THE THIRLWALL INQUIRY

RULE 9 QUESTIONNAIRE FOR NURSES

Name: Jean Peers
Role as per Countess of Chester 2015-2016 Staff List: Nursery Nurse
Enclosed documents: Witness statement dated 25 January 2018 (INQ0001137) Witness statement dated 21 April 2019 (INQ0001138)

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;

I achieved my NVQ Level 3 in 2003 whilst working in paediatric outpatient clinic. I cannot recall what the NVQ was on but would have been linked to childcare.

    b. your nursing qualifications, including your nursing band from 2015 to the present.

I was in 2015 and remain a NVQ Level 3 nursery nurse band 4.

    c. details of your previous and current employment.

I previously worked as a paediatric outpatient's auxiliary nurse at the hospital from 1992 to 2004. Following this I moved to 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?

I am currently a band 4 nursery nurse and I work on transitional care (TC) and the NNU and provide day to day care of our babies. I take bloods, assist with photo therapy and supporting parents with feeding. I also look after special care babies that are not on the HDU (High Dependency Unit).

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 would describe the quality of management and supervision as supportive, close and caring management, as well as my colleagues.

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?

We all worked together equally and respectfully.

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?

Yes, we were. We knew that we could go to our manager and report anything, and it would be confidential. I didn't really have to, but knew how to do it and knew that I had support and backing - like a close-knit family

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, absolutely none.

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?

No, I didn't have any concerns but what happened was that it was around about the time of the triplets and 2 of them died within a day of one another. Again, I did not have any concerns as I was not on shift but thought it was sad. We always said that if a baby died, it was rare, and I did not realise that they were adding up. If anyone lost a child, we always asked who was on shift as a care point of view. We always were told it was Lucy Letby (Letby) on shift and I thought to myself she is bad luck in a superstitious way but had no concerns that she was doing anything.

I came on shift a day or so later and the staff were saying that Letby had been taken off the NNU and I thought she was taken off for a break because she had lost 2 babies in 2 days and then, we were told that she was seconded but we were not to talk about it. I thought it was maybe the Royal College of Nursing Union that was representing her when she came in and left the NNU. Then we were thinking "why would you second someone to office work" and that was it, we did not really speak about it.

Tony Chambers called a meeting around 12 months later with all the staff and I remember him saying Letby is coming back to the NNU and that we had to be nice to her. I thought to myself, you have not explained why she was taken off and now you are saying we have to be nice to her, but we always had been, and I thought this was rude. So then, I was on the weekend and so was Yvonne Griffiths, she said that Letby was coming in with **Nurse Z** and that we would do a tea party to welcome her. We did cakes and tea, and she came in and we were all talking, and she did not say a word to us. Yvonne and I were talking a lot to make it nice and relaxed and when she went, we both said, oh my God, she is going to make it hard for us when she returns as she seems angry and that was it, I never thought any more about it.

We got a long text sometime later advising that she had been arrested and I got upset as I thought it was shocking and I felt for her. I worked with her, and she was just a quiet unassuming girl and I thought imagine if she was my daughter. We did not know anything, why or what was going on, and then it came out in the papers and people would ask me if I worked with her and asked what she was like, and I said she was nice.

The staff did not know anything. It was only after the trial and the Panorama programme that I knew what had gone on and we were shocked. A lot of the girls followed the trial on the podcast, but I didn't. I only knew by the Panorama programme afterwards. I don't know why she did what she did because you could never say you had a feeling about her, she was an unassuming girl and I worked with her quite a bit and we worked well together and treated each other with respect.

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?

The nursing staff involved with the baby would get the debrief. I was never in on any the debriefs, all that I had was the police that came to the house just asking for my information and the details of babies that they asked me about. I was questioned over 3 babies.

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?

It was rare to lose a baby and I did not realise that they were adding up. If anyone lost a child, we would always ask who was on shift as a care point of view. We always were told it was Letby, but it did not enter my mind that she would do anything, her name kept popping up.

Reflections

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

If the camera could be close enough to the incubator maybe it would help, but I don't really know what she did and how much the camera would pick up. The camera would just capture her back, unless it saw her going into the cupboard etc, but I don't really know.

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

I think when a consultant has concerns and goes to top management and they do not act on it, that needs to change. As they would not take her off and they allowed her back on the NNU. I find this horrifying and the last of the babies could have been saved if they had listened to the consultants without a doubt, never mind CCTV, they should have acted on it straight away. There was more than one consultant that complained, and I find this most shocking.

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 don't have any other documents or information. I only have the supporting evidence that has been sent to me by the Inquiry.

Signed: PD

Full name: JEAN ELAINE PEERS

Dated: 6/6/24