Witness Name: Minna-Maria Katriina Lappalainen
Statement No.: 01
Exhibits:
Dated: 31.5.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF MINNA-MARIA KATRIINA LAPPALAINEN

I, Minna-Maria Katriina Lappalainen
will say as follows: -

Minna-Maria Katriina Lappalainen

Qualifications

1990 Registered General Nurse (RGN), Warrington School of Nursing

1993 Registered Midwife (RM) Chester School of Midwifery

1996 ENB 405 Neonatal Intensive Care course, University College London Hospital and South Bank University London

2003 R23 Enhanced Neonatal Practice Course, Manchester University

I worked on the Neonatal Unit at the Countess of Chester Hospital from September 1993 until my retirement in October 2017

Between June 2015 and June 2016 I worked as a Senior Neonatal Practitioner, nursing band 6

As a Senior Neonatal Practitioner my responsibilities were; working clinically in all areas of Neonatal Intensive,High Dependency and Special Care as required when on duty. Part of my role included being a shift leader on some shift, managing and supporting staff,students and junior doctors.

Culture and atmosphere on the NNU at the hospital 2015-

2016: What I can recall, the NNU was busy and we were often short staffed.

Our NNU manager supported us well, but higher management of the Countess of Chester didn't support us or listen to the staff or the NNU manager. Our staffing levels remained poor at times especially during busy periods. This period was stressful and exhausting at times.

I felt medical staff should have supported nursing staff better.

CHILD A [INQ 0000070]

On June 9th 2015. I was working a day shift from 07:30 to 20:00

I was allocated to complete the formal paperwork and liason with all the appropriate agencies following a death of a patient. This work was always allocated to a senior staff member.

I wasn't involved in the nursing care of CHILD A.

I completed the DATIX report on 9th June as part of the formal paperwork necessary to do.

All information included in the Datix report I took from the patient's medical notes.

I can't remember what the choices were for the cause of death on the DATIX form in 2015, I didn't use my own words on the report.

I didn't attend any team briefing for CHILD A. I don't remember whether there was a team brief for all the staff involved in the care of CHILD A.

Team briefing is normal event following any serious event especially following a death of a patient.

CHILD J [INQ 0001065]

I was involved in caring for CHILD J during the day shift on 17th December 2015 I can't remember all the details from memory but I made a statement to the police dated 28th March 2018 from documented nursing notes. The care stated correct management of patient's care for the episode described in the notes.

Mottled appearance of the skin in preterm or ill newborn is not uncommon. This can be due to baby being ill with infection, poor blood circulation. Mottled skin looks like web or marbled pattern to the skin with reddish areas and pale areas.

It is appropriate to alert attention if any Neonatal patient presents with unusual symptoms, this would require for a paediatrician to assess the baby's condition and decide on further management.

I can't recall from memory, all the details are written in patient's nursing and medical notes.

Although I can't remember from memory the events of the shift in question. Reporting and recording all events patient is required nursing practice and information is given to all the the staff during shift hand over. Nursing and medical staff discuss patient's condition and management of care and agreed managing is documented and implemented. This is normal practice of care.

Parents are informed of all care and treatment of their baby.

CHILD N [INQ 0000647]

According to my statement to the police on 3rd April 2018

I was the designated nurse for caring for CHILD N on 12th June 2016 and had no concerns for CHILD N during that shift. On the 15th June 2016 I was on day shift. Apparently Lucy had arrived early for the day shift at 07:10.

I'm unable to remember details of this day shift.

I'm asked to state whether early arrival of Lucy Letby for her shift or any nurse to arrive early for their shift and be involved in the care was unusual. No it wasn't. In urgent care this was sometimes necessary and appropriate. I can't remember being concerned.

I can't recall what was reported and recorded about CHILD N. This is available in writing in patient's nursing and medical notes. The shift hand overs will have detailed information about all significant event that took place during previous shift. I can't remember from memory.

CHILD Q [INQ 0001547]

I was a shift leader on 25th of June 2016. I attended to CHILD Q as stated in my witness statement to the police. I was a court witness for CHILD Q during Lucy Letby trial.

I wasn't aware of any concerns by nurses, medical staff or managers for Lucy Letby being assigned nurse for CHILD Q. I didn't have any concerns either.

During shift hand over to the night shift team, all aspects of patient care and condition would have been discussed and handed over. I can't recall from memory what I said during this particular hand over.

As far as I can remember the issue of increased mortality was not discussed with nursing staff.

CONCERNS OR SUSPICIONS

I was a friend of Lucy Letby. I attended some social activities with her.

I had no concerns or suspicions about her nursing conduct on the Neonatal Unit, nor was I aware of any

other nursing or medical staff members concerns. At least it wasn't openly expressed.

All hospital staff were given training on reporting concerns of staff members, including myself.

As I wasn't on duty during any of the shifts when babies died, I'm unable to comment on the formal or

Informal debrief sessions that would have taken place.

The increase in neonatal mortality wasn't discussed among nursing staff at that time.

REFLECTIONS

It's difficult for me to say whether using CCTV monitoring would be the appropriate way to monitor any activity in critical care area such as Neonatal Intensive Care Unit. Patients's and their families have their right to privacy and confidentiality. Appropriate professional staffing levels on Neonatal Units and open communication between all professional disciplines would improve the way concerns are addressed.

Hospital executive management must respond promptly to concerns raised by nursing and medical managers.

I have no further information or documents to pass onto the Inquiry Team.

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: 31.05.2024