**Witness Name: Caroline Jane Bennion**

**Statement No: 1**

**Exhibits: CJB1 and CJB2**

**Dated: 11 April 2024**

**THIRLWALL INQUIRY**

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**WITNESS STATEMENT OF CAROLINE JANE BENNION**

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I, Caroline Jane Bennion, will say as follows:

Nursing career and employment in the Countess of a Chester Hospital

1. I qualified as a Children's Nurse in 1996, RN Child (Diploma) affiliated to Bangor University in 1993. After qualifying as a Nurse, I worked in Wrexham Maelor Hospital on the neonatal unit as a grade "D" junior nurse. In 2002, I moved to the neonatal unit at the Countess of Chester Hospital NHS Foundation Trust (COCH) for a promotion to a "F" grade senior staff nurse. A grade F Nurse is now equivalent to a band 6 nurse on the agenda for change pay banding scale. I currently work at COCH as an Advanced Nurse Practitioner.

2. I have obtained various qualifications in neonatal care. In 1998, I completed a special course in neonatal care and neonatal intensive care (equivalent to qualifying in neonatal speciality course in Wales). In 2003, I completed the R23 Enhanced Neonatal Practitioner Course. This was a single degree module, which I completed with the University of Manchester. In 2012, I completed a degree in Professional Practice with Chester University. In 2016, I undertook a master level module in Newborn Infant Physical Examinations with Chester University.

3. During my employment with COCH on the neonatal unit from 2002 (including the period between 2015 - 2016), my duties as a senior neonatal practitioner included caring for special care infants, high dependency infants and intensive care infants. I had a role as shift leader, which involves managing the day-to-day running of the unit. In 2018, I also took on the role of deputy manager for the neonatal unit. This role was shared between me and another band 6 colleague. Our duties are part clinical as described and deputising for the unit manager and rota allocation.

4. In 2022, I qualified as an Advanced Neonatal Nurse Practitioner with Liverpool John Morres University. I remain currently employed on the Neonatal Unit as an advanced Neonatal Nurse Practitioner.

**The culture and atmosphere on the NNU at the hospital**

5. During 2015 - 2016, my immediate deputy manager and unit manager were very supportive, approachable, and proactive with personal development. Learning opportunities, study days and courses where often recommended and encouraged. I was aware of the next tier of management however, I had no personal involvement in any managerial activities and cannot comment on the relationship between clinicians

and managers. I feel there was a good relationship with clinicians, allied health professionals and the obstetric team, although the maternity and neonatal units sometimes worked separately. At COCH, we currently work more collaboratively. The current approach is to share practice and learning through joint reviews of term and preterm admission, maternity and neonatal safety huddles, joint midwife and nursing education sessions and joint special interest groups within the network, focusing on improving practice.

6. At that time, between 2015 - 2016, the neonatal unit and obstetric teams were not as collaborative as they currently are, but the relationship between clinicians and the immediate unit management team was good. I do not recall involvement with more senior management at a ward level.

**Child A, Child B, Child C, Child G, Child O**

7. I have reviewed my previous police statements (included at **Exhibits CJB1 [INQ0000334]** and **CJB2 [INQ0000064]**) and I confirm that these statements remain accurate.

8. Following the death of Child A, there would have been a hot debrief immediately following the event with all those involved to check-in on their well-being and ensure that they were okay before going home. I cannot recall who was present and what was said during the debrief. A meeting was normally arranged a few days after the event to discuss matters in more depth and particularly about any learning events or points to discuss with the wider team. This would have been arranged by the Consultant involved and a request would be emailed to the nursing manager to inform the staff involved. This cascade would have been done via face-to-face unit meetings, a safety huddle or via email. I cannot remember any specific learning points, or any reference made to a link between discoloration of Child A and Child B made.

9. Appraisals were performed annually on the unit. These were performed by Eirian Powell (unit manager), Yvonne Griffiths (deputy manager) and Yvonne Farmer (practice development nurse). I did not appraise Lucy Letby. I do not recall personally any discussions related to high death rates on the unit and a link to Lucy Letby. I recall Lucy Letby being released from clinical duties to work in the risk team. I was not made aware of the reasoning for this. This was a manager-employee confidential matter that I was not involved in. As previously stated, I cannot recall any suggestions for learning following the incidents.

10. From reading my Meditech notes, I do not recall Child C's death and therefore cannot comment as to whether this was expected or unexpected. I do not recall telephoning Mrs Joanne Elizabeth Williams to inform her. I would have done this out of care and compassion for a colleague to avoid them having to face such alarming news on their return to work. I cannot recall a debrief taking place following Child C's death. I did not have any concerns that Child C had died six days after Child A because I felt there was no correlation.

11. After consulting my previous statement regarding the events of 21 September 2015 (**Exhibit CJB1 - [INQ0000334]**), on reflection, an extreme pre-term baby like Child G had the capacity to become unwell very quickly so a few indicators of deterioration such as low Hb (low blood count,) low temperature and parents stating that the baby

is not themselves all inform nursing and medical staff that a potential deterioration may occur.

12. From the reading of my police statement (**INQ0000334_0003**) I recall Nurse W informing me that the monitor was switched off. I then informed her to escalate this at the nearest opportunity to the nursing manager, Eiran Powell. My impression was that it had mistakenly been switched off or moved to an alternative limb by the person inserting the cannula to access another limb. However, I recognised this may have been a potential serious issue and informed Nurse W to report this to our line manager. I cannot recall if any Datix was completed, or any learning cascaded. I do believe this would warrant completion of a Datix form and staff being informed at a daily safety huddle to always ensure that monitors are never turned off. Since we have moved to a new neonatal unit, we have central monitoring. If a baby requires monitoring, this is connected and viewed on a central hub for others to also see their readings, and if a monitor was not picking up adequately or even inadvertently switched off.

13. I do not recall when I found out that Child O had died. I do not recall if this was unexpected or expected. I can not recall if there was a debrief.

14. I was involved in the care for Children A, B, C, G and O who died or collapsed. I recall thinking that the death of Child A was sudden and there was no indication that it was imminent. However, I never considered a link between them all or to a member of the nursing team such as Lucy Letby.

15. I did not have any views that I discussed with anyone in the hospital or elsewhere as I did not make any correlations.

16. I realised that others in the hospital had identified a link on the unit when we were informed of the first arrest by the police.

**Concerns or Suspicions**

17. We have mandatory training on conflict resolution. We had a good relationship with our immediate management team to feedback any concerns we may have had regarding colleagues, unsafe practices and not adhering to policies. The manager at the time, Eirian Powell, was very keen for staff to openly report incidents through Datix and log concerns with a no blame culture. I was aware of the freedom to speak up but at the time, I would not have known who to approach or the process for doing so.

18. I recall Lucy Letby being a professional and competent nurse. I had no concerns regarding her practice.

19. I was aware of rumours about Lucy Letby's conduct after the first police arrest and when other members of staff (such as medical colleagues) made an association between several deaths and Lucy Letby as she was on duty each time. I cannot recall exact dates.

20. There were always informal hot debriefs after a death and collapse of a baby. All staff involved including the midwifery and obstetric staff (where appropriate) would be

invited too. A formal meeting would be arranged and sent out by the consultant to all staff involved later. I remember being involved with a Trust initiative with two nursing colleagues where we completed a course called PACE (I not aware of what the acronym stands for). This course was about support and a quick referral process available to Occupational Health services when required. The process is like a self-referral system and a method of receiving support by staff and being resilient. This was Trust wide and not specific to the neonatal unit.

21. I was personally alarmed or alerted to the number of child deaths when one of the triplets died on 21 June 2016. I can remember asking my colleagues (although I can't recall who) about what had happened. It was completely unexpected, they were mature babies born at 33 weeks, good weights and although they were receiving respiratory support, they were very stable. I wondered if there was a significant infection on the unit that we were missing. This was a discussion with nursing staff (although I cannot recall their names) given that infection is always a concern in relation to preterm babies. This was not a conversation I had with medical staff or outside the unit, but it was more of a speculation between the nursing staff.

**Reflections**

22. I cannot comment as to whether having CCTV on the unit would have prevented the crimes of Lucy Letby. If a perpetrator of a crime wants to commit a crime, they will find a way to commit them. If working in close environment such as the neonatal unit didn't deter Lucy Letby, then I believe the presence of CCTV wouldn't have either. We work in an environment of trust, sensitivity, and openness. Unfortunately, this has been shattered by one determined individual.

23. In terms of recommendations, I consider fostering an open culture of respect, freedom to speak up, relationships with senior management and chief executives are important. I believe this Inquiry should also reflect on the lack of support that initially the staff on the unit received. There was minimal support from the Royal College of Nursing and Occupational Health teams as this was seen as a conflict of interest. They were supporting Lucy Letby and unable to support the team. There was no internal support or specific recognition for the staff as a body of people to protect their wellbeing. We relied on internal team support. It is only in the later years that we have received psychological support.

**Request for Documents**

24. I have no supporting evidence apart from the statements given prior to the trial and during the trial.

Signed Personal Data .....

PD

Name ..... Caroline J Burrow

Dated ..... 11/4/2024 .....