Witness Name: LAURA EAGLES
Statement No.: 1
Exhibits: **LEE/01** to **LEE/05**
Dated: 07/04/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF LAURA EAGLES

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1. I, Laura Elizabeth Eagles, will say as follows: -

Personal Details/Nursing Career and employment

2. I qualified as registered nurse (RN Adult) in 1999 from The University of Liverpool. I also obtained my Registered Health Visitor (RHV) qualification at the same time.

3. I have a Bachelor of Nursing (Hons) degree and am a RN and RHV, now called Specialist Community Public Health Nurse (SCPHN).

4. I have further studied at the University of Manchester and obtained my Qualification in Speciality (QIS/405) and Enhanced Neonatal Practitioner course (R23), in 2001 and 2012 respectively.

5. I began Neonatal nursing as my first job in Wythenshawe Hospital in 1999. I moved to The Countess of Chester Hospital in 2003, where I currently work.

6. I became a Band 6 in 2004 when the Agenda for Change banding was introduced. Prior to that I was a D and E grade nurse respectively. In 2015 I was working as a Band 6 Senior Neonatal Practitioner and currently still am. I became a Deputy Ward Manager in 2018 following a period of succession planning.

7. In May 2016 I temporarily moved to the Renal Dialysis Unit at The Countess of Chester Hospital on a 6 month secondment.

8. On the Neonatal Unit (NNU) between 2015 and 2016 my duties were caring for sick and premature babies, and their families, of gestations from 27 weeks and over. This involved those that were intensive care (ITU), high dependency and special care. I

would also have acted as shift leader on some shifts. This involves co-ordinating the team, ensuring that staff allocation is appropriate, that all the medications have been given, dealing with any queries from other departments, liaising with the doctors, covering any staff sickness if possible, providing support to other members of staff that require help. I did not have any management responsibilities at this time.

Culture and atmosphere

9. On the NNU between June 2015 and June 2016 we had very good immediate Managers. Our Ward Manager and Deputy Ward Manager were very present, approachable and strong in their leadership. We had a Head of Paediatrics who was also available when needed but not directly working in our team. Anyone above that in the management structure we very rarely saw and they did not engage with those on my level of nursing that I recall. If any senior managers came to the unit they would have gone straight to the manager's office.

10. We could seek practical support from the hospital coordinators out of hours, if required, but their ability to help was limited due to our specialist area of work and the complexity of our patients.

11. The working relationship between nurses and doctors I would describe as good. We worked together well, particularly with the registrars and SHO's (Senior House Officers). The Consultants were approachable and took the lead on clinical decisions.

12. I cannot comment on the relationship between the doctors and management other than with our Ward Manager, which I also feel was a good relationship.

13. The relationship between the NNU team and the Obstetric Team was more complex. We, as nurses, would directly liaise with midwives. There was very little communication between us and the Obstetricians. If we had challenging conversations to have, we would ask our Consultants to speak with them. We would sometimes face discord from some senior midwives and ourselves. This would be in relation to when we were heading to full capacity or already at it and the midwifery team not valuing our concerns. It could be quite a struggle sometimes when we were full and them wanting to deliver a baby that would need our care and us not having room. We would ask them for help and some appreciation of our situation but would not get it. I cannot say this was all the time but it was quite common to have a struggle when we were getting full and or closed. If we, as a NNU team, felt the best

thing for the pending admission was a transfer out, it would be very difficult to make this heard by the Obstetric team.

Child A and Child B

14. I do not recall what was said about Child A's death as per my July 2018 police statement **[INQ0000067]**. I attach this statement as my **Exhibit LEE/01**.

15. I have no recollection of any debriefs in relation to Child A's death. The only meeting that I recall is the one stated in the supporting documents for this statement, where Child A is discussed. I refer to the minutes of this meeting, not my personal recollection, Thematic Review of Neonatal Mortality 2015 – Jan 2016 held on 8 February 2016 **[INQ0006890]**. I attach the minutes as my **Exhibit LEE/02**.

16. As per my July 2018 police statement, **[INQ0000067] (Exhibit LEE/01)** the discussion was that the rash/discolouration seen on Child A and B could be related to **I&S** Blood samples were taken from Child B and sent for testing.

17. At the same meeting as mentioned above on 8 February 2016 **[INQ0006890] (Exhibit LEE/02)**, the collapse of Child B was mentioned as part of the review of her twin. I do not recall any debriefs.

Child I

18. I do not recall when I found out that Child I had died.

19. It is very difficult to say if a child on the NNU collapsing, is expected or unexpected. All the babies we have, have a reason for being a patient on the NNU. They are not well enough to be cared for at home or on the postnatal ward. As per my October 2018 police statement **[INQ0000524],** which I attach as **Exhibit LEE/03,** Child I was ill on several occasions sometimes needing transfer to a Tertiary unit which is a Level 3 Neonatal Unit. They provide care to babies who need the highest level of support. I am unable to say if I thought the collapse at 0320 on 13 October 2015 was unexpected.

20. As per my October 2018 police statement **[INQ0000524] (Exhibit LEE/03)** Child I had an enlarged abdomen and was waiting for investigations at Alder Hey which she could not have as they did not have a bed. I believe at the time it was thought that

complications with her gut had caused her death. I cannot say if the death of Child I was expected or unexpected.

21. I do not recall any debriefs about Child I's death.

22. As mentioned previously, the only meeting that I recall about any of the deaths is the Thematic Review of Neonatal Mortality 2015 – Jan 2016 held on 8 February 2016 **[INQ0006890]** (**Exhibit LEE/02**).

Child J

23. It is not uncommon for babies on the NNU to have profound desaturations. I recall that Child J's parents wanted informing of any change in condition. As she had been screened and restarted on antibiotics, this was significant and therefore it is good nursing practice to inform parents that their child had become unwell, or condition had changed.

24. As stated, it is not uncommon for babies to have profound desaturations and it is commonly a sign of infection. As Child J had possible routes of infection e.g. indwelling central line, it would not be unexpected that she may have developed an infection.

25. I cannot recall the exact conversation that I had with Child J's parents in November 2015.

26. I cannot recall if I was present when Dr Gibbs spoke with Child J's parents on this day.

27. Any nursing discussions about a baby's condition would involve the shift leader handing over the whole unit to the following shift leader. It is their duty to provide factual details of all the babies conditions. The person caring for the baby hands over the care to the oncoming person taking over. I do not recall discussions regarding Child J on the morning of 27 November 2015.

28. I do not recall any debriefs in relation to Child J.

29. In relation to my statement to the police dated 30 April 2019, which I attach as my **Exhibit LEE/04 [INQ0001128]**, the term "Dusky" is commonly used in neonatal units to describe a general cyanosed appearance, slightly grey/blue in colour.

30. In relation to Child J's collapse on the morning of 17 December 2015, my answer remains the same as previously stated that it is not uncommon for babies to have profound desaturations/ "collapse" and it is commonly a sign of infection. As Child J had possible routes of infection e.g. indwelling central line, it would not be unexpected that she may have developed an infection.

31. I do not recall if there was a debrief regarding this event.

32. As previously stated with regards to handover; the shift leader would hand over the whole unit to the following shift leader and it is their duty to provide factual details of all the babies conditions. The person caring for the baby hands over the care to the oncoming person taking over. I do not recall discussions regarding Child J that morning.

33. In general, we discuss the condition and care of the babies in a professional capacity between nursing staff and doctors and other allied health professionals, in order to provide the most appropriate care to that baby. Maintaining open lines of communication between professionals is in the babies' best interests.

34. I cannot think why we would not have normal professional conversations regarding any baby's condition and care. I cannot recall the content of any specific conversations in relation to Child J.

Thematic Review of Neonatal Mortality

35. My recollection of why I was at the Thematic Review of Neonatal Mortality 2015 – Jan 2016 meeting on 8 February 2016 is that I was taken as experience. My manager, Eirian Powell would take me to meetings for my general development as I had an interest in management. I recall I was unaware of the content of the meeting until I got there.

36. I was not concerned about the mortality rate as a result of this meeting as I was already aware of the number of deaths that had occurred.

37. I do not recall any discussion about Lucy Letby at this meeting other than her name being written, along with all the other staff on duty, at the side of each baby's name. There is no mention of a discussion that I can see, in the minutes.

38. It did not give me cause for concern at this meeting that Lucy was present on duty as she was a full time member of staff with QIS therefore, it would not be unusual to be involved with the sickest babies. She also did a lot of extra shifts. I did not have the benefit of hindsight when present at this meeting.

39. I do not believe I said anything about Lucy being present at all the deaths of the babies. I do not recall a conversation about her specifically. With regard to one of the babies that I was caring for when he died, Lucy was not there as she had finished her night shift and he died on the day shift. This is observed in the minutes.

40. I did not consider taking action in relation to Lucy being present at the deaths as I have stated that I did not have any concerns. As far as I was aware no one else did. This was never brought to my attention.

41. I did not consider any link between the deaths and any member of staff. At the time of these deaths the NNU was very busy and had a high number of ITU in that period. Many of these babies were particularly sick, premature or had complications. It is not normal to be suspicious of one's colleagues.

42. I did not discuss any views with anyone.

43. I believe I became aware that others in the hospital were concerned about a link between Lucy and the mortality rate in May 2017. The Trust announced to the whole hospital that the police were being involved. I personally found out when I was on a bank shift on the adult side.

Concerns and suspicions

44. I do not recall ever having any training on "Whistleblowing" formally. However, I am aware of how to raise concerns. The process would be to inform the manager or higher if necessary and to complete a Datix (incident form), depending on the type of concern.

45. I did not have any concerns about the conduct of Lucy whilst she worked on our unit. If I had I would have raised them at the time. In relation to allocation, this is done on a skill mix basis depending on what staff you have on duty and the dependency of the babies. The only time you may not allocate a QIS nurse to the ITU babies is if they have had a run of ITU/sick babies. This is the case for everyone and is to prevent burnout.

46. I was not aware of any suspicions of others. Lucy was removed from our unit but we were told this was a secondment. The first time I knew that there were concerns about the conduct of Lucy was when we were told the police had been called in to investigate.

47. The debrief process was informal and ad hoc. Generally, the consultant involved would arrange a meeting with as many of the staff involved as possible so there could be a discussion about the case and how we felt.

48. I was aware of the increase in mortality rate. Obviously, all deaths are concerning, and it is important to ensure that all clinical care has been reviewed to make sure that it was correct. As far as I recall the coroner was informed on all the deaths. As I have previously mentioned, there was an increase in activity on the unit and it felt like there were more sick babies than is usual. This could then explain why perhaps that there were more deaths, in my opinion.

Reflections

49. I do not think CCTV monitoring within the NNU would have prevented the crimes. Lucy was meant/allowed to be in the nurseries, at the cot sides, drawing up drugs etc. In my opinion it would show a nurse going about her work. I also think CCTV is an invasion of the parents' privacy.

50. No one ever expects a trusted colleague in the caring profession to commit crime. I do not know what could be done to prevent this ever happening again in any NNU. In my opinion, at the time I felt the babies were safe and that we were all doing our best

to care for them, giving our all. I am passionate about the care I give to babies and their families. I work hard to care for them and give them the best outcomes. I do not know how the actions of one individual could be prevented.

51. I do not have any additional supporting documents or information that is relevant to the Inquiry.

52. My police statements were given as a true statement at the time and remain accurate. I have nothing further to add. I attach my 23 January 2018 statement as **Exhibit LEE/05 [INQ0001127]** in addition to **Exhibit LEE/01 [INQ0000067]**, **Exhibit LEE/03 [INQ0000524]** and **Exhibit LEE/04 [INQ0001128]** which have been exhibited previously in this statement.

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: 7/4/24