Witness Name: Sophie Lea Ellis
Statement No: 1
Exhibits: SLE1 and SLE2
Dated: 10 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SOPHIE LEA ELLIS

I, Sophie Lea Ellis will say as follows: -

Personal details

1. My name is Sophie Lea Ellis.

Nursing career and employment at the Countess of Chester Hospital

2. I qualified as a children's nurse in September 2014 from the University of Chester. I was awarded a 1st class Degree of Bachelor Science with Honours in Nursing. I have obtained additional university qualifications at degree and master's level, which are the Multi-Professional Support of Learning and Assessment in Practice (Mentorship Preparation) in 2017 from the University of Liverpool and the Postgraduate Certificate in Neonatal Care in 2019 from Leeds Beckett University. I was a band 5 staff nurse whilst working on the neonatal unit at the Countess of Chester Hospital NHS Foundation Trust (COCH). I have been a band 6 sister since March 2020.

3. My first nursing post was at Leeds Children's Hospital on the Paediatric Intensive Care from September 2014 to December 2014. I started on the neonatal unit at COCH in January 2015 and remained there until July 2017. I then went back to Leeds Children's Hospital in August 2017 to work within the neonatal service. I worked as a band 5 staff nurse, a band 6 neonatal clinical educator and a band 6 ward sister within the service until December 2021. From December 2021 to present, I have been working as a band 6 transport nurse for Embrace. This is the neonatal & paediatric transport service for Yorkshire & Humber.

4. In terms of my duties and responsibilities as a newly qualified nurse on the neonatal unit between 2015 – 2016, my work involved the planning, implementation, and

evaluation of care to babies requiring special care and high dependency care. If babies were categorised as intensive care according to the British Association of Perinatal Medicine (BAPM) guidelines but required minimal intensive care intervention and were physiologically stable, I may have been the allocated nurse to gain experience but had support from a more senior nurse. I was an advocate for my patients and their parents/carers and would act in their best interest by providing evidence-based care. I would escalate any concerns regarding any deterioration or change in medical condition to senior nursing staff and medical staff if needed. I implemented family integrated care and empowered families to be involved in aspects of their baby's care, including basic hygiene needs, nasogastric tube feeds and involvement in decisions surrounding their baby's care. This care would be provided as part of a multi-disciplinary team (MDT) which for example, included nurses, doctors, pharmacists, and dieticians. I kept up to date with mandatory and priority training and would undertake additional courses to develop my skills and knowledge. This included the Newborn Life Support Course and the North West Neonatal Foundation Induction Programme, which provided us with the foundations for neonatal care.

The culture and atmosphere on the Neonatal Unit (NNU) at the hospital in 2015 - 2016

5. As a junior nurse working on the neonatal unit between 2015 - 2016, it is difficult to comment on the quality of the hospital's senior management team as I had very little insight into this. From memory, the nursing management on the neonatal unit were always very supportive, approachable, and knowledgeable. There was an open-door policy and I felt I could talk about both personal and professional matters, and I felt I was listened to with compassion. However, as a junior nurse, I did not have a huge involvement with nursing management.

6. Similar to the above, I cannot reliably comment on the relationships between clinicians and managers between June 2015 and July 2016 as I was a junior nurse with little insight into those aspects. Due to the passage of time between June 2015 and July 2016, it is difficult to accurately explain and recall the working relationships between different staff groups. I cannot remember what the relationships were like between nurses and midwives. I would describe the relationship between nurses and the nursing management on the neonatal unit as generally positive.

7. As a newly qualified nurse, I was allocated a preceptor and undertook a preceptorship programme. A preceptorship programme is for newly qualified registered professionals

to help them integrate into the team. From memory, I was provided with preceptorship materials, which included competencies relevant to the neonatal unit. I had meetings with my preceptor to identify what was going well, any learning needs and a general welfare check. This was on-going for the first 12 months of my employment at COCH. I felt very supported by my allocated preceptor.

8. I remember that the relationships between nursing staff and medical staff could have been more positive, however, it is difficult to accurately elaborate on that point due to my recollection of events. The relationships between the nursing staff were generally very positive. There were a lot of very experienced nurses on the neonatal unit who were willing to teach and support me as a junior nurse. It was generally a very friendly and positive culture between the nursing staff.

Child C

9. I have reviewed my previous police statements and there is nothing further that I would like to include in my Inquiry statement.

10. In terms of a debrief following Child C's death and what I had previously said in my police statement (included at **Exhibit SLE1**), I maintain my position and still unable to recall who was present at Nurse W's debrief and I cannot remember if any informal discussions took place regarding Child C. However, it is likely that we had discussions amongst nursing staff regarding Child C to support each other, although I have no recollection of this.

11. At that time, I was not able to comment on whether it was usual or unusual to hold a debrief immediately after a collapse or death of a baby on the neonatal unit as I had not been involved in a similar situation before. However, I have since worked in another unit, and I have participated in debriefs immediately after a collapse and/or death of a baby. This is known as a 'hot' debrief involving different members of the muti-disciplinary team (MDT) involved in the relevant event.

12. I don't believe from my recollection of working at COCH that attending a nurse debrief was compulsory between 2015 – 2016.

13. I have no memory of the debrief that took place following Child C's death, but I do believe we as nurses, would have been given the opportunity to raise any concerns

and discuss our thoughts and feelings due to the positive nursing culture on the neonatal unit. I am not able to elaborate on this point given the passage of time since the incident.

14. I have reviewed my previous police statement, in which I talk about a formal debrief led by Dr Gibbs a few weeks after Child C's death. Within the statement I state that:

> *"This was a combination of our welfare and also a look at what might have gone wrong in [Child C's] care. I had been quite concerned that as [Child C's] designated nurse at the time I might have missed something but the de-brief re-assured me that I had done nothing wrong, albeit we don't know, even now what caused [Child C's] collapse and ultimate death."*

15. I remember that Lucy Letby was present at Dr Gibbs' debrief and according to my police statement, Eirian Lloyd Powell was also present. I have no recollection of anyone else who attended.

16. I cannot be certain or comment on whether consultant-led debriefs were usual or unusual practice after a collapse and/or death of a baby on the neonatal unit at that time. I have no recollection of this.

17. From my memory of events, I don't believe attendance to such debriefs was compulsory in 2015 and 2016.

18. I believe nurses were given the opportunity to raise any concerns or anything that was unusual at this debrief. After reviewing my police statement, I can see that I had expressed as Child C's designated nurse that I was worried I might have missed something but was reassured that I had not. I felt that I could raise that concern.

Child O and Child P

19. I have reviewed my police statement, (included at **Exhibit SLE2**), I can confirm that the summary provided about Child O is accurate from memory. However, I would hope that I handed over that I requested the review of Child O by Dr Mayberry on the morning of the nightshift from 22nd June to 23rd June 2016 due to his full and slightly loopy abdomen. Dr Mayberry reviewed, and he was happy for us to continue feeding and he was generally happy with Child O and stated that he did not appear in any discomfort.

20. I can confirm that the summary provided in my police statement included at **Exhibit SLE2** about Child P is accurate, from memory. However, I would like to highlight that I did get Child P reviewed by Dr Mayberry overnight on the 22nd – 23rd June 2016 due to large aspirates. As a result, Dr Mayberry advised me to place Child P on Nil By Mouth (stop the milk feeds) and commence on 10% dextrose via a cannula. I also informed the Senior House Officer (SHO) that Child P had a lower lying heart rate, which was intermittent. I documented that I handed this over to Lucy Letby on the following shift.

21. Lucy Letby informed me about Child O's death at the beginning of my nightshift on 23rd June 2016 as I was coming into the hospital and before I got into the neonatal unit, from memory. At the time, I did not have a similar situation to compare this interaction with to comment on whether the way she conveyed the message was unusual in any way.

22. Once Lucy Letby informed me that Child O had passed away, I expressed how upset and shocked I was due to how sudden and unexpected Child O's death was. Around the time of handover from the day to the night shift, I remember Lucy Letby referring to a lactate reading from a blood gas overnight from 22nd – 23rd June 2016, when we were discussing the death of Child O, however, I cannot accurately remember what it was relating to.

23. I have no recollection of whether there was a debrief or meeting about the sudden death of Child O and Child P, and I am not able to provide any details. As nursing staff, it is likely that we had informal discussions about the deaths of Child O and Child P to support each other however, I have no recollection of this or what was discussed other than what I have already mentioned above.

24. I have reviewed my previous police statement (included at **Exhibit SLE2**) and confirm that my statement contains an accurate summary of Child P's condition and the care I provided on the night shift of 23rd – 24th June 2016.

25. I have reviewed the WhatsApp chatlog between me and Lucy Letby on 24 June 2016 (**INQ0001443_0019**) when she told me about Child P's death and removal of Child R to Liverpool Women's hospital. I confirm that it is an accurate account of what was said between me and Lucy Letby.

26. I was very shocked and upset about the death of Child P, particularly as Child O had died the night before. After reviewing the WhatsApp messages between Lucy Letby and I (**INQ0001443_0019),** the medical notes (**INQ0001453_0013**) and Lucy Letby's nursing notes (**INQ0001344_0036**) I note that Child O and Child P presented with a similar clinical picture during their deterioration. I thought at that time, Child P and Child O could have had an undiagnosed underlying condition, which contributed to the way they collapsed and to their death. I cannot comment further on what the cause could have been, this was a thought I had at the time to possibly try and explain their collapse and subsequent death.

27. I was with some of the nursing staff from the neonatal unit when I received the messages from Lucy Letby regarding the death of Child P. I remember Yvonne Griffiths was sat with me, but I cannot accurately remember anyone else. It is likely that I did discuss the death of Child O with other members of the nursing team on the neonatal unit, but I cannot remember what was said or who I discussed it with.

28. As stated above, I have no recollection of whether there was a debrief or meeting about the sudden death of Child O and Child P. I am therefore not able to comment on any details or confirm who was present if a debrief took place. As nursing staff, it is likely that we had informal discussions about the deaths of Child O and Child P to support each other, however I have no recollection of this or what was discussed other than what I have already mentioned.

29. In terms of my thoughts on the sudden death of Child C, Child O and Child P and whether I considered that there was a link between their death and Lucy Letby, I would say that I did not link the collapses and deaths to the actions of Lucy Letby. That possibility never occurred to me as she gave me no reason to believe that was the reason. I was aware that she was on shift during the collapses and deaths but that was the only link I made at that time. From memory, it was a busy period on the neonatal unit and when we had discussions amongst the nursing staff about the number of sudden collapses and deaths, it was often put down to prematurity and this is what can happen to premature babies. As a junior staff nurse, I had no previous experience to compare these sudden collapses and deaths against to suggest how unusual they were.

Royal College of Paediatrics and Child Health ("RCPCH") Invited Review

30. From memory, we were informed that the nature and purpose of the RCPCH review was to try and explain and identify reasons for the increased number of collapses and deaths on the neonatal unit during June 2015 and July 2016.

31. Given that I have no recollection of being interviewed by the RCPCH, I'm unable to recall the questions asked of me and my responses to those questions.

Concerns or suspicions

32. I cannot remember whether we received any formal training about how to report concerns about another member of staff. Although, if I did have any general concerns, I knew that I could speak to my line manager and escalate as appropriate if needed. For example, if I felt I could not approach my line manager or did not get the response I was hoping for, I knew that I could go to their senior, which could be a matron or equivalent and so on. I was aware that concerns could be reported verbally and in writing and so reporting matters might have been incorporated into some form of training.

33. I did not have any concerns or suspicions about Lucy Letby while I worked on the neonatal unit.

34. From what I can recall, I was not made aware of any suspicions or concerns that others had about Lucy Letby. As nursing staff, we were informed Lucy Letby was taking a break from clinical work due to the number of collapses and deaths she was involved with, for her own well-being. During this time, she had undertaken an admin role. I cannot remember who delivered this information or how it was delivered.

35. From my recollection of events, there were discussions amongst nursing staff about the increase in deaths on the neonatal unit. I do not remember the point at which these discussions took place. I was a relatively new member of staff and so I had no experience of previous years to compare to. I was only subject to what other nursing staff were saying. During the general discussions amongst nursing staff, the increase in deaths were often associated with the increase in admissions. As previously mentioned, it was a busy period, and the deaths and collapses were linked to prematurity and what can happen to premature babies. As a junior staff nurse, I had

no previous experience to compare these sudden collapses and deaths against, or comment on whether I believed they were unusual at the time.

Reflections

36. It is very difficult to say whether monitored CCTV would have prevented the crimes committed by Lucy Letby, but I appreciate why the Inquiry has raised this. I believe if someone wants to commit a crime, they will find a way to do so. If there was CCTV covering every angle of the neonatal unit not just where the babies are cared for then this might have reduced the risk but, in my opinion, it would not fully eliminate the risk. I do not know enough about how CCTV cameras operate to have an opinion about its effectiveness in cases like this. I think that there are several issues to consider with implementation of CCTV. I consider that the thoughts and opinions of all staff groups particularly nursing and medical staff who work in neonatal units should be gathered. In my opinion, in some instances, presence of CCTV cameras may make nursing and medical staff feel uncomfortable and not trusted when they are trying to provide the best possible care to their patients and families. This could lead to accidental mistakes due to the additional pressure they may feel by being watched and therefore, this could affect morale in the work environment. It also may discourage staff from working on neonatal units, which may contribute to the staffing issues, particularly for nursing. Many of the babies cared for on the neonatal unit are in incubators with incubator covers. These covers are for their own development so removing them could have a negative impact on the baby. Due to the covers, CCTV would not reach inside the incubators unless there is a type of CCTV that is able to do so. In my opinion, it is also important to obtain the opinions of parents and carers who have had a baby cared for in the neonatal unit.

37. I have thought about the recommendations that could be made to help prevent the criminal actions of staff in the future. I found this a difficult question to answer as thankfully these actions are very rare. However, there should be an open and honest culture with a freedom to speak up within all staff groups. Individuals who raise concerns should have guaranteed support from management and/or a dedicated team to support whistle blowers. A clear process of how to report concerns specifically about criminal actions of staff need to be created and outlined. This should then be streamlined within all hospital Trusts. Staff may then be more likely to raise any concerns without fear of negative judgement and instead be commended for their

courage. This can be very difficult to do even with a positive culture. Some of these aspects may already be in place in some hospital Trusts, if so there needs to be consistency amongst all hospitals.

Request for documents

38. I have no further documents or other information which are relevant to the Inquiry's Terms of Reference.

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

Name: **Sophie Ellis**

Dated: **11/04/2024**