

Thirlwall Inquiry

THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE – MIDWIVES

Name: Susanne Boggan

Role as per Countess of Chester 2015-2016 Staff List: Midwife

Enclosed documents: Witness statement dated 20 March 2018 (INQ0001291)

Questionnaire

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

1. Please provide a short summary of your midwifery career. This summary should include at least the following information:
 - a. when you qualified as a midwife, including the educational institute or awarding body;
 - b. your midwifery qualifications, including your midwifery band from 2015 to the present;
 - c. details of your previous and current employment.

I qualified as a Registered Midwife from the University of Salford in February 2014 where I received a BSc (Hons) in Midwifery. Upon qualifying I worked as a Band 5 Rotational Midwife at St Mary's Hospital in Manchester, where I had completed my practice placements.

I came to work at the Countess of Chester Hospital in October 2014, where I continued as a Band 5 Rotational Midwife until approximately November 2015 when I completed the Preceptorship programme and was promoted to Band 6 Rotational Midwife.

I continued to work at the Countess of Chester until June 2023, when I secured my current post at Liverpool Women's Hospital as a Band 7 Governance & Risk Midwife.

2. Did you have any management responsibilities of any kind within the Countess of Chester hospital between 2015 and 2016?

No

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

3. Please explain the extent to which you carried out work on/in connection with the neonatal unit (the "NNU") between 2015 and 2016, or any other situation in which you worked alongside nurses or clinicians based in the NNU.

I would primarily have contact with the neonatal team if their attendance was required at a birth where it was anticipated the baby may need assistance or monitoring outside of midwifery scope of practice – for example instrumental or operative births, premature babies, or babies who required resuscitation at birth. In such cases, it was usually a neonatal doctor who would attend first, and the team would include senior neonatal nurses if their assistance was required.

I would also come into contact with the neonatal nurses if a baby in my care was receiving intravenous antibiotics, as it was the neonatal nurses who would come to administer those.

If a baby required admission to the NNU after birth, I would often accompany the parents to the NNU to see their baby once the mother was well enough.

Occasionally I would see the NNU shift leader when they would come to Labour Ward to ask for updates of any anticipated birth that might require their presence.

On one occasion I cared for a family in the Bereavement Suite after their baby had unexpectedly passed away, and two neonatal nurses attended to help with bathing the baby and memory making (taking photos, hand and footprints).

4. How would you describe the quality of the management, supervision and/or support of midwives who carried out work on/in connection with the NNU between June 2015 and June 2016?

I always felt well supported by the shift leader and managers if I was caring for a baby who required admission to the NNU or needed resuscitation at birth.

5. How would you describe the relationships between: (i) clinicians and managers; (ii) nurses, midwives and managers; and (iii) between medical professionals (doctors, nurses, midwives and others) at the hospital between June 2015 and June 2016?

From memory, I did not have reason to think there were any issues with any of these relationships at the time.

6. How would you describe the culture on the NNU between June 2015 and June 2016? Please feel able to compare it (for good or bad) with your experience elsewhere.

I do not feel able to comment as I did not work on the NNU so I don't know what the culture was like. I do not recall being aware of any issues at the time.

Concerns or suspicions

7. Were you given any training on how to report concerns about fellow members of staff? When? If so, how were any concerns to be reported?

I don't remember specifically but it is likely part of the Trust Induction training that all staff get when they are first employed by the Trust.

We are all aware that we can report concerns to the management team.

8. Did you have any concerns or suspicions about the conduct of Lucy Letby ("Letby") while you worked as a midwife in connection with the NNU? If so, what were your concerns or suspicions, and did you raise them with anyone, either formally or informally?

I did not have any suspicions or concerns – I do not remember much about Letby. I have previously given a police statement regarding a mother and baby I cared for (the baby later passed away) – it became clear that Letby was the nurse who attended the bereavement suite to help care for the baby and I do not remember having any concerns with her conduct at this time.

9. Were you aware of any suspicions or concerns of others about the conduct of Letby and, if so, when and how did you become aware of those concerns?

I was not aware of any suspicions or concerns.

10. Were you ever aware or worried about the increase in the number of deaths on the NNU? If so, when was this and what did you think?

The first I remember hearing of any concern about an increase in deaths was being informed during a daily safety brief that the NNU had escalated concerns to the Police as they were not satisfied that an internal investigation had found no cause for the increase.

I remember feeling that this sounded worrying, but that it sounded as though the appropriate action was being taken.

11. What discussion was there (formal or otherwise) with or between midwives after the death of a baby at the hospital?

I do not remember any significant discussions following the death of a baby beyond how tragic it was for the family.

12. How were deaths on the NNU investigated? Did midwives participate in any investigation? If so, how? If not, why not?

I was not asked to participate in any investigations following deaths on the NNU; I cannot comment for my colleagues.

13. When did you first hear it being said that Letby was present at the time of unexpected collapses and deaths of babies on the NNU? Please explain your answer and provide dates if possible.

The first I remember hearing about this was the day it broke in the media that a staff member had been arrested. I remember feeling shocked as I had not been aware of any suspicion toward any member of staff. I do not recall any discussion as to who the staff member was.

Reflections

14. Do you think if the babies had been monitored by CCTV the crimes of Letby could have been prevented?

It is difficult to say – I think it would depend on the methods that were used (for example, if intravenous (IV) medications were contaminated prior to administering to a baby this would not be captured by CCTV which focussed on the baby, but it might capture somebody tampering with breathing tubes etc).

Perhaps it could be seen as a deterrent, although I think there are also concerns with privacy and confidentiality and it could be seen as a lack of trust in healthcare workers overall when such crimes are so rare.

15. What recommendations do you think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff?

I'm not sure. I believe that the majority of staff (99.99%) are caring and professional and would not commit such crimes.

Any other matters

16. Is there any other evidence which you are able to give from your knowledge and experience which is of relevance to the work of the Inquiry?

No

17. Please review your previous statements attached. Do you consider that these are accurate or is there anything in them that you would wish to amend? If so, please provide details.

I am happy that they are accurate.

Signed:

PD

Full Name: Susanne Boggan

Dated: 17/04/2024

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