Witness Name:
Bernadette Butterworth
Statement No.1
Exhibits: Exhibit BB1 to BB4
Dated: 29 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF BERNADETTE BUTTERWORTH

I, Bernadette Butterworth, will say as follows:
I have been asked to provide a witness statement as part of the Thirlwall Inquiry.

1. I commenced my nurse training at the University of Chester, February 2002. I studied and trained for three years and in February 2005 I gained a Diploma in Health Education and became a qualified Registered Sick Childrens Nurse (R.S.C.N). The awarding body for nursing is The Nursing and Midwifery Council (N.M.C).

2. After qualifying my first role as a trained nurse was working on a children's ward at Arrowe Park Hospital as a Band 5. I had initially worked on the children's ward from 1996 as a Health Care Assistant (H.C.A) up until the time I was seconded (Feb 2002) by Arrowe Park Hospital to commence my nurse training.

3. In 2008 I worked as a School Nurse, again as a Band 5. As well as working as a School Nurse, I continued to work one day a week on the children's ward at Arrowe Park Hospital to keep up my clinical skills. In 2010 I commenced and continue to work at the Countess of Chester Hospital, where I work on the Neonatal Unit, again as a Band 5.

4. Having had no previous experience working in neonates, apart from the 2 placements on a neonatal unit during my nurse training, I was enrolled onto the Neonatal Induction Course where I gained the knowledge and skills to enable me to care for the sick preterm/term baby. I then went onto to complete an intensive care course which enabled me to care for babies who required a higher level of care and more intervention. Having gained the Intensive care qualification, I was able to care for babies requiring respiratory support such as being nursed on Ventilators, NCPAP and Optiflow, babies with chest drains and babies requiring a more invasive type of intravenous line such as Longlines, Umbilical Venous Catheters and Arterial Lines. These lines are used to give intravenous fluids and drugs which I can do. I also have

my Newborn Life Support (N.L.S) qualification which enables me to assist in the resus/management of the delivery of a baby born in poor condition. The Neonatal Induction qualification, Intensive Care qualification and Neonatal Life Support qualification have all been gained whilst working as a Band 5 on the Neonatal Unit at the Countess of Chester Hospital. My duties and responsibilities are as mentioned above.

4. During 2015-2016, I remember the ward being very busy, some shifts being busier than others. I felt the management on the unit itself were supportive of the team and would often come out the office to help on the unit if needed. In general, I felt there was mainly a good team spirit where we would all support each other. I can only comment on what I have experienced and witnessed; I felt the nurse and doctor relationship was in general good.

5. The information for the care given by myself to Child C on the 10-11th and 11-12th of June 2015 has been taken from the police statements using my nursing notes for the dates concerned. My police statements dated 26 June 2020 [INQ0000141] and 17 July 2020 [INQ0000142], are exhibited to this statement as Exhibit BB1 and Exhibit BB2. At the beginning of shift I would have received a handover for the care that had been given in the previous shift. I would have completed the safety checks this would include checking the emergency equipment was working correctly, checking daily and hourly fluids requirements. Child C was receiving intravenous fluids so I would have checked what fluids Child C was on and if the fluid prescription was correct, checking when drugs where due. Child C was being nursed NCPAP which was a machine that gave respiratory support, Child C was also receiving phototherapy for Jaundice, a condition which is a build-up of bilirubin in the blood, jaundice is quite common in newborns.

6. Child C was also receiving Intravenous (IV) Fluids which he was receiving via a UVC which is an intravenous line which goes into the umbilicus. Child C was classed as requiring Intensive Care and would have been closely monitored and having hourly observations which would have included, Temperature, Respiratory, Heart Rate, Oxygen Saturations, NCPAP readings, Intravenous Fluids hourly amounts and Intravenous pressures and checking the site.

7. On my first shift 10-11th June 2015 I have documented that Child C continued to be nursed on NCPAP and was requiring up to 37% oxygen to maintain satisfactory oxygen saturations. I have documented that the temp was slightly raised, and I have reduced the incubator temperature. I have said IV fluids continue to be given and pressures have been satisfactory. I have documented that there is slight oozing around the umbilicus (were the UVC placed) and I have applied alginate, a material which absorbs and helps stop oozing and that I had also

tied an umbilicus cord to the umbilicus stump and redressed with gauze. I have documented that a blood sample for a blood gas was obtained and apart from the lactate being raised the blood gas result was good. Dr Ireland was informed of result; she reviewed Child C and prescribed a fluid bolus. I have documented that Child C had been unsettled during the shift and I have given containment holding (placing hands on the baby in a certain position which can sometimes help settle the baby). I have documented that Child C was the same at the end of the shift as he was at the beginning.

8. On my second shift 11-12th June 2015, I have documented that a blood sample for a blood gas was satisfactory, but the glucose was raised, Dr Ireland was informed, and she had requested a repeat blood glucose to be taken with the morning gentamicin (antibiotic) level. This would indicate Child C was receiving antibiotics at the time I had cared for him. A gentamicin level is taken to ensure that the baby is receiving the correct therapeutic dose. It was when I had gone to obtain the blood sample that I had noticed the bed was damp and the UVC was out, it was thought that as the bed was only damp and the UVC had been in on the previous observations which were being done hourly that the UVC had not been out long.

9. A blood gas sample taken at this time was good, but the glucose had fallen to 1.7, Dr Ireland was informed, and she requested IV fluids to be changed to peripheral canula which must have been already in place and to repeat a blood glucose in one hour, which was done, and glucose was satisfactory at 4.9. There is not a documented time that this happened in my statement, and I cannot recall the time due to the passing of time. I have documented Child C's tummy looked distended and was soft to firm, bowels had been opened and had passed urine, obtaining clear minimal aspirates, which would have been from a feeding tube. Child C remained on phototherapy for jaundice and had continued to be unsettled during my second shift and required an increase in oxygen when being handled. Mum had visited the unit and had brought some expressed milk overnight.

10. With regards to having any concerns about the safety of any of the babies on the unit at the time I cared for child C, I can say that I did not have any concerns about any baby on the unit at that time. I cannot recall if I was aware or had been made aware of the death of Child A on June 8th 2015 or the deterioration requiring resuscitation of Child B on June 9th 2015.

11. With regards to having any concerns about the Umbilical Venous Catheter (U.V.C) which had come out whilst I was caring for Child C, apart from the immediate concern at how long it had been out and how long had Child C had been without fluids, which giving that I was completing hourly observations which would have included checking the U.V.C site, and the

bed being only damp as opposed to it being wet would indicate that it had not been out long, apart from that, I did not have any concerns. Once I had discovered the UVC was out I rang Dr Ireland, and I would have informed the shift leader, whose name I can't recall giving how long ago it was. There was no investigation into the UVC coming out and I personally do not think it warranted an investigation, occasionally lines unfortunately do come out.

12. I do not recall when I became aware of being informed of Child C's death and I don't recall being involved in any debrief about Child C's death. I was involved in the police investigation named Operation Hummingbird, when I was asked to give a statement into the care, I provided for Child C.

13. Following the death of Child C, I continued to have no concerns for the babies on the unit, if I had any concerns at the time, I would have raised them at the time. I can't recall if I did or did not discuss the increase mortality rate on the unit with my colleagues, although there was an increased mortality rate, we were busy at the time, and I probably would have thought it was due to being busy and the babies being poorly, or babies becoming poorly as babies can deteriorate quickly.

14. The information I have been asked to give for the care given by myself to Child I, on September 30th 2015, which was a night shift has been taken from the police statement I had been asked to make using my nursing notes for the date concerned. My police statement is exhibited to this statement as Exhibit BB3 [INQ0000518]. At the beginning of the shift, I would have received a handover from the nurse caring for the baby on the previous shift. The handover had been given at the side of the incubator. Shortly after starting the handover Child I, had a desaturation (drop in oxygen level) and a bradycardia (drop in heart rate) and had become apnoeic (not breathing). I applied the neopuff to Child I (a machine which gives breaths and oxygen/air) it was noted that Child I's tummy was getting more distended and appeared hard, I had asked the nurse who had been handing over to aspirate the nasogastric tube (NGT) which is a feeding tube which goes into the nose and down to the babies tummy.

15. I have documented a lot of air and 2mls of milk obtained when the NGT was aspirated, we then got chest movement which we previously didn't have. Oxygen saturations and heart rate normalised, the colour of Child I remained pale. A doctor was called; I can't recall what doctor it was who came at that point as I have not documented the name of the doctor who came but it would have been the day doctor, the doctor prescribed Cefotaxime and Metronidazole which where antibiotics which were used to treat a condition called Necrotising Enterocolitis (NEC) which is what Child I was thought to have. The antibiotics are given intravenously via a canula,

which is a small tube inserted into a vein. The Metronidazole is administered via an infusion pump and should have been administered over 30 minutes but for some reason, it was administered over a reduced time. Dr Harkness the evening doctor informed and a Datix completed (accident/risk report).

16. I had documented a blood gas had been repeated, the gas was satisfactory, but the blood glucose had been raised at 10.9 a repeat blood glucose requested in 6 hours which was 6.1 when repeated. I have documented not for blood transfusion, so I presume Child I's haemoglobin level (HB) must have been low. Child I continued to self-ventilate in air, initially oxygen saturations had been dipping to 89/90% (should have been above 92%) and was having desaturations and bradycardias when being handled, I have not documented any intervention required for these and would therefore presume they had been brief and self-correcting.

17. Over the course of the night Child I was handling better and not having desaturations or bradycardias, oxygen saturations levels had improved to mid-high 90%s, Respiratory rate between 44-66 breaths a minute, Child I temperature had been 36.1-37.5 incubator temp had been reduced, Child I's temperature then satisfactory, Child I's colour had also improved, very pale initially at beginning of shift. Tummy had remained distended and firm but less distended than at the beginning of shift, tummy remained veiny but colour on tummy had improved also, minimal clear aspirates had been obtained, these would have been obtained from the NGT. Child I had passed urine and had bowels opened. Child I was nil by mouth (NBM) not being fed enterally but had been having intravenous fluids which had been given via the intravenous canula, the site of the canula and the pressures on the intravenous pump which had been administering the fluids had all been satisfactory these would have been checked hourly. Child I is documented as being unsettled at times, possibly due to straining or rooting for feeds. Reviewing my documentation Child I appears to have improved over the course of the shift. All the information within this witness statement had been obtained from nursing notes and the police statement I gave.

18. Although I do not recall the exact conversation with the doctor who had attended the call, the information I would have given to the doctor, would have been what had happened during this episode which was Child I had had a desaturation and bardycardia and was apnoeic, required neopuff, no chest movement, tummy more distended and hard, NGT aspirated, air and milk obtained from NGT, chest movement eventually obtained and saturations and heart rate normalised but remained pale. I did not have any concerns at the air or milk that was aspirated from the NGT. When using the neopuff to give breaths your putting 'air' in and this

can sometimes distend the tummy, with regards to the milk obtained I just presumed it was milk that had not been digested and had just been sat in the tummy despite the vomit earlier in the day. At the time of this incident, I do not recall discussing or mentioning the air and 2 mls of milk aspirated from Child I's Ngt, with anyone at the time apart from the people who needed to know. I also do not recall there being a debrief or any informal discussion regarding this incident, neither do I recall any investigation into the cause of this incident at the time. The only investigation I have been involved with, is the Operation Hummingbird police investigation for which I was asked to make a statement for. As previously documented, I did not have any concerns for the babies on the unit at the time or after the time of this incident, and would like to reiterate if I had had any concerns, I would have raised them at the time.

19. I did not have any concerns about the safety of any baby on the unit in the period of time following the incident of Child I's handover 30th September 2015, any concerns would have been raised at the time if I had had any.

20.I have been asked to give information into my involvement with Child N's desaturation and apnoea on the 15th of June 2016. Due to the passage of time the information given has been taking from my police statement given for the police investigation, Operation Hummingbird. I exhibit my police statement as Exhibit BB4 [INQ0000644].

21.I was not the designated nurse caring for Child N on 15th of June 2016 that would have been Lucy Letby. I had only assisted with the episode of desaturation and apnoea. I have documented that I thought I had been working in nursery 2 which is close to nursery 1 where Child N was being cared for. I have stated in my police statement that I had remembered helping Lucy Letby with an episode of desaturation (drop in oxygen levels) and apnoea (not breathing). I have stated the time this episode occurred was 14.50pm and that this time had been taking from Lucy Letby's nursing notes, as I was not the designated nurse for Child N I would not have written any nursing notes as I had only assisted. I have stated in my police statement that I do not recall exactly what role I took assisting Lucy Letby or how long in total I assisted her for. I have stated the doctor arrived but I cannot recall the doctor's name as in the police statement given to me for the purpose of this witness statement the doctor's name has been blanked out. I have also stated that I cannot recall who else was present. I cannot recall how I came to assist Lucy Letby but at the time of this episode the unit was small and nurseries where close together. If I had been working in nursery 2 and Lucy Letby had called for help or if I had heard the monitor alarms going off, I would have gone to see if help was needed.

22. In my police statement I have confirmed I have signed for intubation drugs (these are specific drugs administered when a baby requires to be ventilated). I have stated that I could not recall by looking at the prescription if I had just checked and countersigned the prescription or if I had administered the drugs. There must be two nurses to check and sign any drug to be given to ensure you have the right baby, right drug, right dose, right route and right time. Although both nurses check and sign for the drug on the prescription, the prescription does not require documentation of which of the nurses signing, has administered the drug.

23.I have documented at the beginning of my police statement that when I had first been asked by the police about Child N I did not initially recognise the name and it was only when I had read Lucy Letby's nursing notes for the episode on 15th June 2016, and that Child N had been a difficult intubation and had required an I-Gel airway, after several failed attempts to intubate in the usual way, that I remembered Child N.

24. Due to the passage of time I cannot recall being briefed or being aware informally or formally of any desaturation or deterioration of Child N earlier than the 14.50pm episode. I have however documented in my police statement, being asked about other episodes which occurred at 07.15 am and 19.40pm. I have stated that I would not have been on shift at 07.15am, my shift would have started at 07.30am. I cannot recall if this episode had been mentioned at the handover that we have at the beginning of each shift. With regards to the episode at 19.40pm again the night shift would be starting their shift at 19.30pm, and I would have been handing over to whoever was taking over from me. I have documented that as I was leaving that evening that the Ear, Nose and Throat (ENT) team from Alder Hey Childrens Hospital had arrived with the transport team, they had come for Child N.

25. I continued to have no concerns about the safety of any babies on the unit in the period after the episode involving Child N on 15th June 2016.

26. In relation to the Royal College of Paediatrics and Child Health (RCPCH) review and the interview myself and colleagues of the unit were asked to participate in, I can remember it being in relation to the increased mortality rate on the unit and Lucy Letby. I vaguely recall the interview as being informal and quite relaxed, with colleagues from the unit and I sat around the table with members of the review team. I cannot recall everything that we spoke about, due the time that has passed, neither do I recall all the questions we were asked. I vaguely remember being asked about Lucy Letby and my response was along the lines that I thought she was a good nurse who worked hard. There was nothing at the time that suggested anything different to me.

27. With regards to any training we had been given regarding reporting concerns involving fellow members of staff, I cannot recall what training we received at the time, apart from discussing concerns with the manager. We now receive 'Speak Up – core training for all workers' which is mandatory for all staff. We would still raise concerns with the manager and if we feel nothing is being addressed or resolved we could then speak to Freedom to the Speak Up Guardians or Freedom to Speak Up Champions who we have within the Trust now.

28. I did not have any concerns or suspicions about the conduct of Lucy Letby whilst working on the unit at the time. Apart from not often being on shift with her, when I was on shift with her, she never did anything that raised any suspicions with me. Not only this, during the period of increased mortality, we had also been very busy, you could be working in a nursery on your own at times and may not see a person in another nursery for long periods of the shift, as you were busy caring for the babies in your nursery and vice versa.

29. In relation to concerns and suspicions of others on the conduct of Lucy Letby, I cannot recall exactly when I became aware of this, but I think it was the time that Lucy was relieved of her duties on the unit and put to work in a nonclinical dept until further notice. I cannot recall exactly what we were told or by whom, I can just remember it was to do with concerns that some of the doctors had regarding Lucy and the increased mortality on the unit, I was not aware of any specific concerns at the time.

30. During and before this time period of 2015-2016, I cannot recall for certain if a debrief or discussion occurred after the death of every baby.

31. As previously stated, I was aware that there was an increased number of deaths but as I have previously stated earlier in this witness statement, we were busy at the time, and at the time I probably would have associated the increase in mortality to being busy and therefore an increase in poorly babies or babies becoming poorly, as previously documented babies can deteriorate quickly. I never had any suspicions at the time, that the increase in deaths on the unit could be associated to someone, a colleague you had worked with who was supposed to be caring for the babies but instead of caring for them was committing such crimes.

32. I feel I cannot answer the question regarding CCTV due to the crimes having already been committed, it is something that we will never know due to this. Hindsight is a wonderful thing but does not help when answering the question in relation to such awful crimes that have been committed.

33. Unfortunately I do not have any suggestions to how the inquiry can make the NNU safe against the criminal actions of staff.

34. I have no documents or other information that are relevant to this inquiry.

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: 29-4-24