Thirlwall Inquiry

THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE FOR NURSES

Name: Nicola Dennison
Role as per Countess of Chester 2015-2016 Staff List: Nursery Nurse
Enclosed documents: Audio recorded witness interview dated 26 January 2018 (INQ0007598)
Witness statement dated 26 January 2018 (INQ0001139)
Witness statement dated 29 January 2018 (INQ0001140)
Witness statement dated 11 April 2019 (INQ0001141)
Extract from transcript of Day 70 of trial (14 February 2023) relating to your evidence (INQ0010302)

Questionnaire

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

1. Please provide a short summary of your nursing career. This summary should include at least the following information:

    a. when you qualified as a nurse, including the educational institute or awarding body;
    b. your nursing qualifications, including your nursing band from 2015 to the present;
    c. details of your previous and current employment.

I qualified as a Nursery Nurse in 1984 from Carlett Park College of Technology, which was part of Wirral Metropolitan College, having completed the National Nursery Examination Board.

I began working at the Countess of Chester NHS Hopistal (the "hospital") in 1985 as a Nursery Nurse on the Neonatal Unit.

I had a small break between 2000 – 2002; however, I remained on the Bank with the hospital and continued to do some shifts.

To the best of my knowledge and belief I returned to the hospital full time in November 2002 as a Nursery Nurse on the Neonatal Unit where I continue to work today.

2. What were your duties and responsibilities (including any management responsibilities) as a nurse on the neonatal unit (the "**NNU**") at the hospital in 2015 and 2016?

As a Nursey Nurse on the Neonatal Unit at the hospital in 2015 and 2016 I predominantly worked within Nurseries 3 and 4 which included most of the special care babies and I could be responsible for up to 4 babies at a time. A special care baby required no mechanical respiratory support but could have nasal cannula oxygen or what is known as ambient oxygen through an incubator, and they would usually have no in dwelling long lines or Broviac lines. We often referred to them as "feeders and growers".

When I started my shift, I would be responsible for checking my equipment, checking the feeds were appropriate and checking the incubators settings were correct. During my shift I was responsible for basic baby care needs which included, nappy changing, feeding, and checking their temperature, pulse and respiration (TPR). I would help to teach the parents resuscitation, feeding, how to use breast pumps and how to bath the baby, for example. I would assist doctors by holding babies they were cannulating or who they were doing a lumbar puncture on.

My role involved caring for babies struggling with feeds or who were cannulated and receiving clear fluids but not babies who had a long line or were receiving total parental nutrition (TPN) which would take a baby outside the criteria of a special care baby and into high dependency.

Special care babies do not need someone sitting by their bedside constantly; however, they may still be on monitors and have alarms. All staff walking by could and would answer the monitors or alarms if they went off, this would

exclude housekeepers and domestic staff who might notify staff in the vicinity that a child is alarming. This means that I could be a free agent at times which allowed me to support registered staff on the Neonatal Unit by bringing in any equipment required which in turn allowed registered staff to stay with the baby.

Whilst I am not responsible for babies that are on any mechanical respiratory support which includes Optiflow, Continuous Positive Airway Pressure (CPAP) or ventilation, if registered staff are preoccupied with a sick baby and to avoid the baby missing their feed, I would, if available, assist with feeding a baby in the High Dependency Unit (HDU) on CPAP or a baby on Trophic Feeds which is not a full feed. If I assisted with a feed, I would document this on the feed chart which was located at the cot-side. There would be no other recorded documentation which I would complete to note the feed though the registered staff may have noted it in their electronic entry.

To the best of my knowledge, in 2015 and 2016 I was responsible for ordering bloods on Meditech, taking the bloods and sending them to the labs. The responsibility of ordering bloods has since been removed from Nursery Nurses as it was felt this was outside a non-registered staffs remit of responsibility. I would and still do liaise with both the Shift Leader and Paediatric team on duty to discuss the blood results as and when they become available.

I would be responsible for drawing up oral medication or oral antibiotics included in the sign off list of medication/antibiotics I could give. This was always checked by a registered member of staff.

Other duties sometimes took me off the ward, for example, I would go under the stairs to get stock for the Nursery 1 stacking shelves, take the dirty linen out to the laundry room for washing or go to the pharmacy in general hospital. I would always inform another member of staff that I was going off the ward and ask them to listen out for my babies.

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

3. How would you describe the quality of the management, supervision and/or support of nurses on the NNU between June 2015 and June 2016?

I had no issues with the management or supervision. I had my appraisals annually with Senior Nurses and Yvonne Farmer would inform me when she had booked me onto relevant training or of upcoming training I may wish to attend.

4. 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?

I cannot comment on the relationships between clinicians and managers as their discussions took place behind closed doors.

The relationship between the nurses and midwives overall was appropriate; however, there were times where more timely communication from the midwives to the Neonatal Unit could have been given. For example, a mother of a pre-term baby who would likely need to come to the Neonatal Unit would have been on the Labour Ward for a number of hours, but we would only be informed when the mother was delivering leaving a shorter period of time to prepare for the baby's arrival.

I am unable to comment on the relationship between the nurses, midwives and managers and the medical professionals as I was not involved in this.

I felt all staff on the Unit had a good rapport with doctors who came on to the Unit. There was a changeover of Foundation Doctors every 6 months. If the Foundation Doctors or Consultants had a leaving do, I would often attend.

Concerns or suspicions

5. 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 cannot recall any specific training being provided on how to report concerns about a member of staff.

I was and am fully aware of how to report an incident on Datix which may include concerns about a fellow member of staff if they have done something wrong.

If I had concerns, I would have had no issue speaking with the managers and/or Shift Leaders to raise the concerns.

6. Did you have any concerns or suspicions about the conduct of Lucy Letby ("**Letby**") while you worked on the NNU? If yes, what were your concerns or suspicions and did you raise them with anyone, either formally or informally?

I had no concerns or suspicions about Lucy Letby's ("Letby") conduct while she worked on the Neonatal Unit.

7. 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 of others about the conduct of Letby.

8. What discussion or debrief was there (formal or otherwise) with or between nurses, or between nurses and doctors, after the death of a baby?

To the best of my knowledge, I think a debrief session was organised following the death of a baby; in particular for those who were poorly for a long period or following an unexpected death. However, I never attended any of these debriefs and cannot recall being invited.

9. 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?

I was not particularly worried about the increase of deaths on the Neonatal Unit because we had a lot of babies who were very poorly, some of which were born to very poorly mothers and as such our statistics naturally increased. We also had a high incidence of congenital abnormalities which included heart conditions and gastroschisis, for example. We were at maximum capacity for the majority of the time; however, I do not feel that care was ever compromised, and we would often get the parents involved to provide basic baby care such as changing nappies.

Reflections

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

I do not think CCTV would have picked up any of the crimes Letby was accused of.

I do not think it would be appropriate to have CCTV in a clinical area for privacy and confidentiality reasons.

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

I have no recommendations.

Request for documents

12. Do you have any documents or other information which are potentially relevant to the Inquiry's Terms of Reference? For example, any documents relating to concerns that were raised about Letby or the safety of the babies on the NNU in 2015 and 2016. If so, please itemise them and provide copies with your signed statement.

I have no documents or other information which are potentially relevant to the Inquiry's Terms of Reference.

Personal Data

Signe

Full Name: Nicola Anne Dennison

Dated: 21/5/24