Witness Name: Christopher Neil Booth

Statement No: 1

Exhibits CNB/1 - CNB/12

Dated: 15 May 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF CHRISTOPHER NEIL BOOTH

I, Christopher Neil Booth, will say as follows:

Personal details

1. My full name is Christopher Neil Booth.

Nursing career and employment at the Countess of Chester Hospital (COCH)

2. I began my nurse training in February 1988 at the Sheffield School of Nursing and qualified as a Registered General Nurse in June 1991. My additional qualifications include the ENB 405 Special and Intensive Nursing Care of the Newborn course at Chester School of Nursing in 1996 and the ENB 998 Teaching and Assessing in Clinical Practice course, also at the Chester School of Nursing, in 1998. I completed the R23 Enhancing Neonatal Nursing Practice course at The University of Manchester in 2017.

3. I started my nursing career in 1991, soon after qualifying and worked at Leighton Hospital on a vascular/general surgical ward for two years. I began working on the Neonatal Unit (NNU) at COCH in June 1993. I began working as a junior D grade nurse, and upon completing my ENB 405 course, I was promoted to an E grade. I was later promoted to a senior post of F grade, which was changed to a Band 6 when the Agenda for Change was implemented in 2004.

4. During the period of 2015 - 2016, I was a band 6 Senior Neonatal Practitioner. I was responsible for the care of the sickest infants and supported colleagues and more junior staff and students. I also took charge of shifts and worked as a shift leader.

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

5. I would describe the NNU nursing team at COCH during 2015 – 2016 as a cohesive one with great camaraderie and a loyal, supportive NNU manager in Eirian Powell. It was an incredibly busy period with high acuity, and it was a demanding time for all team members. As so much time has now passed, my memory is somewhat sketchy, but I do remember team members being asked to show greater flexibility with shifts worked and indeed, even being asked to work extra shifts on a regular basis. I do

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remember grumblings of us needing more registered nurses to help cope with the increased workload, but that did not seem to be forthcoming.

6. I would describe the relationship between the nursing staff and direct line management as mutually respectful, trusting, and healthy. I do believe that our direct line manager and NNU manager, Eirian Powell, was as equally frustrated with the shortcomings in staffing levels and the constant firefighting in trying to resolve staffing crises. The relationship between nursing staff and more senior management was quite possibly less mutually respectful as I feel they probably treated our need for more nursing staff with a degree of disdain.

7. I would describe the relationship between medical professionals during this period as good. We were a strong, mutually supportive team and all worked well together for the wellbeing of our babies and their families. My only slight concern at this time though, and it is a concern I have held for some time, is that we at COCH really could have benefitted from the expertise of a neonatologist, who could offer more specific, focussed, and cutting-edge expertise in this very specialised field.

Child G, Child I, Child N, Child O and Child P

8. I shall attempt to set out my recollection and involvement of care in respect of Child G, Child I, Child N, Child O and Child P.

9. I have reviewed the statements made by me to the police referenced **[INQ0000330]**, **[INQ0001409]**, **[INQ0000539]** and **[INQ0000628]**. These statements were made in 2018, and therefore only two - three years after the incidents took place. I had the benefit of a fresher memory then and had full access to the medical and nursing notes. A further eight - nine years have now passed, and I can honestly say I could not add anything further to my original statements. I confirm that the statements I previously provided are accurate to the best of my knowledge.

Child G

10. I have reviewed the statement I made to the police **[INQ0000330]** as well as the medical records **[INQ0000272]** in relation to Child G. I have set out below an extract from my statement relating to Child G's second collapse where I stated:

> *"We wondered whether [Child G] had aspirated or could that have been a symptom of sepsis. I cannot remember who said what or who was there it was just a reflection between staff about what had just happened. Staff [sic] we were all shocked and upset by the incident. This took place within the NNU, possibly nursery 1."*

11. I honestly cannot recall who was present during the discussion referred to in the above extract.

12. From my recollection, the consensus was that Child G's condition and instability was a possible symptom of sepsis. Babies do vomit and so Child G's projectile vomiting did not cause me significant concern at the time.

13. It is not unusual to encounter sepsis in infants, and it can manifest itself in many ways such as vomiting, abdominal distention, apnoea, metabolic acidosis among many others. Our concerns were allayed by the fact that Child G was receiving appropriate care and treatment. Again, I cannot recall with whom I may have had these discussions.

Child I

14. I have reviewed the statement **[INQ0000539]**, which I made to the police on 16th May 2018 relating to Child I. As far as I can recall, the below is an accurate summary regarding Child I's deterioration and my involvement in her care.

15. In brief, I stated that Child I had been about 10 weeks old when she collapsed at around midnight on 23rd October 2015. A crash call was put out and resuscitation commenced. I performed cardiac compressions on Child I. Dr Rachel Chang attended and Dr John Gibbs was called in. Child I recovered, but about an hour later she collapsed again. I described that Child I had lost her colour; her oxygen levels and heart rate had dropped. Me and Lucy Letby (Letby) managed Child I's airway and undertook normal ABC resuscitation manoeuvres while Nurse Ashleigh Hudson ran to get Dr Rachel Chang. The senior doctors took charge of the resuscitation, with Dr Gibbs acting as team leader. Nurse Hudson took over the cardiac compressions while me and Nurse Melanie Taylor drew up the medication.

16. In addition, I would like to add that as a team on that shift (including the registered nurses, medical staff, and nursery nurses), we were all profoundly saddened and distraught by the outcome. I, as the shift leader felt the need to send an email at the end of that shift to my manager commending my colleagues. The e-mail I sent out on Friday 23 October 2015 at 08:48 is set out below and included at **Exhibit** CNB/1 INQ0098317

> *Hi Eirian;*
>
> *I just wanted to send an email to commend the great team I was lucky enough to work with last night (Thursday night), a really traumatic night, but everyone: Lucy, Mel, Ashleigh and Val, worked incredibly hard and maintained an incredibly high professional standard in the midst of such a difficult and upsetting situation. Bearing in mind we admitted a 33+6/40 infant right in the epicentre of resuscitation attempts, and that the baby was well cared for bears testament to the great team I worked with last night.*
>
> *I just felt that members of our team who are thrust into a difficult situation and can summon the capacity to maintain a high level of care and display great team spirit, deserve some recognition. Last nights shift showed me that my team went above and beyond, and I was very impressed by them.*
>
> *Take care;*
>
> *Chris*

11. It is correct that in my police statement **[INQ0000539],** I had made comments about a discussion regarding the management of Child I during a debrief that I did not attend. I have set out the relevant extract below.

> *"I am aware things were said by the team, about whether it was right or wrong to extubate her the first time, whether that was the right course of action. But*

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at that moment in time, [Child I] had been fighting against the ventilator and had bounced back."

12. In terms of how I became aware of what was said in that debrief, I feel there is a degree of merging with the discussion of the issue about extubating Child I. We all as a NNU were deeply upset by the loss of Child I and emotions were running high. I don't honestly think I can pinpoint a specific time when the events were discussed. It would be perfectly possible that an informal debrief between team members towards the end of that shift might have taken place. I am aware that there was some conflict as to whether extubating should have taken place, but it was extremely contentious in that Child I became vigorous and active, and so effectively displaying strong signs of recovery. Nobody could have foreseen the events that followed and her subsequent death. I feel it was simply human nature to try to make sense of such a horrible situation.

13. Without full recollection, I would speculate that the invitation to attend the debrief would have included the medical and nursing team members, who were involved in the events on the night of 22nd – 23rd October 2016.

14. Attendance at debriefs was not compulsory in 2015 and 2016. Indeed, it would be difficult to enforce as so many of us work shifts.

Child N

15. I have reviewed the statement I made to the police dated 23rd April 2019 **[INQ0000628]**. in relation to Child N.

16. I have also reviewed the statements made by Nurses Mel Taylor **[INQ0000630]**, Sophie Ellis **[INQ0000632]** and Valerie Thomas **[INQ0000625]**.

17. I have further reviewed the nursing notes entered by me on the 3rd June 2016 **[INQ0000579 - page 54]**. To the best of my knowledge, this is an accurate reflection of Child N's nursing notes, which I have set out below.

"One episode whilst I was on my break, whereby [Child N] was crying ++ and not settling. He became dusky in colour, desaturating to 40's. Responded to facial oxygen within 1-2 minutes. Crying subsided within approximately 30 minutes and colour returned to normal, pink. Dr Loughnane aware of this episode. No further episodes occurred."

18. I cannot recall the individual who provided me with the information for the note above.

19. It is unusual for a collapse not to be documented in the medical notes, however, according to my notes, the episode was quite brief and may not have necessitated the summoning of medical assistance, being managed by the nurse who was present in my absence. To the best of my recollection, the entries that I made following my return from my break was the information that was relayed to me by that individual. I would usually expect the notes to cover details such as who attended Child N and who called

Dr Loughnane, but I can't recall whether this information was passed to me on my return from my break.

Child O

20. I note the extract in my police statement **[INQ0001409]** in relation to Child O, where I stated that:

> *"When it became apparent that [Child O] was not going to survive, the mood amongst staff was understandably sombre and we were all shocked and disappointed. [Child O] had looked like a triplet that potentially was going to sail through, he was a good size and not even that premature. It was so unexpected that he just suddenly collapsed with no indication that would happen and so it caught us all by surprise."*

21. When I referred to *"us"* in the extract above, I was referring to the immediate team caring for Child O, which very probably including both medical staff and nursing colleagues. This is to the best of my knowledge as the statement was made to the police in March 2018.

22. I cannot recall what was discussed regarding Child O's death at the handover from the day to the night shift on the evening of 23rd June 2016.

23. I cannot recall whether there was there a debrief, meeting or informal discussion involving nursing staff within the NNU team to discuss this unexpected death of a baby on the NNU and so I cannot comment on this any further.

24. I have reviewed the statement made to the police by Yvonne Farmer dated 13th March 2018 **[INQ0001408]**.

25. I have no recollection of being delegated to complete the paperwork regarding the death of Child O by Yvonne Farmer, as suggested by her in her statement.

26. I honestly cannot say for certain why Yvonne Farmer would ask me to complete the paperwork regarding Child O as opposed to Lucy Letby, who was Child O's designated nurse. I could surmise that I may have been the shift leader and, in that capacity, I would be seen as the most appropriate person to complete the paperwork, given my role as a senior Band 6 nurse.

Child P

27. In terms of Child P's condition, he was displaying the same signs and symptoms as Child O the previous day. It was almost like a complete repeat of the course of illness and tragic death. This would have been discussed amongst myself and colleagues I was working alongside that day.

28. My concerns at the time, and as mentioned in my police statement **[INQ0001409]** were that both infants were displaying signs of acute sepsis. Again, these concerns would have been discussed with the immediate team working to help Child P.

29. I cannot accurately recall, but I would surmise that we were all devastated, shocked, and exhausted following the death of two siblings in two days. I cannot recall what would have been discussed at the handover from the day to the night shift on the evening of 24 June 2016, but I would imagine that everyone was devastated by the event.

30. I cannot accurately recall, but I am sure a debrief would have taken place to discuss the unexpected death of a baby on the NNU. I did not attend those meetings as I work predominantly night shifts and was probably on a night duty.

31. I have reviewed the statement made by Nurse Nicola Lightfoot to the police on 5th July 2018 **[INQ0001480]** regarding the events of 24th June 2016. She states:

> *"At the time of the initial hospital investigation a nurse and one of the junior doctors had made derogatory comments about Lucy probably being involved in the deaths and collapses on NNU. This nurse was* Nurse ZC *and the Doctor was Cassie BARRATT. There were strong words of advice given to* Nurse ZC *by her peers to avoid further speculation and unnecessary gossip surrounding the inquiry.* I&S

I&S

32. I was not aware of any derogatory comments made by anyone about Letby as above and therefore cannot elaborate on this further.

33. At the time of these collapses and tragic deaths of Child G, I, N, O and P, I had no specific concerns or considered a causal link between them. I felt that each infant had specific issues, be it prematurity, infection/sepsis and each episode could be explained logically. It was an exceptionally busy time for us on the NNU, and the heavy workload and high acuity was almost relentless.

Concerns or suspicions

34. We have all been made aware on a Trust-wide basis for many years about the need for openness, whistleblowing and more recently the implementation of Freedom to Speak Up Guardian. I was aware of the accepted culture of whistleblowing at COCH as it was covered on the mandatory training days, and was often and still is themed on the hospital's intranet. The only training I would have received on how to report issues concerning fellow members of staff would have been captured by the whistleblowing training. I cannot recall any other specific training being given on this matter.

35. I had no concerns whatsoever regarding Letby.

36. I was not aware of any suspicions or concerns of others regarding the conduct of Letby.

37. After the death of a baby, formal debriefs did occur, usually a few days after the event. I did not attend any formal debriefs as either I was working a night shift or chose not to attend. I did however make use of informal debriefs with colleagues where we would talk, discuss, assimilate, and try to rationalise what had happened.

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38. I was of course worried about the increased number of deaths on the NNU. It was extremely harrowing and emotionally exhausting. As I have outlined earlier, in my mind, the collapses and deaths could all be rationally explained as we were experiencing an unprecedented level of acuity with the NNU being at capacity or close to capacity for such a long time.

39. The issue with running water was experienced by everyone working on the NNU for a significant period between 2015 - 2016, although I cannot remember the specific period. The water pressure was extremely low, essentially a dribble, and for a time there was little or no hot water. This was not ideal for hand washing in a nursery containing potentially extremely sick and vulnerable babies. Our manager did raise the issue with the estates department, but the time it took to completely resolve the issue was in my opinion overlong.

40. The water issue which was seen as an annoyance and a real issue at the time, but it is only since the events were investigated that I reflected upon it and saw it as a potential factor in perhaps cases involving sepsis. At the time, we were all aware of the tap water problem, and as it was being dealt with by the estates department, nothing more could be done.

Reflections

41. I feel that CCTV monitoring to prevent such crimes would have little impact or effect. If a person is determined to commit any unlawful deed, the CCTV camera system could be easily circumvented. I also have issues with the privacy of parents who may be enjoying skin-to-skin time with their baby, or indeed breast-feeding mothers.

42. In terms of my recommendations to the Inquiry, I think using the utmost vigilance in the screening of potential staff members at the time of recruitment would be a good place to start. This could involve possibly conducting personality tests as part of the recruitment process to seek to identify any personality disorders such as narcissistic personality disorder among others, which would mean such people would probably be incompatible with working in such a stressful environment. This is not to say that I feel Letby necessarily suffered from such a disorder, but it seems to be a glaring oversight in the recruitment process.

43. I also think improving staffing numbers would always have a positive effect on neonatal nursing teams' wellbeing as throughout this period between 2015 - 2016, we were almost constantly short staffed with team members being asked to change shifts at short notice or work extra shifts. This is not good for staff mental health or morale.

Request for documents

44. I do not have any documents or other information, which are relevant to the Inquiry's Terms of Reference other than the e-mail I had sent and exhibited with this statement.

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: 16.05.2024 | 12:24:52 BST