Witness Name: Ailsa Heather Simpson

Statement No: 1

Exhibits:

Dated: 16 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF AILSA HEATHER SIMPSON

Personal Details

I, Ailsa Heather Simpon, will say as follows:

1. My full name is Ailsa Heather Simpson.

Nursing career and employment at the Countess of Chester Hospital

2. I qualified as a Registered Children's Nurse in 2009 with a Diploma from Edgehill University. The nursing qualifications I currently hold are a Degree in Children's Nursing, which I gained in 2016 from the University of Chester. I have worked as Bank 6 Nurse from 2015 – 2016. Since qualifying in April 2009, I completed Children's nurse bank work at Alder Hey Children's Hospital for 4 months until August 2009 when I got my current job with the Countess of Chester Hospital. My job role is a Senior Neonatal Nurse Practitioner.

3. From 2015 – 2016, my role and responsibilities as a nurse on the Neonatal Unit (NNU) was to take a patient workload and care for babies requiring intensive care, high-dependency care, and special care. I was also required to take charge of shifts, support my colleagues with their workload and liaise with the multi-disciplinary team such as the junior doctors, consultants, and maternity colleagues.

The culture and atmosphere on the NNU at the hospital

4. In my opinion and from what I observed, the ward manager between 2015 – 2016 was supportive and appreciated all our hard work as a team during an extremely difficult period. The matron of the Women & Children's Ward between 2015-2016 was also very supportive and we saw her daily.

5. I feel that I am not able comment on the relationship between the clinicians and managers. The NNU was so busy that I was more focused on the care of the babies

and their families rather than what was happening higher up. From what I can remember, the relationship between the nurses, midwives and managers was amicable. It could get stressful at times, for example, if the obstetric team wanted to deliver babies when we were at full capacity, then we would not have any space for the new babies on the NNU. This might have strained the working relationship during the busy periods. In terms of the relationship between doctors, nurses, midwives, and others, I would say that there were stressful periods. Sometimes when a baby required a senior review by a doctor, they wouldn't always be available to attend straight away as they would be reviewing patients on the Children's Ward first. Overall, despite the business of the NNU, the doctors and nurses on the NNU collaborated well together as a team and the atmosphere was happy at times, despite the stressful phases.

Child G

6. I agree with the Lucy Letby's entry in the nursing notes on 7 September 2015 about Child G's clinical presentation at 0215, which stated:

   "[Child G] had large projectile milky vomit at 0215. Continued to vomit++. 45 mls milk obtained from NG tube with Air++. Abdomen noted to be distended and discoloured. Colour improved few minutes after aspirating tube, remained distended but soft. Reg Ventress asked to review. To go nil by mouth with IV fluids. Dr called to theatre."

7. The entry, "Continued to vomit++" means that after sitting up Child G and attending to them with a Neopuff, Child G continued to be sick a lot. "With Air++" relates to when the Nasogastric Tube is aspirated, sometimes there is air still in the stomach, which will have been aspirated out with Child G's milk from her stomach.

8. It is not common to projectile vomit as much as Child G. When looking back over why this could have happened, I noticed that on the drug prescription reviewed in court during the criminal process, Child G had been given an oral medication of sodium chloride with her feed (which is salt). Therefore, this could have been one of the causes of Child G's projectile vomiting.

9. The distance of the projectile vomit together with 45mls of milk being aspirated made me think that this was a larger than normal amount of vomit.

10. I have reviewed the medical records of Child G [INQ0000272 pages 2362-2365 and pages 2461-2466] and confirm that the entries are accurate.

11. I would assume that I was present during a discussion about why Child G had aspirated and the possibility of it being a symptom of sepsis as I was the shift leader and was involved in the incident, but I cannot recall exactly what was said. There was as a general conversation about sepsis as we consider it as a potential issue with a lot with patients and medical presentations.

12. I do not recall anyone else present, who expressed concerns about Child G's projectile vomiting and their frequent and unexpected collapses.

13. I would have only discussed Child G's projectile vomiting with the staff on shift at the time and no one else.

14. The normal practice as a shift leader in circumstances where there have been sudden and frequent collapses requiring resuscitation is to handover the incident to the next shift leader and make them aware of the issues. I can't remember details of any informal discussions at handover.

15. To the best of my recollection, Child G's projectile vomiting and collapses would have been discussed in the handover to the nurses working the day shift on 7th September 2015.

16. I can't remember the details of the discussion that took place due to the passage of time since the incident.

Concerns or suspicions

17. In terms of reporting concerns about members of staff, if anyone had any concerns about other colleagues, then they would be encouraged to speak up and inform their ward manager or matron. We have online e-learning training about 'Freedom to Speak Up'.

18. In my opinion and personal observation, I felt that Lucy Letby involved herself with more babies than she needed to be involved in. For example, if a baby collapsed or required cardio-pulmonary resuscitation (CPR), but she wasn't caring for that baby, she would involve herself anyway, despite being told by a shift leader that she needed to look after her own babies.

19. I was not aware of any concerns or suspicions in relation to Lucy Letby whilst I was on the NNU.

20. In terms of any concerns or suspicions regarding Lucy Letby, after the death of the third or fourth baby, it was generally noted that she (Lucy Letby) was involved in each case. This was the only point that the NNU staff observed. At that point, I did not consider that she was cause of the issues and I thought that her involvement might have just been a coincidence.

21. After the death of a baby, there is usually a debrief held by a consultant and all nurses, doctors and nursery nurses involved are also invited to discuss what happened and highlight any learning points that can be taken forward.

22. The increase in the number of deaths on the NNU during the period of 2015 - 2016 was very concerning. It is usually very rare for a baby to die and even they do, it's usually in cases where the babies are extremely unwell, either with sepsis, or if there is a congenital abnormality.

Reflections

23. I feel that even if CCTV cameras were in place at the time, these crimes would not have been prevented. I believe that Lucy Letby would have found a way regardless of CCTV cameras as she had the intention to harm the babies.

24. In terms of my recommendations to the Inquiry, I believe a culture where members of staff can freely express their concerns without the fear of repercussions is necessary.

Request for documents

25. I do not have any documents or other information that 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

Dated: 24. 04. 2024