Thirlwall Inquiry

THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE FOR NURSES

Name: Clare Bevan
Role as per Countess of Chester 2015-2016 Staff List: Registered Nurse
Enclosed documents: Witness statement dated 10 February 2023 (INQ0001260)
Extract from transcript of Day 76 of trial (23 February 2023) relating to your evidence (INQ0010307)

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 trained as a Children's Nurse at Nottingham University and qualified in February 1996. I moved back to Countess of Chester Hospital (COCH) and began working on the Neonatal Unit at COCH in February 1999 as a band 5 Staff Nurse (Grade D at the time).

I gained my specialist qualification in Neonatal Intensive care in 1997 and became a Band 6 (Grade E) and continued with my career development on the Neonatal Unit at COCH, working as a Senior Staff Nurse until 2014. I then trained to become a Health Visitor in Shropshire but continued to work as a Band 6 Bank Nurse on Neonates at COCH.

In 2019, whilst still working fulltime, I retrained as a mortgage and protection consultant and set up as self-employed in February 2020.

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?

In terms of my standard Band 6 responsibilities, I worked predominantly night shifts and so I would usually be in charge or second in charge on the unit, co-ordinating staffing and care for the Neonatal Unit during the shifts and allocating patients/staff for the shift, as well supporting staff.

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 was only working as a Bank Nurse during this period, so I am not able to make a judgement on the period between June 2015 – June 2016. Support since that time, for anyone not still working on the Neonatal Unit has been non-existent.

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?

Tensions increased especially between medical and nursing staff. If your face fit – you're fine but that wasn't new. I noticed when I went back to the unit after a short break around 2014/2015 (when I completed my Health Visitor

training), that the relationship between Doctors and Nurses was different somehow. Each was more wary of the way they interacted. When I had been there previously, there had always been banter between the two and relationships on the whole were positive. I am unsure of the reason for the change - perhaps because it was a new batch of Doctors or something else that I was unaware of. I think it may have correlated with Lucy being removed from the unit which made people more wary as they didn't really know what was going on and there was speculation.

Some staff found management much more approachable than others. The Unit generally felt neglected by senior management as we were constantly short staffed and it appeared they weren't listening to our requests for help.

If we had sickness on shifts it was always very hard to get help from other areas of the hospital - we felt like we were on our own. I think people were frightened to come and help because it was such a niche area of nursing.

Personally, I didn't have any issues with anyone. I always got on well with rest of the team, including midwives, doctors and other clinicians but always kept it professional.

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?

Annual training updates included whistleblowing updates. I cannot remember the detail but throughout my training and career as a nurse I was always taught that any concerns about staff, procedures, protocol not being followed etc. should always be raised. There was lots of information on the intranet about how to do it. I believe that most senior staff on the Neonatal Unit were approachable. Even if a junior member of staff felt uncomfortable approaching management directly, the friendship groups within the Neonatal Unit were such that all staff either directly or indirectly had a route to raise concerns. I can't think of any member of staff on that unit that (if they felt for whatever reason couldn't follow official channels) didn't have someone relatively senior to discuss concerns with, that then would have been formally reported.

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?

No. If I had any concerns, I would have ensured they were addressed at the time.

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 concerns of others until Letby was removed from the Neonatal Unit and relocated to another area of the hospital. Letby and we (i.e. the nurses/nursery nurses) were told not to have any contact.

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?

Debriefs were usually conducted by medical staff and some were better than others at instigating these. As senior staff, we would often informally support each other and the junior staff, especially in the absence of a medical led debrief. It was an extremely emotional time for all involved (no matter how much experience you had) and it helped to cope by having a better understanding of what happened and why, although answers weren't always available.

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?

The increase was concerning but nobody to my knowledge expressed any concerns, including doctors. As far as I am aware, although the deaths were unexpected and some apparently unexplainable, nobody voiced any concerns. In my recollection, staff were discussing how 'odd' it was but there was never any suggestion of anything untoward.

There are a few baby deaths that I experienced (particularly later in my career) that I still find troublesome. These occurred outside of the time frame under consideration by the Inquiry.

Reflections

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

I don't know if CCTV monitoring would have assisted. I think the wider implications need to be carefully considered before implementation of CCTV. I can see the argument for CCTV and potentially agree if it would stop anything like this happening again but don't think that decision should be taken lightly. However, I think it puts a massive amount of additional pressure on all staff, who are simply trying to save lives and provide optimum care to vulnerable patients in exceptionally stressful environments. This is very hard to verbalise and put on paper to someone who hasn't worked in this type of environment.

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

I think senior staff should have been made aware of concerns much earlier. We could have allocated care appropriately to make observations and supervision easier. Other recommendations I have are better staffing levels, improved communication and psychiatric evaluation of all staff regularly.

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 do not have any further documents or information that are helpful to the Inquiry's Terms of Reference.

Personal Data

Signed: ______________________________

Full Name: __________Mrs Clare Elizabeth Bevan__________________

29/05/2024

Dated: ______________________________

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