Witness Name: Samantha O'Brien

Statement No.: 1

Exhibits: SOB1 and SOB2

Dated: 15 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SAMANTHA O'BRIEN

I, Samantha O'Brien, will say as follows: -

1. My name is Samantha O'Brien and I have been a Registered Children's Nurse since September 2014. I completed my undergraduate nurse training at the University of Chester. Since qualifying, I have undertaken further qualifications throughout my career, including the Neonatal Qualification in Specialty Course at Liverpool John Moores University in 2016, my mentorship qualification with the University of Liverpool in 2016 and more recently, I completed the Specialist Community Public Health Nurse – Health Visiting PgDIP course with the University of Bolton in 2021.

2. I have worked as a Band 5 Staff Nurse on the Neonatal Unit at both the Countess of Chester and St Mary's Hospital in Manchester. I worked in Manchester from October 2014 – January 2016 and then again from July 2017 – January 2020. I then left the ward in 2020 and worked as a Band 5 Staff Nurse in the 0-19 Service with Northern Care Alliance NHS Foundation Trust at Salford Royal Hospital, where I completed my health visiting training. I worked as a qualified Health Visitor until February 2023. I have since changed my job role and now work as a Band 6 Paediatric Research Nurse at Royal Bolton Hospital.

3. After doing three placements as a Student Nurse on the Neonatal Unit at the Countess of Chester (two short placements in 2012 and 2013 and one ten week placement in 2014) I decided that I wanted to work at the hospital on a long-term basis as I really enjoyed my time there. I started my role at the Countess of Chester in January 2016

and worked there until July 2017. My duties were to work with the multidisciplinary team and provide clinical care to premature and sick babies.

4. After I started my role in 2016, it had been noted that there was an increase in deaths on the Neonatal Unit. This was when matters were investigated internally, and I generally noticed that there was an increase from what I recall when I was working as a student at the Countess of Chester. The increase was discussed amongst nursing staff, but I cannot remember specifically who, it was noted that there was an increase from previous years.

5. I felt supported in my role at the Countess of Chester from the management, medical team, and peers. When the Neonatal Unit at the Countess of Chester was downgraded to a level 1, I remember being on shift. We were made aware of the downgrade in an informal meeting, but I cannot remember who was present, or exactly what was said. We were advised that any babies born less than 32 weeks gestation, or requiring intensive care would be transferred to a different hospital for further care. The nursing staff did speak about this, and these discussions took place whilst I was at work. I remember general conversations about it, but I do not remember who with. Based on my recollection of events, my colleagues and I understood the need for an investigation.

6. In terms of working relationships, I knew who my managers were, and I found everyone approachable and friendly. I am not able to comment on the relationships between others, such as clinicians and managers, nurses, midwives and managers, doctors, and other hospital staff as I had no involvement with them beyond what my role required.

7. I have read my previous statements (included at **Exhibits SOB1 [INQ0001297]** and **SOB2 [INQ0001406]**) and confirm that they remain accurate.

Child M

8. In terms of my involvement, I cared for Child M on the night shift of 9th to 10th April 2016, following their collapse on the day shift of 9th April 2016. Following their collapse, I do not remember if there was a debrief, I do not remember attending the debrief if there was one as I was not present at the time of Child M's collapse. I was given a

handover from the day staff, who advised that Child M required a prolonged resuscitation.

Child Q

9. In relation to Child Q, I do not recall them being unwell during my night shift on 24th to 25th June 2016. On reflection of my nursing documentation, I also did not identify anything that I found concerning. I do not remember being informed about Child Q's collapse or when I found out, as it happened after I had gone home. Similarly, I am not aware if there was a debrief or informal discussions about Child Q.

Child O

10. I was on a day shift on 23rd June 2016 when Child O died. I had helped draw up the emergency drugs during their resuscitation. I attended a debrief after their death, which took place with some medical and nursing staff on the unit. I do not remember who was present other than Dr Brearey, who led the meeting. I do not remember what exactly was discussed during the debrief and if there were any other meetings in relation to these events.

Child P

11. On the 24th to 25th June 2016, I was on a night shift. I was a little bit late to that shift and so I missed the full unit nursing handover. I was informed by a colleague (I do not remember who) that Child P had died during the day shift. I was not aware of any debrief or meetings in relation to Child P's death, and I was not present during the events.

12. The events referred to above happened within a small timeframe, but at that point, I did not have any suspicions that they were caused by a member of staff on the Neonatal Unit. This was because I had never seen anything in practice that I found concerning or strange. I first became aware of the link between Lucy Letby and the unexpected collapses on the unit when she was removed from Neonatal Unit to an administrative role. You don't routinely get put into an administrative role and that was the basis of why I might have made the link at that time. As a nurse, you are taught to escalate concerns during your undergraduate training. It is also part of the Nursing and

Midwifery Council's Code of Conduct, therefore, if I had any concerns, I would have reported them to the appropriate members of the team.

Concerns or suspicions

13. I do not remember any formal training on reporting concerns, but if I had concerns, I would have discussed them with my manager. If I felt I was not listened to, I would have identified how to escalate my concerns further if required.

14. Whilst I was working on the Neonatal Unit at the Countess of Chester, I was not aware of any concerns the medical staff had in relation to Lucy Letby. However, after seeing the evidence following the criminal proceedings, it is clear that their concerns should have been acted upon immediately.

15. I was on shift when one baby died. Therefore, I am not entirely sure about the process or procedures of conducting debriefs, or informal discussions between nurses following the death of a baby.

Reflections

16. In terms of recommendations, I do not know what can be done to ensure this does not happen again, but escalation of concerns must be addressed.

17. I do not know if CCTV cameras on the Neonatal Unit would have helped stop the crimes of Lucy Letby, but I do not think it would be a bad thing to implement it.

18. I do not have any other documents or material in my possession, which might assist the Inquiry with the 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

Dated: 16/04/2024