists and dieticians) teams. The mixed acuity model of working will be adopted and teams are working towards developing shared guidelines that meet the needs and requirements of both Trusts. The LNP will be based on a FiCare model, where families are partners in care delivery and a single room model with a family suite will ensure these needs are met.

## Training Placements

LL Training Placement Details - 2012

32. The first placement that Letby undertook at LWH commenced on 8 October 2012 (week 2 of the placement, with week 1 being an induction week) and was then known as the Regional Neonatal Induction Programme [RNIP] (now known as Foundations in Neonatal Care [FiN]) (**Exhibit MT/11 [INQ0011625]**). The RNIP ran for a 26-week period overall in order to ensure new nurses would learn the basics of neonatal care.

33. The placement phase of the RNIP was run and funded by the NWNODN but supported and taught by teams at LWH. As part of this programme nurses would be offered a placement within a tertiary centre to gain experience of caring for the smallest and sickest babies. This was usually a 12-week placement. There was an expectation within the Network that every new neonatal nurse would undertake this training but there was no formal qualification achieved at the end. The rota indicates that the 12-week placement was allocated to the care of intensive care babies, but it is possible that there were high dependency babies within the intensive care space at times. Attached to this submission is the RNIP plan and content for Letby's intake as per **Exhibits MT/4 [INQ0011642] and MT/5 [INQ0011643]**).

34. Letby's last working day of placement at LWH was 13 December 2012 (week 11). Letby worked 34.5 hours per week. Please see **Exhibits MT/6 [INQ0011644], MT/7 [INQ0011645] and MT/8 [INQ0011646]** for rotas.

35. In order to undertake the RNIP Letby would have needed to be a Registered Nurse with the Nursing and Midwifery Council (NMC), no other qualification would be needed. Adult, paediatric nurses and midwives could undertake this course. At this time Letby was a qualified nurse and was employed by the Countess of Chester Hospital (COCH). Letby was not a paid employee of LWH at any time and placements were facilitated through secondments.

36. LWH were not involved in any way with the selection process for the RNIP and this would have been facilitated by the COCH. Generally speaking, once a nurse was recruited to a neonatal unit within the Northwest, their manager would put their name forward for a place on the programme. For some this would be within weeks, for others this may take a few months, depending where in the year they were recruited, given the programme only ran twice a year. There was no formal qualification awarded following completion of the RNIP.

37. Training placements were arranged through the Course Lead who would have been the LWH Education Lead at the time, who worked in partnership with John Moores University (JMU). An individual student would be seconded to either LWH or APH to complete their placement. When on placement, the student was not included in the daily numbers at LWH. The students only worked day shifts and some of these shifts included weekend days.

38. The RNIP was an introduction to neonatal nursing because the physiology of a premature or sick baby is very different from an adult or a child after 28 days of age. During paediatric, adult or midwifery training the level of detail needed to be a neonatal nurse is not sufficient, so the idea of this programme is to bridge the gaps in learning and clinical experience.

39. During the placement, students were assessed on their work within clinical areas and the knowledge possessed in relation to the care they were delivering. Students were expected to show clinical competence and a critical understanding of the care and treatment they were delivering (competency-based assessment). These specific competencies were not necessarily achieved in any order, as it would depend on what babies were on the unit at the time and when the student was exposed to that specific learning. A sample of the clinical competence document is provided at **Exhibit MT/12 [INQ0011626]**.

40. Each student was assigned two mentors who would assess whether their knowledge and skill was progressing as the course went on. During their induction programme the mentor

and mentee would agree learning outcomes, and these were reviewed on a 4-weekly basis. Each student was also asked to complete structured reflections and share this with their mentors.

41. During her placement, Letby worked on the NICU at LWH. She may have attended deliveries on delivery suite and visited the post-natal ward and transitional care as part of her placement with her mentor, but there is nothing to suggest she would have worked in any of these areas.

42. As indicated above, Letby would have been allocated mentors to work with during her placement but would have worked alongside other senior nurses also; please see the attached rotas (**Exhibits MT/6 [INQ0011644], MT/7 [INQ0011645] and MT/8 [INQ0011646]**). Letby would have been working within the intensive care environment. Within this she would have been responsible for the recording of observations and ensuring fluids were being delivered via pumps, she would not have had responsibility for preparing, setting pumps or changing fluid regimes. She would have administered feeds, changed nappies, helped with x-rays, intubation of babies, insertion of lines, resuscitations and taking babies out for cuddles. This would have all been done under the supervision of a qualified nurse.

43. Letby's mentors during this placement were Staff Nurse Mary Joseph (QiS) and Staff Nurse Louise Coleman (QiS). As referenced above, her mentors did not work all shifts with her but within the rota the names of the individuals she worked with can be seen, all of whom would have been registered staff nurses with QiS.

44. Letby would have worked in a room with other nurses during her placement and while it is unlikely, there is a possibility that she would have been left in an intensive care room without another nurse present. While Letby was in the room the nurses may not always have had direct sight of Letby if they were for example attending to another baby, giving medications, talking to parents etc. For the most part, Letby's hands on care of a baby would have been observed, but again if a baby desaturated it is possible she would have made contact with a baby without being overseen.

45. Letby would not have been allocated a baby independently as a "designated nurse", this role would be reserved for a nurse who was employed by LWH and that has already completed the QiS.

46. Postgraduate student nurses like Letby were not allowed to give drugs on the NICU at LWH. Each hospital has a training process of competence for administration of drugs, those who come on post graduate placement do not undertake this course so therefore cannot administer drugs within the unit. Drug administration on a neonatal unit always requires two registered nurses and postgraduate student nurses like Letby could possibly be a third checker to develop the skill of administering more complex intensive care drugs.

47. Depending on where the individual was in their placement and their level of competence would depend on how much they would be able to do, this would be totally individualised. For example, in the first week if a baby required bag mask ventilation during a resuscitation this may not be appropriate but by week 11 if they are more confident and their mentor felt they are ready then the student would be supported with completion of that task.

48. The controlled drug key would be held by a registered nurse and during this period it is likely that a nurse in the intensive care room would have held these keys, only sharing with other registered nurses who are employed by LWH. It is therefore very unlikely that Letby would have had access to the controlled drugs cupboard and the drugs within it, but LWH cannot evidence this by way of documentation.

49. The drugs room had a Digi lock and this number would have been shared with all staff including students on the unit, as drugs such as vitamins for example would have been kept in this room. As insulin is not a controlled drug there is a possibility that Letby would have had access to insulin via access to this room.

50. The RNIP required each nurse to complete the following assessments:
    - Achievement of practice outcomes – Clinical Profile
    - Short presentation
    - Short written reflections

51. The details pertaining to each of these assessments are outlined within the JMU and LWH Handbook (**Exhibit MT/14 [INQ0011628]**).

52. Unfortunately, all completed documentation relating to the course is kept by each individual student and LWH has therefore been unable to find any feedback in relation to Letby. The RNIP does not conclude with a formal qualification, just a pass or fail. LWH understands that Letby passed this course but has no written evidence to support this.

LL Training Placement Details - 2015

53. The second placement Letby undertook at LWH was the Qualified in Speciality Course (QiS). This course is for nurses who have decided they would like to specialise in neonatal intensive care. Again, this is a course that is supported by the NWNODN but unlike the RNIP, it is registered with Higher Education England (HEE) and there is a formal qualification on completion of the course. This course was and continues to be run in collaboration with JMU, but the content is delivered by the Education Team at LWH. The QiS provides more detail on the care of the intensive care and sick baby, for example covering topics such as; blood gas analysis, ventilation, care of central lines and use of nitric oxide.

54. To undertake the QiS Programme Letby would have needed to be an Adult Nurse, Paediatric Nurse or Midwife registered with the NMC. She would also have been required to have successfully completed the RNIP.

55. As was the position with the RNIP, LWH were not involved in any way with the selection process for the QiS and this would have been facilitated by the COCH. Generally speaking, Letby would have been put forward for the QiS programme by her Ward Manager. Once on the course she would have been allocated a placement within a tertiary unit to achieve the skills, knowledge and competence to become a Neonatal Nurse.

56. As already outlined, training placements were arranged through the Course Lead and this would have been our Education Lead at the time who worked in partnership with JMU. An individual student would be seconded to either LWH or APH to complete their placement. When on placement, the student was not included in the daily numbers at LWH. The students only worked day shifts and some of these shifts included weekend days. Letby was not a paid employee of LWH at any time and this placement was facilitated through secondment.

57. The QiS course started on the 5th October 2014 and finished on the 14th March 2015 (see dates in **Exhibit MT/9 [INQ0011647]** and sample timetable in **Exhibit MT/10 [INQ0011624]**). The clinical placement lasted for a period of 6 weeks, and it is understood that it started at some time in either January or February 2015.

58. All QiS students worked long days (12.5 hour shifts) including weekend shifts. LWH have been unable to locate rotas to substantiate the exact dates Letby undertook her second placement at LWH (the Trust provided swipe access, but this data was lost following a system upgrade). We are however aware, following a review undertaken in April 2019 by Dr Yoxall (Clinical Director for Neonatology), that Letby worked for 15 shifts during the

period 14th January 2015 to 14th February 2015, 11 of which were in the intensive care area. Dr Yoxall was requested to undertake this review by Cheshire Police, in order to identify if there were any specific incidents that caused concern around the time Letby was on the unit. The findings from this review were shared with Cheshire Police – as per **Exhibit MT/18 [INQ0011632]** 'Chester Investigation Report 4 2 2019' and further detailed case note review at **Exhibit MT/23 [INQ0011638]**.

59. The QiS course had a defined competency structure with expected levels of achievement for each student. This competency structure was developed and agreed with JMU to ensure educational standards were being met and adhered to. These competencies included the following:

    a) Communication

    b) Family centred developmental care

    c) Nutrition and growth

    d) Fluids and electrolyte balance

    e) Assessment and monitoring

    f) Conventional ventilation

    g) Non-invasive ventilation

    h) Transport

    i) Surgery

    j) Critically ill neonate

60. The competency booklet is attached at **Exhibit MT/12 [INQ0011626]** and shows the subject and expectations of achieving competency in more detail. The RCN Knowledge and Skills Framework were used to build this competency document, as per **Exhibit MT/13 [INQ0011627].**

61. In 2015, the QiS Course required the following assessments be achieved by those students participating:
    - Oral Case Presentation (VIVA) in Practice (20% overall score) - pass mark 40% **(Exhibit MT/15 [INQ0011629]).**
    - Written assignment (50% overall score).

- Objective Structured Clinical Examination (pass/fail) - The Objective Structured Clinical Examination (OSCE), is based around 3 skill stations, which last about 6 minutes each.
- Clinical competences with reflective diary (30% overall score).

More detail of the requirements can be seen in **Exhibit MT/14 [INQ0011628]**.

62. During the placement, Letby will have worked on the NICU at LWH. As she was on an intensive care placement is it likely that she will also have attended delivery suite with the neonatal team. Letby would have been working within the intensive care environment. Within this she would have been responsible for the recording of observations, ensuring fluids were being delivered via pumps, she would not have had responsibility for preparing, setting pumps or changing fluid regimes. She would have administered feeds, changed nappies, helped with x-rays, intubation of babies, insertion of lines, resuscitations and taking babies out for cuddles. This would have all been done under the supervision of a qualified nurse.

63. Letby also spent some shifts with the Transport Team, again LWH cannot find a rota to evidence this, but it was practice at the time for QiS students to spend a shift or two with the Transport Team.

64. Letby would have been allocated mentors to work with during her placement but would have worked with other senior nurses during her placement; unfortunately, we have been unable to locate any rotas outlining who these individuals were.

65. Letby would have worked in a room with other nurses during her placement and while it is unlikely, there is a slim possibility that she would have been left in an intensive care room without another nurse present. While Letby was in the room the nurses may not always have had direct sight of Letby if they were for example attending to another baby, giving medications, talking to parents etc. For the most part, Letby's hands on care of a baby would have been observed, but again if a baby desaturated it is possible she would have made contact with a baby without being overseen.

66. Letby would have had more contact with higher acuity babies during this placement to ensure she met the competency set for nurses undertaking this programme of learning and would likely have had to explain her actions and why she was undertaking care in this way to ensure she understood the complexity of the care she was delivering.

67. On this second placement, Letby would still not have been allocated a baby independently as a "designated nurse" and would have worked with a nurse who was employed by LWH and who had already completed the QiS qualification.

68. Postgraduate student nurses like Letby were not allowed to give drugs on the NICU at LWH. Each hospital has a training process of competence for administration of drugs, those who come on post graduate placement do undertake this course so therefore cannot administer drugs within the unit. Drug administration on a neonatal unit always requires two registered nurses and postgraduate student nurses like Letby could possibly be a third checker to develop the skill of administering more complex intensive care drugs.

69. Depending on where the individual was in their placement and their level of competence would depend on how much they would be able to do, this would be totally individualised. For example, in the first week if a baby required bag mask ventilation during a resuscitation this may not be appropriate but by week 11 if they are more confident and their mentor felt they are ready then the student would be supported with completion of that task. To achieve competence in the QiS it would be expected that this level of practice had been achieved.

70. The controlled drug key would be held by a registered nurse and during this period it is likely that a nurse in the intensive care room would have held these keys, only sharing with other registered nurses who are employed by LWH. It is therefore very unlikely the Letby would have had access to the controlled drugs cupboard and the drugs within it, but LWH cannot evidence this by way of documentation.

71. The drugs room had a Digi lock and this number would have been shared with all staff including students on the unit, as drugs such as vitamins for example would have been kept in this room. As insulin is not a controlled drug there is a possibility that Letby would have had access to insulin via access to this room.

72. As outlined within paragraph 57, this was an assessed placement. The programme guide for the Development of Special and Intensive Care of the Newborn sets out what the requirements were in relation to assessment, as per **Exhibit MT/14 [INQ0011628]**. Sample of competency documentation is included at **Exhibit MT/12 [INQ0011626]**.

73. Unfortunately, all completed documentation relating to the course is kept by each individual student and therefore LWH is unable to find any feedback in relation to Letby.

LWH understands that Letby passed this course but has no written evidence to support this. The QiS programme concludes with a formal qualification of speciality and having completed the course Letby would be in the position to call herself a Neonatal Intensive Care Nurse and register this with the NMC. Having achieved that formal qualification, Letby would be capable of looking after babies requiring high dependency or intensive care, attending deliveries, resuscitation and supporting end of life care.

**LWH connection with babies named on the Indictment**

74. The following babies (and their mothers) are identified by their names and the ciphers that were assigned to them during the criminal trial. We note that the ciphers used during the trial differ from those used within the sentencing remarks. Cross referencing of information both available and provided to LWH has allowed LWH to consider their connection (if any) with all of the babies referenced during the criminal trial.

Child E and Child F [Trial Ciphers - Baby E and Baby F]

75. Mother E&F the mother of Child E and Child F (twins) [Baby E and Baby F], booked her pregnancy at LWH. She received care under the multiple pregnancy clinic. She was admitted to LWH on 22nd July 2015 (at PD) following an assessment in the Fetal Medicine Unit (FMU). There were concerns about I&S as well as the growth of one of the twins and the function of the placenta (absent end diastolic flow and intrauterine growth restriction on the 10th centile). The plan was to administer steroids due to possible imminent pre-term birth (standard treatment to reduce the risk of mortality and morbidity) and for daily assessments of fetal well-being with cardiotocograph (CTG - a transducer placed on the mother's abdomen that detects and reports the fetal heart rate and presence of uterine contractions) to be undertaken.

76. The mother remained in hospital over the next few days with counselling provided by a member of the Paediatric Training Team regarding outcome for babies born at 28 weeks gestational age.

77. On 25th July 2015, the mother was informed that the neonatal unit was closed due to there being no neonatal cot on the NICU at LWH, however there was no imminent risk of delivery and she therefore remained at LWH undergoing CTG and scanning assessments. The "closure" of the neonatal unit was based upon the number of babies on the unit and the

number of ventilated cot spaces available. A Red/Amber/Green (RAG) status was applied to the unit (see Unit Admission status guidelines as per **Exhibit MT/16 [INQ0011630]**).

78. On 27th July 2015, there were concerns regarding the CTG. At 13:00 the Obstetric ST7 Doctor had been informed by the Obstetric Consultant, Dr Shaw, and the neonatal team to arrange transfer to a neonatal unit. The doctor had been informed there was a cot in Sheffield, and they contacted Dr Selby at Sheffield Jessops Hospital via the cot bureau. The consultant in Sheffield advised that as there was no immediate plan to deliver the babies, the ST7 Doctor should discuss with the LWH FMU Consultant. The case was discussed with Dr Agarwal, Consultant Obstetrician and Fetal Medicine Specialist, and a plan agreed to keep mother at LWH for the foreseeable future.

79. That evening at 21:15, the CTG had not met the Dawes Redman screening criteria (these are criteria, widely used to determine the nature of an antenatal computerised CTG recording to determine if there is or is not fetal wellbeing – see **Exhibit MT/25 [INQ0011640]** for the information regarding the application of the criteria. Following review mother remained an in-patient overnight.

80. On 28th July 2015 on the morning ward round, the plan was to scan mother in the FMU and aim for elective caesarean section at 30 weeks. The CTG met the Dawes Redman criteria during 28th and 29th July.

81. On **PD** July 2015 (29+5 weeks) an ultrasound scan was performed in the FMU. This showed a deterioration in the blood flow patterns in the placenta (reversed end diastolic flow). The FMU team plan was to aim for delivery that day. The neonatal unit remained closed to admissions and so the obstetric team contacted the cot bureau regarding the transfer out to deliver. The cot bureau had identified a cot in COCH. Dr Andrew Sharp, Specialist Registrar in Obstetrics, had met with mother at 11:30am to explain the transfer with a plan to deliver with caesarean section after 3:00pm. It is not recorded at what time the mother left LWH for the transfer over to COCH.

*Transfer from LWH*

82. **Mother E&F** [mother of Baby E and Baby F] was transferred to the COCH at 29+5 weeks gestational age. The decision on which unit to transfer to was made by the network cot bureau. The COCH was, in 2015, designated as a Local Neonatal Unit (LNU) and would care for babies born at greater than 27 weeks gestational age. It was therefore an

appropriate location to transfer the impending delivery of 29+5 week twins according to the BAPM toolkit.

83. Regarding admission to an LNU the BAPM Neonatal Toolkit 2009 states that:

> *Local neonatal units (LNUs) provide neonatal care for their own catchment population, except for the sickest babies. They provide all categories of neonatal care, but they transfer babies who require complex or longer-term intensive care to a NICU, as they are not staffed to provide longer-term intensive care. The majority of babies over 27 weeks of gestation will usually receive their full care, including short periods of intensive care, within their LNU. Some networks have agreed variations on this policy, due to local requirements. Some LNUs provide high dependency care and short periods of intensive care for their network population. LNUs may receive transfers from other neonatal services in the network, if these fall within their agreed work pattern.*

84. In 2015 the transfer of a mother from LWH to another hospital to deliver was uncommon. Transfer out was based upon the availability of cots on the neonatal unit. The neonatal unit used a "RAG" system to determine the status of the unit and what actions needed to be taken (please see **Exhibit MT/16 [INQ0011630]**). There were two reported incidents of the neonatal unit being at a "red" status on 8th and 15th August 2015. It is possible that although the unit was closed at other times, incident forms were not completed for each day and/or shift.

85. Between 1st July and 31st August there were 9 women identified on our reporting system who were transferred from LWH to another Trust. This was due to the activity level on the neonatal unit being high and there being insufficient cots to care for expected deliveries. During the rest of 2015 (January to December) there were only an additional 7 women transferred out, but this number also includes at least 2 women who were transferred to another hospital as they required ITU care themselves and not because there were insufficient cot numbers.

86. The overall occupancy for July and August 2015 is included in the "Neonatal Databook 3" (Figure 3.0 below) produced locally by the Neonatal Digital Support Nurses, which shows that overall occupancy was at 96.5% for July and 91.4% and August . The standard was for neonatal units to operate at an average of 80% occupancy to allow for peaks of activity to be accommodated. For the financial year April 2015 – March 2016, the average monthly occupancy rate was 84.3%. The data book is completed each month by the LWH Badger

Nurse (digital nurse). This data highlights that the period between July and August 2015 was particularly busy for the neonatal unit.

| | 15/16 | R | A | G | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NICU Occupancy | Neonatal Unit Occpancy | | | | 79.2 | 87.1 | 81.2 | 96.5 | 91.4 | 89.9 | 85.5 | 74.4 | 83.5 | 81.6 | 74.4 | 86.7 |
| | ITU | | | | 68.1 | 62.5 | 76.7 | 82.7 | 56.5 | 64.4 | 62.8 | 54.2 | 80.1 | 75.0 | 78.3 | 77.7 |
| | HDU | | | | 59.4 | 76.3 | 67.8 | 106.5 | 116.1 | 106.4 | 134.7 | 87.5 | 64.8 | 56.5 | 73.3 | 83.6 |
| | LD | | | | 99.8 | 113.2 | 92.8 | 101.6 | 104.5 | 100.5 | 104.2 | 81.8 | 96.8 | 100.6 | 72.7 | 93.9 |

***Figure 3.0 – Screenshot taken from Neonatal Databook 3 showing occupancy levels for each month April 2015 to March 2016.***

87. The unit occupancy has been obtained for the period before and after the admission of Mother E&F Mother E&F Baby E and Fs mother] on 25th July through to 29th July 2015. The data shows that from 22nd to 31st July the unit had more than 48 cots of activity. There were 7 – 9 intensive care cots of activity and 14 – 18 high dependency cots of activity. The unit was therefore over the high dependency cot capacity during this period. In total, there was between 48 and 51 cots of activity during this period – See Figure 4.0 below.

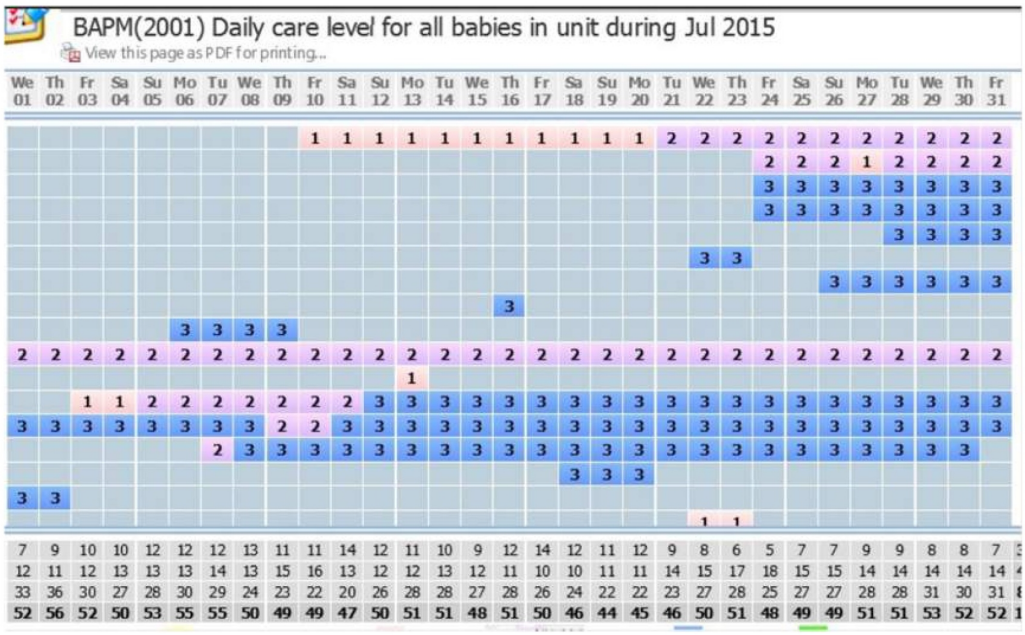


***Figure 4.0 - Screenshot from the electronic patient record system (Badger 3) showing daily cot occupancy in July 2015. The bottom 4 rows show the intensive care, high dependency and low dependent unit cot activity. The bottom row shows the total cot activity.***

88. In the last 12 months (November 2022 – November 2023) there have been 13 women transferred out of LWH to another Trust for delivery. Four of these transfers were documented as occurring due to the neonatal unit being closed to admissions due to cot capacity.

Child A and Child B [Trial Ciphers - Baby A and Baby B]

89. Child A and Child B's [Baby A and Baby B's] mother, Mother A&B I&S I&S I&S

Child C [Trial Cipher - Baby C]

90. Child C's [Baby C's] mother, Mother C I&S Child C's [Baby C's] I&S I&S There was no care provided by LWH in the index pregnancy.

Child I [Trial Cipher - Baby I]

91. Child I was referred to as Baby I at trial, Baby H at sentencing and Baby G on the list previously provided to us by Cheshire Police. She will be referenced using her name and corresponding Trial Cipher hereafter.

92. Child I's [Baby I's] mother, Mother I had her pregnancy booked at the COCH. She underwent spontaneous rupture of membranes on 31st July 2015 at 26 weeks gestational age and attended there. She was then transferred to Royal Oldham Hospital for ongoing care I&S due to the pre-labour, premature rupture of the membranes. She was discharged home from Royal Oldham Hospital on 3rd August 2015.

93. On 5th August 2015 she attended at the COCH as she felt unwell and blood tests showed she had a high inflammatory marker in her blood (C-reactive protein [CRP]). She was then transferred to LWH as there were cots available. On arrival she appeared well and continued to receive Erythromycin medication. She remained an in-patient undergoing assessment with CTGs. On the evening of PD August 2015 PD she went into

spontaneous labour, being transferred to the delivery suite. Labour proceeded with Child I [Baby I] being born at 20:47 hours.

94. I&S

95. Child I [Baby I] was born in good condition and cried at birth. Her progress through the first weeks of her neonatal care was fairly typical for a baby born at PD gestational age. She was intubated and received medicine, called surfactant, into her lungs to support her breathing. She was ventilated for the first 10 hours of life before being extubated onto Continuous Positive Airway Pressure (CPAP - a method of providing respiratory support without a tube passing into the trachea), following which she then commenced weaning. She received 5 days of antibiotics for possible infection with raised inflammatory markers (CRP) but with negative blood and cerebrospinal fluid (CSF) cultures. She received a second course of antibiotics with negative blood cultures. She commenced parenteral nutrition and her milk feeds were slowly introduced and increased. Her cranial ultrasound scan was normal.

96. Child I [Baby I] was transferred to COCH on 18th August 2015. This was usual practice once a baby had reached a point in their care pathway where an LNU was able to provide the care a baby was receiving and no longer required the specialist services in the level 3 NICU. This would mean the baby could be closer to home and planning for discharge home could commence.

97. Child I [Baby I] was transferred back to LWH from COCH on 6th September 2015 after experiencing a deterioration on the evening of 5th September with frequent desaturations requiring intubation and ventilation. Her abdomen was tense and tender. Baby I remained ventilated until 8th September at which time she was extubated into air. She was conservatively managed for a potentially serious bowel condition that affects pre-term infants, called necrotising enterocolitis (NEC), with antibiotics which were stopped on 11th September with feeds introduced and increased.

98. As Child I [Baby I] had improved and was no longer requiring level 3 NICU care, she was discharged back to COCH on 13th September 2015. She was on no respiratory support and was receiving milk feeds which were increasing.

99. The electronic records held at LWH provide further information regarding subsequent transfers and locations of care for Child I [Baby I]. The records indicate that Child I [Baby I]

was subsequently transferred from COCH to APH on 15th October, before being transferred back to the COCH on 17th October. There is no further information in the electronic records regarding these admissions nor what care was provided in COCH or APH.

Child J [Trial Cipher - Baby J]

100. Mother J Child J [Baby J's] mother was referred from COCH to LWH FMU clinic on 14th July 2015 with concern regarding the development of Twin-to-Twin Transfusion Syndrome (TTTS), which is a situation whereby one twin transfuses blood from one twin to another, causing one to be anaemic and one to be polycythaemia, meaning to have too many red blood cells. Child J [Baby J's] mother was seen in clinic the following day (15th July 2015) by Dr Surhabi Nanda, Consultant in Fetal Medicine, and TTTS was diagnosed.

101. Following discussion with the expectant mother, it was decided that she would undergo laser ablation of the placenta, aiming to stop the transfusion of blood between the twins. She was referred to Kings Hospital in London to undergo the laser ablation on 16th July 2015. Following the laser treatment Twin 1 was confirmed to have died in utero. There were follow up scans at LWH FMU on 20th July and 5th August.

102. On 18th August mother was scanned in COCH, with there being excess fluid (known as hydrops) around the surviving twin, Child J [Baby J]. Mother was rescanned at LWH on 19th August, confirming these findings. Further scans were performed at LWH on 26th August and 21st September. A fetal MR scan was performed on 21st August with a subsequent scan on 29th September. Both reported a normal fetal brain. There is no further record of the pregnancy at LWH.

Child O [Trial Cipher – Baby O], Child P [Trial Cipher – Baby P] and their surviving co-triplet [ Child R [No Trial Cipher – Will be referred to as the 'Surviving Co-Triplet']

103. Child O [Baby O], Child P Baby P] and Child R's [Surviving Co-Triplet's] mother, Mother O&P&R Mother O&P&R was referred to the FMU in January 2016. She was seen on 27th January and 17th February 2016. She was scanned by an FMU Consultant. Triplet 3 was smaller than the other triplets but there were no other concerning features, and the pregnancy was referred back to COCH for ongoing care.

104. Child R [Surviving Co-Triplet] was transferred to LWH on 24th June 2016. This was following the death of Child O and [Baby O and Baby P] whilst in the COCH. The transfer was arranged due to the uncertainty as to why Child O and [Baby O and Baby P] had suddenly died. Child R [Surviving Co-Triplet] was receiving antibiotics prior to admission to LWH due to the uncertainty as to why his two co-triplets had died. He remained in hospital at LWH receiving on-going care and establishing feeds. He had an uneventful neonatal course whilst at LWH and was discharged home on 14th July at PD PD corrected gestational age.

**Concerns or Complaints**

Complaints

105. There we no complaints or Patient Advice Liaison Service (PALS) referrals relating to neonatal care recorded for the period October 2012 to December 2012. There were no complaints relating to the neonatal service recorded for January 2015 to February 2015. There were two PALS referrals recorded relating to the neonatal service in January 2015 to February 2015; one related to a family who, for personal reasons, required a letter following the death, the second was in relation to a parent requesting accommodation, however this was not provided as the parent had access to accommodation locally.

106. There were no complaints received regarding patient care during either timeframe.

107. There are no recorded complaints with respect to Letby's conduct during either timeframe.

Neonatal Deaths or Serious Untoward Incidents

108. Between 1st October 2012 to 1st January 2013, there were 9 reported incidents of moderate harm or above on the neonatal unit at LWH. Between 1st January 2015 to 1st March 2015 there were 3 incidents of moderate harm or above. None of the reported incidents in either period proceeded to serious adverse event reviews.

109. In October to December 2012 there were 13 neonatal deaths. There were an additional 2 deaths of babies who died on the delivery suite before being admitted to the neonatal unit. At the time of these deaths, there was no nationally mandated requirement to review the care of babies who had died, however the LWH neonatal department had introduced

an internal review of babies who died on the neonatal unit. This review was of the babies who were born at LWH and who were admitted to the neonatal unit. During the time period in question there were 10 deaths reviewed under this process.

110. The review included providing an overall grading of care. This used the "Confidential Enquiry into Stillbirths and Deaths in Infancy" (CESDI) ratings as follows:

- Grade 0 = No suboptimal care.
- Grade 1 = Suboptimal care, but different management would have made no difference to the outcome.
- Grade 2 = Suboptimal care – Different management might have made a difference to the outcome.
- Grade 3 = Suboptimal care – Different management would reasonably be expected to have made a difference to the outcome.

111. This review was prior to the introduction of the Perinatal Mortality Review Tool (PMRT) process that was introduced in 2018 and adopted a similar scoring system.

112. During the 2012 review, four cases were deemed to be Grade 1, 1 Grade 2 and the rest were graded as 0.

113. As well as being reviewed internally, all deaths were reviewed by Merseyside Child Death Overview Panel (CDOP). This panel was a multi- agency panel and reviewed all child deaths aiming to identify any modifiable factors in the care. There were also neonatal specific panels which were attended by a neonatal consultant from LWH.

114. In the period January to February 2015 there were 6 neonatal deaths. By this time, LWH had started to grade the care of all baby deaths, not just deaths of babies who were born at LWH (in-born deaths). Two were graded as 0, with 3 graded as Grade 1. One death wasn't graded but was referred for coronial investigation. This child was born at Russel Hall Hospital and transferred to LWH. Following death, a coronial investigation was triggered. The medical records at LWH indicate this was initiated due to concerns raised by the family had with respect to care in their local hospital, not at LWH. The results of this coronial investigation, which was more likely conducted by the coroner local to where the child was born, are not known to LWH.

115. As was the case in 2012, all deaths occurring in 2015 were also subject to review at the CDOP.

116. Following contact with Cheshire Police in Summer 2018, a review of case notes was undertaken for both periods when Letby worked at LWH. The process that was followed is outlined below (data relates to both time periods, 2012 and 2015).

> *In order to review any potential suspicious events at LWH a review was undertaken. All incidents reported in the incident reporting system that included the name LL were examined. All deaths occurring on the days when LL was on duty were reviewed. The electronic patient record system (Badger system) was searched to identify any note entries made by LL. She had contact with 33 babies on a total of 324 patient days. Each of these days of care was reviewed by a neonatal consultant to identify any unusual or suspicious deterioration in the patient's condition. In addition, all babies who were on the neonatal unit on the days when LL was on duty were identified using the Badger system. Each of these days of care were reviewed by a neonatal consultant to identify unexpected or unexplained deterioration in clinical condition. There were 257 babies on the unit during those days with 1,308 days of care requiring review (source Chester Investigation Report 40219 as per* ***Exhibit MT/18 [INQ0011632]).***

117. Cheshire Police have been provided with the outcome of these reviews and continue to investigate any issues of concerns.

Communication with COCH

118. To the best of LWH's knowledge and belief there was no communication received by LWH from COCH with respect to Letby prior to the police involvement in May 2017.

119. In around January 2016, Dr Steve Breary (Consultant Paediatrician at COCH) had called LWH Consultant Neonatologist Dr Nim Subhedar in his capacity as the Neonatal Lead for the Cheshire and Merseyside Network to discuss if the Network would undertake an overarching review with respect to the individual babies who had died at COCH. On the 28th January 2016, Dr Subhedar received an email from the Personal Assistant to the Risk and Patient Safety Lead at COCH inviting him to attend a meeting on Monday 8th February 2016 to undertake a Thematic Review of the neonatal deaths. Letby's name was not mentioned during this communication.

120. Around the time of the publication of the Royal College of Paediatrics and Child Health (RCPCH) Report (published in November 2016), Dr Bill Yoxall, Consultant Neonatologist and Clinical Director for Neonatology at LWH between 2015/16, was contacted by telephone by Dr Steve Breary. There was a discussion about the mortality rates at COCH. Dr Yoxall asked Dr Breary if he thought there may have been a "Beverley Allitt" on the unit. Dr Breary replied that this was possible. Letby's name was not mentioned during these communications (source: telephone conversation between Dr Chris Dewhurst (LWH Deputy Medical Director and Dr Yoxall in November 2023).

121. LWH were not aware of either the name Lucy Letby, or that an individual under suspicion had worked at LWH at any time during their training. On 3 July 2018, Cheshire Constabulary met with LWH and requested that any available information on Lucy Letby be provided. Please see **Exhibit MT/17 [INQ0011631]** for the timeline of interactions since this point.

Communication with the Police

122. Please see **Exhibit MT/17 [INQ0011631]** for a full log of LWH'S interactions with the Police**. Exhibit MT/19 [INQ0011633]** provides a list of exhibits provided to the Police from LWH.

Communication with Parents

123. Parents who have children directly involved in the investigation are being supported by the Police Liaison Team and LWH have been advised by the Police that we should not have contact with these families.

124. There has been information on the LWH website advising families what to do if they feel they have a concern, and any contact is directed to the Head of Neonatal Nursing (HoN) or the Deputy Head of Nursing (DHoN). The HoN or DHoN will then telephone the family and have a conversation about their concerns, seeking to reconcile these as swiftly as possible.

125. Individual families who have been concerned that Letby may have looked after their baby and have contacted LWH have all been contacted individually and reassured where possible, by checking the date period and available records. In any instance where we think there may have been significant contact between a baby and Letby this has been

referred to Cheshire Police. This process has been agreed with Chesire Police and it includes any baby who was in the unit during the timeframes agreed and those whose baby may have had contact with Letby. There is a low threshold of referral.

126. The unit has had a very open and proactive approach to the investigation and trial of Letby. All parents have had letters by hand throughout this process acknowledging the sad and difficult situation and reassuring them their babies are safe in our care. We have also spoken individually to parents to ensure they are feeling safe and confident with respect to the care their baby is receiving. Letters and communications have been included as **per Exhibits MT/20 [INQ0011635] and MT/21 [INQ0011636],** these were sent / communicated in August 2023.

**General reflections and changes in practice**

127. The training placements available to nurses have not been changed. There is no standardised approach to speciality training, just a broad expectation of the competencies to be achieved, with the training programme designed to meet the clinical needs of each Trust participating and by the academic needs of the university.

128. The Letby trial highlighted the need for rotas to be kept with a record of who an individual student's mentors were. In addition, for all those who come to placement at LWH from another Trust, LWH is now asking for a letter of recommendation which outlines if the individual has any outstanding disciplinary issues or concerns that we should be made aware of (please see **Exhibit MT/22 [INQ0011637]**).

129. LWH believe that investment is required to support clinical facilitators to enable them to spend more time with the students assessing them in clinical practice. Within tertiary units with large establishments, it is more difficult to provide consistency in mentorship, therefore subtle nuances can be missed, for example gaps in knowledge and skills and interactions with colleagues and families.

130. It is LWH's view that there should be a more standardised approach to the QiS course nationally, so all neonatal nurses are working to the same level of competence. This has been raised by the NWNODN and other Operational Delivery Networks around the country and the National Lead Nurse for Neonates is raising this at national level.

131. The reporting of concerns in neonatal services at LWH is integrated into a Risk Management and Governance Framework. Delegated responsibilities, particularly under the Chief Nurse's authority, create a structured approach to handling risks. LWH's divisional structure, led by Divisional Managers, oversees neonatal services within the Division of Family Health. Monthly Divisional Performance Reviews provide a platform for addressing concerns, including those related to neonatal services. There are also the following arrangements:

- Regular safety huddles on the unit where concerns can be escalated.
- A daily Safety and Operational Meeting where concerns can be escalated.
- 2x daily bed meetings where concerns can be escalated.
- Weekly divisional senior leadership team meetings, where concerns can be escalated.

132. LWH follow NHS England's guidance for managing serious incidents, emphasising open discussions and investigations. Two Freedom to Speak Up Guardians, including a Clinical Guardian with a specific remit for engaging with the junior medical workforce, facilitate a culture of openness. Regular updates are submitted to the Putting People First Committee, ensuring early identification of actions to promote concerns and address emerging trends. The Guardians present their Annual Report to various committees and the Board, and a mid-year update is scheduled.

133. A designated Non-Executive Director serves as the Freedom to Speak Up lead, connected to the Guardians. Regular meetings with the Chairman, Chief Executive, and Chief People Officer, as well as 'walkabouts' involving Non-Executive Directors and Governors, provide avenues for staff to escalate concerns. Overall, LWH's reporting system is embedded in a comprehensive framework, ensuring a proactive and dynamic approach to addressing potential challenges in neonatal services.

134. LWH seeks feedback regularly through an embedded engagement cycle which includes the annual NHS Staff Survey, People Pulse surveys (ran three times per year) and the twice yearly 'Big Conversation' which is a LWH-wide approach that sees Non-Executive Directors and Executive Directors (amongst other senior leaders) attend clinical areas to ask for feedback on all aspects of working, including culture and leadership – main themes from the recent Big Conversation can be found in **Exhibit MT/24 [INQ0011639].**

135. The neonatal service also hold regular HR drop-in sessions led by the HR Advisor and has led 'Well-being Wednesdays' which whilst a well-being initiative, allows colleagues to come and talk about their feelings and experiences. LWH encourage the Freedom to Speak Up Pathway for feedback, with one of the current Guardians a colleague from the neonatal service who is invited to the monthly Divisional Board meeting. Listening sessions were held in the service by the Deputy Chief Nurse and Deputy Director of Workforce in November 2023.

136. An anonymous complaint was received in mid-November 2023, alleging bullying behaviours by colleagues and leaders within the neonatal unit. The concerns were raised by members of staff within the Unit, including directly to the Chief Nurse and via the Freedom to Speak Up Guardian, Dr Shri Babarao. In response, a series of listening events were conducted by the Deputy Director of Nursing and Midwifery, Nashaba Ellahi, and the Deputy Director of Workforce, Rachel London, providing a safe place for any further discussions and or escalations. The sessions were conducted between November 2023 and January 2024, and included the psychologist team who work within the neonatal unit supporting parents and staff. The responses have been a mix of positive and negative feedback about culture and leadership within the neonatal unit. Themes which have been raised include management visibility and willingness to support staff during busy periods, perception that the unit is busier and babies are sicker, a need for management support with challenging situations such as aggression from parents and some challenges with mixed acuity. The Trust's working document which summarises the feedback is exhibited as **Exhibit MT/26 [INQ0017182].** The Chief Nurse is reviewing the feedback obtained and sessions are being diarised with the leadership team to follow up on the feedback. Sessions will also be diarised with the wider workforce to outline next steps and the organisational response to the feedback from staff.

137. LWH continue to work to streamline and optimise pathways for neonatal babies. Predominantly, the vehicle for this is the LNP but the following also provides examples of improvements made:

- The retaining of rotas of post graduate students who undertake the QIS training.
- That all accidental extubations must be incident reported, ensuring that the team have line of sight on trends, issues with equipment, processes etc. (in place since 2020).
- Extreme pre-term pathway - only experienced QIS nurses look after extreme preterm babies in the first 72 hours of life (in place since October 2021).

- Swipe access added to the pharmacy room – (implemented in December 2019 [new unit opened March 2020 and this practice was retained]).
- For Serious Incidents consideration is given to who was involved in the incidents and whether there any names that repeatedly appear (in place since 2018 and aligned to the LWH Fair and Just approach).
- Two consultants to agree cause of death for death certificates (implemented in 2019).

**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 of its truth.

**Signed**: Personal Data

**Dated**: 15 February 2024