Witness Name: Amy Davies
Statement No.: 1
Exhibits: AD/01 – AD/04
Dated: 10 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF AMY DAVIES

I, Amy Davies, will say as follows: -

1. My full name is Amy Judith Davies.

2. I have worked at the Countess of Chester Hospital since 2006. I was first employed as a Nursery Nurse (Band 4) on the neonatal unit. I left in 2008 to do my nurse training and studied at Northumbria University in Newcastle. I remained on the bank to do bank shifts throughout my training. I qualified in 2011 and I worked in St Mary's Children's hospital as a Neonatal Nurse. I returned to the Countess of Chester Hospital in a full-time role as a Neonatal Nurse (band 5) in 2012. I became a band 6 Neonatal Practitioner in October 2013. I remained a Neonatal Practitioner/Senior Neonatal Practitioner until 2023, when I became the Neonatal Feeding lead. This role is 20 hours at a band 7 and my remaining hours are as a band 6 Senior Neonatal Practitioner. I have always worked full time (34.5-37.5 hours) although I have had 3 periods of I&S: March 2013 - October 2013, March 2015 - January 2016 and November 2018 - August 2019. During this time, there will have been occasional 'keeping in touch days.' I am unsure of the specific dates; however, they will have been towards the end of the I&S.

3. Throughout my time on the neonatal unit, I have completed various courses and further education. These include: Advanced Diploma in Childrens Nursing (2011), Neonatal induction Course (2011), Qualification in specialty (2013), Bachelor of Science in Nursing Degree (2015), Enhanced Neonatal nursing qualification (2017), Lactation Consultant qualification (2022) and Tongue tie Qualification (2022).

Culture and atmosphere on the neonatal unit 2015 - 2016

4. Between 2015 and 2016, my role as a Senior Neonatal Practitioner was to care babies on the neonatal unit. This was either clinically, by being the allocated nurse for the babies and supporting parents to care for their babies, or as the shift leader, overseeing the care for

the babies on the unit and overseeing the day to day running of the neonatal unit. I could care for babies requiring transitional care, special care, high dependency and intensive care. As I mention above, I was on I&S from March 2015-January 2016 although I will have had 'keeping in touch days.'

5. I have always felt well supported by management throughout the time I worked at the Countess of Chester Hospital, by both my past and current manager. That has enabled me to carry out my role sufficiently. I was supported to enhance my learning and learning opportunities were provided for me to progress in my career. I always felt I could approach management if I needed to, via an 'open door policy'.

6. I cannot recall having any concerns about the relationships between managers and nurses, managers and doctors or doctors and nurses. As far as can remember, relationships were always professional.

7. I have reviewed my previous statements dated 23 March 2018 **[INQ0001554**], 23 May 2018 **[INQ0001400**], 23 October 2018 **[INQ0001224]** and 8 February 2023 **[INQ0001258]**, which are attached as my Exhibits **AJD/01, AJD/02, AJD/03** and **AJD/04**. I confirm that these statements remain accurate and I have no further information to add.

Child L and M

8. I do not have much recollection of my involvement in looking after child L and M and I therefore cannot recall when I was first made aware of the fact that child L's blood sugar remained low despite at one stage 15% dextrose being administered or of child L's collapse. My first memory of this is explained in my police statement discussing this case (dated 23 October 2018 [INQ0001224] and attached as Exhibit AJD/03).

9. To my knowledge/memory, there was no formal process to discuss where there was an unexpected event or unexpected response from a baby to treatment. However, as a team we may discuss it and I would have felt very comfortable to discuss any such event with my colleagues, including doctors and nurses, when on a shift together.

10. I am not aware of and cannot remember any discussion about Child L's condition or treatment and I do not believe I was part of any discussion on it.

Child O and Child P

11. In my police statement dated 23 May 2018 ([INQ0001400] – Exhibit AJD/02), I refer to being informed of the deaths of child O and child P upon my return to work and my statement included the following comment: "*I was mainly surprised and upset at the news, as I didn't expect this to happen and this was the same feeling for my colleagues on the*

unit. I can't recall if anything was specifically discussed but we supported each other amongst ourselves, and I wasn't involved in any debrief."

12. I was surprised at the deaths of child O and child P because they were very stable when I looked after them on my shift and I was not aware of any health concerns that may lead me to believe death was a possibility.

13. I cannot recall why I thought staff felt surprised at the death of child O and P. I believe it will have been for similar reasons to myself, which was because they were stable with no health concerns other than prematurity. I cannot recall when I discussed their deaths with staff. I feel it would have been when on shift in work and I believe it will have been with my nursing colleagues that also cared for child O and child P.

14. Although I was surprised at the deaths of child O and child P, I did not raise any concerns as I felt the deaths were being looked at by the medical team and through a postmortem. I assumed that there would have been an underlying health condition that we were not aware of that lead to their death, or a sudden infection.

15. I am not aware of any debrief taking place on the deaths. I would not have expected to be involved with any debriefs as I was not present for the time leading to the deaths of child O and child P.

Child Q

16. In regard to child Q and my night shift on 25 June 2016, I do not recall the handover that myself and Lucy Letby had. The fact that child Q needed to be intubated will definitely have been discussed as intubation is a very significant event and would need to be raised. It is normal practice to do so. However, I do not recall the handover and I do not recall any specific information that Lucy or any other nurse gave me about child Q.

17. In my statement to the police dated 23 March 2018 ([INQ0001554] – Exhibit AJD/01), I refer to child Q being restless and unsettled at the beginning of the shift and that I asked the doctor to review him. From reading my notes, the concerns that led me to get child Q reviewed was the possibility that he could be in pain. I cannot recall from memory however I feel that I would be getting him reviewed to see if he required pain relief. I do not believe my concerns will have been related to the deaths of child O and child P.

18. To my knowledge, I was not aware of any concerns raised by any member of staff in relation to Lucy Letby being the assigned nurse to child Q following the deaths of child O and child P.

19. I cannot recall having any concerns that Lucy Letby had been caring for child Q.

Concerns or suspicions

20. I cannot recall whether we had specific training on how to report concerns about fellow members of staff at the time. However, I know I knew about 'whistle blowing' and I felt confident that I could report any concerns to my line manager or higher management if I had concerns and I would have done so if I had any concerns.

21. I did not have any concerns about the conduct of Lucy Letby. If I did, I would have discussed these with my manager. I was not aware of any suspicions of other people.

22. After the death of a baby on the neonatal unit, I do not believe there was a formal process for a debrief. I think they were organised by the staff that were involved with the baby at the end of their life, often organised by the consultant involved. There will have been discussions between nurses, either at hand over or whilst on shift.

23. When I returned I&S in January 2016, I was aware there had been an increase in the rate of babies that had passed away. I do not recall how I knew that, and I am not aware of any discussion about a cause for the increase.

24. The increased death rate was upsetting for the babies and the families involved. However, I do not believe I was concerned as I did not know the reason for the deaths and presumed that babies had been unwell or had underlying health issues.

Reflections

25. I feel very unsure about whether CCTV would have stopped the crimes from taking place. Babies are not always in full view due to incubators, incubator covers, position of staff etc. so I feel that it would probably not help.

26. I have been asked what recommendations the Inquiry should make to keep babies on neonatal units safe. I have given the matter careful thought, but I do not know what recommendations could be made.

27. I do not have any supporting documents which are relevant to the Inquiry.

Statement of Truth

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

Signed: Personal Data

Dated: 10/4/2024