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Name of Witness: Jennifer Jones-Key

Statement No.: 1

Exhibits:

Dated: 23 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JENNIFER JONES-KEY

I, Jennifer Jones-Key, will say as follows:

Personal Details

1. My full name is Jennifer Jones-Key.

Nursing career and employment at the Countess of Chester Hospital

2. I qualified as a nursery nurse in 2006 gaining a diploma in National Nursery Examination Board with Bury College. I currently work as a specialist band 4 perinatal mental health nursery nurse in the community with Greater Manchester Mental Health NHS Trust.

3. My previous jobs have been at St Marys Hospital in Manchester (from 2016 – 2022) as a band 4 neonatal nursery nurse, Countess of Chester Hospital (COCH) as a band 4 neonatal nursery nurse (from 2006– 2016), Leapfrog Day Nursery in Ellesmere port (from approximately between 2005 - 2006) as a base room manager, Newborn Nannies (from approximately 2004 – 2005) in Oldham as a nanny in people's homes, Hopscotch Day Nursery (from approximately 2002 – 2004) in Chester as a deputy manager, The Grange Day Nursery (from approximately 2001 - 2002 in Wrexham as a nursery nurse and Brookfield Day nursery in Oldham as a nursery nurse.

4. In my role as a nursery nurse, I was responsible for the care of special care and high-dependency babies. On a day-to-day basis, I had to provide them with the care they needed, working in partnership with the parents whilst looking after the babies' medical and development needs.

5. I was responsible for up to four babies, whilst keeping my shift leader up-to-date about any changes or illness in babies. I had to admit, discharge, and provide care plans on the computer for each baby, record observations, tube feeds, help parents bottle feed

and support and help mothers with breastfeeding. I also worked on the transitional care, which is situated on the postnatal ward and is for babies who are require additional support but do not need to be on the neonatal unit. For example, care is provided to babies born above 34 weeks gestation and those with downs syndrome, cleft palate, drug withdrawal and palliative care. I also provided parents with immunisation updates, weaning and other baby information and more importantly, helped parents to bond with their baby. I liaised with doctors, health visitors, social services, students, and other health professionals. I also supervised and supported neonatal assistants and students when they started in their role. I would introduce them to the unit and show them how to use equipment, where policies and procedures were and who was who.

The culture and atmosphere on the NNU at the hospital in 2015-2016

6. All the staff who worked on the neonatal unit were highly qualified and had gained expertise in neonatal care. There was good support between staff and managers and there was always support available if you needed to seek support or advice. There was a good working relationship between all staff involved in the unit including doctors, nurses, midwives, and management.

Child N

7. I was working the night shift on Tuesday 14th to Wednesday 15th June 2016. I commenced my shift at 19.30pm and was in Nursery 3. Lucy Letby (Lucy) handed-over to me and reported no concerns about Child N.

8. Child N was nursed in an incubator and taking bottle feeds of their mother's expressed breast milk. In the early hours of the morning, Child N looked pale and mottled in colour. I noted that their abdomen was bloated and veiny. I notified the shift leader, Belinda Simcock about Child N's deterioration, and I connected Child N to the full saturation monitoring. Child N was having desaturations, but no interventions were required. I asked Doctor U to review Child N. Doctor U then did a septic screen and bloods were taken, IV antibiotics were commenced and given by the nursing staff.

9. At 05.30am, Child N started to have more desaturations, IV fluids were commenced, the feeds were stopped and ambient oxygen was commenced in the incubator. At 07.15am, Lucy was in Nursery 3 as she had come to have a chat with me before commencing her shift. I can't recall the details of the conversation.

10. Child N started to desaturate and was mottled all over their body and was blue in colour. Lucy responded and commenced resuscitation using the neopuff. The doctors were on the unit, and I asked them to review Child N. Child N had a second desaturation and a decision was taken to move Child N to Nursery 1 for intensive care and closer observation and treatment. I then handedover Child N's care to Lucy.

11. I have no recollection of Kathryn Percival-Ward being the shift leader as I would have written this in my notes. I do not remember having any discussions about Child N. I do not recall Kathryn coming in to review my baby (Chid N) and I recall that I had been liaising with Belinda Simcock.

12. Lucy arrived early for her shift on 15 June 2016 and came to see me. It was not unusual for a member of staff to start their shift 15-20 minutes early. This was a regular occurrence on the neonatal unit, especially if colleagues in there were also friends. We often would see how the babies we looked after the previous shift were doing, and if there were any changes. If something happened on the neonatal unit whilst we were there, we would get involved and assist as we could, even before our shift started.

13. I do not recall any discussions around Child N's sudden collapse and did not have any concerns. I do not recall a debrief happening. It is usual for a debrief to happen but not in all situations and it depends on staff availability and doctors.

14. After a baby passes away, we would message staff and see how they were doing. I did not feel it was odd that Lucy wanted to go back to Nursery 1 and I did not discuss this with any other member of staff. I had no concerns regarding Lucy's responses in the WhatsApp messages **[NQ0000101]** about wanting to go back to Nursery 1, after she was put in Nursery 3 and found her behaviour to be normal for the situation. When I said "odd" in the WhatsApp message, I was talking about how I would feel odd myself because I do not work in intensive care. I did not mean to say that Lucy was odd for wanting to go back.

15. I discussed with nursing staff about how busy we had been and how sad it was with a run of babies passing away. I was not concerned by the number of deaths as we had a very busy time and had been full most of the time.

16. I did not raise concerns about the increase in the deaths as I did not have any.

17. A few other staff had been in the neonatal unit for a lot of the deaths too. Lucy's WhatsApp message **[NQ0000178]** to me about babies and their conditions and her response to their deaths did not give me any concern and so I did not discuss this with anyone. Lucy had been there for a quite a few of the deaths and this can happen on a neonatal unit, in particular during night shifts.

18. It would be nice for staff to have nice shifts, and when I said to Lucy, "being on your shift", that is what I meant.

Concerns or suspicions

19. When I started in 2006 with COCH, I was given training on speaking to managers and staff regarding any concerns I had with staff, doctors, or other professionals or whistle blow if I felt I was unable to take my concerns to the managers.

20. I had no concerns regarding Lucy's conduct whilst she was on the neonatal unit. She was a professional, hardworking, caring, and compassionate nurse, who offered the best care to the babies she looked after. I was not aware of any concerns or suspicions around Lucy until she no longer worked on the unit and was moved.

21. A debrief was normally held after a baby passed away but it could depend on staff availability and doctors. I was rarely involved in debriefs due to not working in the intensive care unit.

Reflections

22. I do not believe CCTV would stop crimes happening on a neonatal unit.

Request for documents

23. I have no supporting documents, or information which is 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: PD

Dated: 24.04.2024 | 11:33:00 BST