Witness Name: Nurse X
Nurse X
Statement No.: 1
Exhibits: 0
Dated: 10/04/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Nurse X

I, Nurse X will say as follows: -

1. I&S

Nursing career and employment at the Countess of Chester Hospital (the "hospital")

2. I qualified as a children's nurse - BN (HON) - in I&S from the I&S In I&S I completed a Master by Research also at the I&S I hold a Postgraduate Certificate in Paediatric Intensive Care Nursing (I&S) from the I&S I&S. My additional neonatal qualifications are the Enhanced Care of the Neonate (QIS) (I&S from I&S, and the Enhanced Care of the Neonate (R23) I&S from the I&S

3. QIS is Qualified in Specialty; this is the course that neonatal nurses undertake to be able to take care of all patients, including high dependency and intensive care level patients. This qualification is the one that the British Association of Perinatal Medicine (BAPM) refer to in their guidelines for neonatal unit staffing. The R23 course is a higher-level course for nurses once they have more experience. Not all units use this course.

4. From I&S I worked in general paediatrics at the I&S I&S, before moving to I&S in I&S I worked on the Paediatric Intensive Care Unit (PICU) at I&S in I&S from I&S I returned to the UK and started working in I&S in I&S I worked bank and agency shifts (ad hoc) in several hospitals in PICU and neonatal units (NNU). During this time, I had substantive hours at I&S (neonatal intensive care) from I&S I&S, and at I&S (PICU) from I&S

5. I joined the bank for the neonatal unit at the Countess of Chester in I&S, and joined substantively, part-time, in I&S as a Neonatal Practitioner. I have

continued to work on this unit since then, becoming a Senior Neonatal Practitioner in I&S I&S, once I obtained my R23. Both these roles are Band 6. In I&S I was the Paediatric and Neonatal Research Nurse for a year I&S, I continued to work on the neonatal unit during this time.

6. Each shift I was responsible for the care of my allocated babies and their families. This included providing all the care the baby required, raising concerns to the medical team, teaching families how to care for their babies as needed (including preparation for home), and providing support to families. For some of my shifts I would also be the shift-leader. This role included supervising all ward staff and providing support to them, cot management to allow admissions from labour ward and transfers from other hospitals, ensuring that all ward safety checks were complete, and ensuring that stock and medications were available on the ward. As shift-leader I would also have patients, ideally special-care level (the least dependent babies) but this depended on the ward acuity and staffing. The role also includes non-clinical activities to support the development of the unit. Currently, I ensure that our nursing guidelines for practice are up to date, I am responsible for the accuracy of our Badger data (Badger is the nationwide system for recording and auditing neonatal unit activity), and I am the infection control link nurse.

The Culture and Atmosphere on the NNU at the Hospital in 2015-2016

7. The unit nursing team was generally supportive of each other, and asking for assistance or guidance was part of the day-to-day functioning of the unit. As shift-leader it could be difficult to oversee everything going on in the unit when it was busy as we also had patients to care for. During weekday daytime shifts there was often one of the senior nursing team (ward manager, deputy ward manager, practice development nurse (PDN)) in the ward office for support in management decisions if required. At nights and weekends there was more of a workload as shift-leader and minimal support available. If it was also busy elsewhere in the hospital, we also might not have seen the medical staff much.

8. Our ward manager was open to general concerns or issues being raised. She could be defensive of nurses on the unit and would generally support nurses if issues were raised by doctors, for example. That said, she had obvious favourites amongst the staff as well as a couple of staff that she clearly did not like. This meant that her response to issues / incidents varied depending on who was involved.

9. At this time, there was minimal confidentiality from the office; and I found out a few things about staff members that I should not have known. I&S

I&S

10. The relationship between NNU nurses and management (those above ward manager) was minimal, although I am aware that they spoke to the unit manager regularly. For example, Karen Rees (I cannot recall her job title) came to the unit most weekdays but did not speak to staff as she walked through to the office. There were many members of the more senior team that I would not recognise if they came on to the ward. I do not have enough knowledge about the relationships between either clinicians or midwives and management to comment on these.

11. The NNU was busy at this time, and the labour and postnatal wards were also. There was no set communication strategy between NNU and either ward. There could be frustration on both sides relating to 'cross-over' care. Examples of this are NNU nurses giving IV antibiotics to post-natal ward babies, and midwives assisting new mothers with expressing when they were unable to visit the NNU. Both require coordination between each ward's staff and busy workloads often meant that it was difficult to do this.

12. The clinicians were part of the paediatric team, who were also responsible for the neonatal unit, and it did feel like we were two teams (nurses and doctors). It could be difficult to get engagement from the medical team sometimes, and decisions could be deferred for days at times. There were two consultant ward rounds per week, and we saw little of them outside of these. The registrars had differing levels of neonatal experience and were not always keen to make decisions.

Child D

13. From my recollection of events of the night shift commencing 21 June 2015 please refer to my statement (INQ0000805), this recollection (guided by patient notes) was from 2.5 years after the shift and is more detailed than my recollections now.

14. In my statement (INQ0000805) I refer to having seen 'a couple of other babies around this time with a similar rash [to the one Child D had]'. This statement was taken in January 2018, I was referring to babies after Child D, although I cannot remember these now. I have looked through notes to find any babies I cared for that may have had this rash but have not been successful so far. I was aware that Children A and B had had this rash, but I did not see it. It is possible that this is what I was referring to in the statement.

15. I remember that there were discussions on the night shift of the 21 June 2015 about the rash, but I cannot remember details. Somebody (I think Caroline Oakley) asked me if I had

seen that rash before and I said I had not. I also remember discussing the rash, and hearing it discussed, at other times but cannot remember details.

16. Following the death of Child D, I do not recall there being a debrief for staff. At the time debriefs were uncommon. I do not remember debriefs being common at any of the hospitals I have worked at. I spoke to the Ward Manager and neonatal Practice Development Nurse after that shift, because of issues that had arisen during the resuscitation. I recounted to them that we had difficulty finding the drug dose chart, that only the Registrar and I had known the doses needed, and asked if we could have the laminated chart on the wall of the intensive care room as well as on the resuscitation trolley (this was done).

17. In 2015 I was involved in a debrief for a baby (on this unit). The debrief was after the post-mortem had provided a cause of death and because the nurses and junior doctors involved had been frustrated by the management of this baby. I believe that the feedback given was taken back to the Consultant team, but I do not know the outcome of this.

18. Following the death of any child there are always informal discussions between staff. Deaths are upsetting and can be traumatic. The team provides support.

19. On the unit now, there is always a debrief following a death or collapse. An initial debrief is done as soon as the event as possible (during the same shift), which is more for emotional support. Within a few days a more structured debrief will be held, led by a consultant. This is when any issues and points of good practice are shared. Everyone involved in the event is invited and encouraged to participate. This debrief involves all teams who cared for the baby and will include a timeline from antenatal care through to the time of collapse/death.

Increased Mortality on the NNU

20. In statements to the police dated 24 March 2018 (INQ0001413) and 25 September 2019 (INQ0000805) I explained that I was aware that there was an increased mortality rate on the unit between June 2015 and June 2016.

21. I also refer to the morale on the unit being low and people being worried about the number of deaths. (INQ0001413).

22. Morale was low on the unit at this time. We had been consistently busy for months. Nurses were stressed and tired. People were working overtime and swapping shifts at short notice to cover the unit.

23. After a death, people continue working and are professional but are subdued. I have found this to be the case wherever I have worked, but on a small unit it is more apparent. The nursing team was (and is) close-knit and supportive and will enable staff to take time out as needed if possible. I do not recall any changes in relationships between staff because of this.

24. I did consider the increase in mortality and sudden non-fatal collapses at the time. Especially those in 2015, as there were so many close together.

25. Anecdotally, the unit was much busier than it had been when I first started working there. The unit had gone from 7-10 patients being average to routinely having 16-20 patients, without an increase in staffing. This placed pressure on staff who were not used to working with that level of occupancy. This applied to both nursing staff on the ward and the medical staff who were not used to the neonatal unit requiring that level of attention. My perception was that the children's ward took priority for consultants. We had a consultant ward round twice a week, compared to daily on the children's ward, and it could be hard to get decisions on care at times.

26. I was aware, probably from talking with the ward manager although I cannot recall specifically, that our ratio of QIS trained to non-QIS trained staffing was poor compared other units. I have confirmed this through our Badger unit report data (which I did not have access to at the time) while writing this statement. I remember there were some shifts where the nursery nurses had a light patient load, compared to trained staff, as there were not enough special care level babies to allocate to them. We also shared care a few times, so that a nurse could oversee a patient that a nursery nurse was providing the feeds/cares for, i.e., a stable baby on optiflow (optiflow is a high-flow, humidified air/oxygen mix that supports babies breathing via short tubes that go up the nose).

27. I was aware (again verbally, I cannot recall specifics) that the unit averaged 2-3 deaths per year. With an increase in patient numbers, it did not surprise me that the number of babies dying had also increased. I considered that the increase in acuity had increased the mortality rate further.

28. I did not consider intentional harm as a cause of our increased mortality (and non-fatal collapses). While I can see how intentional harm would increase acuity, I cannot see how it would account for the increase in admissions during this time.

29. I know that I was not aware of every collapse/death on the unit during this year, so I know that I had, and still have now, an incomplete picture of events to work with. There are also babies that I knew had died or collapsed but I did not know the circumstances or events. I

also knew of at least two babies that year who had died of a congenital abnormality, or of complications of this. Babies with congenital abnormalities make up about a third of neonatal deaths. One of these babies was referred for a post-mortem only because I, and other nurses as well as the Registrar on duty, pushed for it. Otherwise, this baby would have been presumed to have a heart defect, would not have had a definite cause of death. I have had a police interview about this baby, but do not know the outcome of that investigation.

30. The conclusions that I came to at the time, poor nursing and medical staffing numbers and skill mix, and lack of medical oversight, are broadly in line with the of the Royal College of Paediatric and Child Health (RCPCH) report into the unit that was conducted in August 2016 and published in February 2017.

31. I have had informal conservations with other nurses on the unit– no recollection of when or with whom specifically – about the issues above, and so I know that the conclusions that I came to at the time and afterwards were in line with at least some others. I was not aware of anyone having concerns about intentional harm as a cause at the time.

32. I remember being told by the Neonatal Practice Development Nurse that our mortality was in line with other level 2 units nationally. I cannot recall the rest of this conservation, other that it was in the context of our spike in mortality rate. I cannot recall when this conversation took place; it may have been after July 2016.

33. I was aware that there were formal discussions between ward management and the neonatal lead (and I assumed others) about the collapses and deaths, but I was not informed of specifics. I knew that there had been a 'common themes' review into the collapses in 2015, but do not remember any results being shared from this. I remember the ward manager telling me that she was repeatedly raising staffing issues with senior management and that this was on the hospital risk register.

34. I only found out that the unit was becoming a level 1 a couple of days before it happened, this was part of an informal conversation with the deputy ward manager during a shift; she assumed I already knew.

35. In the statement from 24 March 2018, I state that 'we were all worried'. In saying this I was referring to nursing staff and doctors. The nursing staff talked about the increase in numbers and acuity of our patients, and the additional pressure this placed on us. I assumed that the doctors were also concerned because there was a number of consultants on the unit the day that Child O died, and this was unusual (INQ0001413). I

do not remember anyone saying that they were concerned about intentional harm as a reason for the increased mortality.

36. In my statement to police dated 24 March 2018 (INQ0001413) I refer to my thoughts when Child O died on the 23 June 2016 as 'not another one'. The death of Child O was, for me, an unexpected death following a prolonged period without one (that I was aware of). The last sudden death that I was aware of was in January 2016.

Concerns or Suspicions

37. We now have training on raising concerns though the NHS Freedom to Speak Up training. I cannot recall what training there was, if any, prior to this. There is a policy in place (and I think it was in place in 2015 and 2016) on how to report concerns about junior doctors, but nothing relating to nurses or consultants that I am aware of.

38. I had no concerns or suspicions about the conduct of Lucy Letby while she worked on the NNU. I did register that she was present at many of the deaths that I was aware of, but I put that down to her full-time hours and the fact that she worked a lot of overtime.

39. I was unaware of any suspicions regarding Lucy Letby until after she was removed from the unit. When she was removed the Ward Manager emailed the nursing staff saying that clinical supervision for staff was underway and that Lucy had volunteered to go first. Lucy Letby was still on our roster on management days but was not on the unit. There was no mention of any accusations against her. I remember hearing from other nurses that Karen Rees was annoyed because people were asking where Lucy was.

40. I became aware informally at around that time that there were concerns about Lucy's practice but did not know that she was accused of intentionally harming babies until much later. I knew that she had raised a grievance, but I did not know the details of this. Lucy emailed the nursing staff before she was due to return to the unit (April 2017) and said that hurtful allegations had been made about her. That was the first official acknowledgement of events. Also, in March/April 2017 we were informed about a plan to put CCTV on the unit. We were told that this was due to the theft of a parent's purse from the unit. I found out about the matter being referred to the police from a BBC news report.

41. Following the death of a baby there was usually informal discussion between nurses and between nurses and doctors involved about the events. Each death is reported via the Datix incident reporting system and discussed monthly, these meetings were between the ward manager or deputy, a consultant, and other office-based staff (I do not know who exactly attended). Findings from these meetings were shared by email to all staff. In

addition, all deaths were discussed at Mortality and Morbidity meetings, which included maternity and neonatal senior staff.

Reflections

42. I think that CCTV monitoring of babies would have had a limited effect in preventing intentional harm against them. It would not have been feasible or ethical to monitor the babies 'live.' Recordings may have been helpful in pinpointing who was present at the cot side at particular times. However, an important part of neonatal nursing is neurodevelopmental care; that is the protection of the developing brain. Incubators are covered, and the cots of more premature babies have a canopy over them, to protect them from bright light in the nurseries. Nurseries are also dimly lit when able. This means that CCTV cameras would have been limited in what they picked up.

43. CCTV in clean utilities (storage areas) and drug storage areas could have aided the police investigation, assuming the data was kept for lengthy periods. Again, I do not think that it would not have been feasible to monitor these 'live.' Babies are generally safe on neonatal units. This was an extremely rare event.

44. Parents can stay in our neonatal unit, at the cot side. As money is made available to upgrade neonatal units, these should be designed to accommodate parents at the cot side.

45. Central monitoring has been useful for us as it enables staff not in a nursery to see real-time monitoring and respond if needed. This is useful for all patient management and is not specific to preventing intentional harm. Swipe card access to drug storage areas (and CCTV) would track access to these areas more accurately. Any recommendations need to be proportional to the risk, not detrimental to the babies and families, and not discourage staff from working on neonatal units.

46. I have no supporting documents to add to 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: 10/4/24.