Witness Name: Caroline Oakley
Statement No.: 1
Exhibits: Exhibits CO/01 – CO/15
Dated: 30 April 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF
CAROLINE OAKLEY

I, Caroline Oakley, will say as follows: -

Personal Details

1. My name is Caroline Jane Oakley. I have been asked by the Thirlwall Inquiry to provide a witness statement providing information in response to questions asked of me by the Inquiry. I set out that information below.

2. I have previously provided statements to the Police, which I exhibit to this statement dated: 31 January 2018 **(Exhibit CO/01) [INQ000808]**, 2 March 2018 **(Exhibit CO/02) [INQ0001119]**, 13 March 2018 **(Exhibit CO/03) [INQ0000341]**, 20 March 2019 **(Exhibit C0/04) [INQ0000627]**, 6 April 2018 **(Exhibit CO/05) [INQ0000228]**, 6 April 2018 **(Exhibit CO/06) [INQ0000528]**, 6 April 2018 **(Exhibit CO/07) [INQ0000535]**, 31 July 2018 **(Exhibit CO/08) [INQ0001401]**, 2 May 2019 **(Exhibit CO/09) [INQ0001120]** and 8 October 2021 **(Exhibit CO/10) [INQ0000675]**.

3. I gave evidence to the Crown Court in Lucy's trial on 4 November 2022 – I exhibit a transcript of my oral evidence as **Exhibit CO/11 [INQ0010274]**.

4. I can confirm that the contents of my Police statements and my oral evidence at the Crown Court are correct to the best of my knowledge and belief.

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

5. I trained in 1985 at Salford School of Nursing. I completed a four-year course in Registered Sick Childrens Nursing and Registered General Nursing. I qualified as a Registered Sick Children's Nurse and Registered General Nurse in 1989. Following qualification, I worked at The Duchess of York Childrens Hospital, Withington, Manchester, for two and a half years as a Staff Nurse.

6. My next role was on The Neonatal Surgical Unit at St Mary's Hospital in Manchester. Whilst at St Mary's, I completed the ENB 405 Special and Intensive Care of the Newborn course. I worked there for eight years.

7. After relocating to The Wirral, I secured a job on the Neonatal Unit at the hospital and began working there in February 2000. I progressed to a Band 6 in 2004 following the introduction of Agenda for Change NHS Pay System. I was supported by the hospital to attend Chester University to achieve a diploma in Higher Education and a Bachelor of Science degree with Honours; however I cannot remember the date in which I completed this. I was also supported by the hospital to complete R23 Enhancing Neonatal Practice course at Manchester University. I am currently still employed by the hospital as a Band 6 nurse.

Duties and responsibilities as a nurse on the Neonatal Unit at the hospital in 2015 and 2016

8. In 2015 and 2016 as a Band 6 nurse on the Neonatal Unit at the hospital, I was either the Shift Leader or was allocated patients. It was not frequent for the Shift Leader to be allocated patients and that would only occur if the Unit was particularly busy or if there was an issue with staffing. The Shift Leader led and co-ordinated the clinical management and delivery of care and worked collaboratively with the medical team and other professionals such as Physiotherapists. This is still the case today.

The culture and atmosphere on the Neonatal Unit at the hospital

9. In 2015 and 2016, the manager of the Neonatal Unit was Eirian Powell. I found her to be approachable, helpful, and supportive.

10. We did not and do not have clinical supervision, instead we have an annual appraisal with our line manager, where we discuss aims and objectives, how we feel we are doing, and how the Trust can help us to achieve our goals. Our line manager then and now has an open-door policy, whereby you can raise concerns at any time.

11. I cannot comment on the relationships between clinicians and managers between June 2015 and June 2016. To the best of my memory, in my role, I only had a relationship with my immediate manager, Eirian Powell, which was good.

12. I remember some conflict between the nurses and the midwives/obstetricians on the

Labour Ward. They did not accept when we told them we could not take more babies and/or we needed to close the Neonatal Unit due to being at full capacity. Neonatal nurses would report such incidents via an online reporting system.

13. To the best of my knowledge, there were no issues between medical professionals, the doctors got on well with each other and the nurses and doctors also got on well.

Child D

14. In my statement **[INQ0000808]** I described Child D as "*blotchy and appearing over the trunk and top of her legs*" and noted that "*around that time there was a cluster of similar rashes that had appeared on other babies on the unit*". I cannot recall discussing Child D's skin discolouration; however my standard practice would be to discuss concerns with my nursing colleagues and the on-call doctor who on 21 June 2015 was Dr Andrew Brunton. No formal meeting would have been held to discuss concerns as part of the events concerning Child D, we discussed concerns when and as they arose.

15. I did not know what the rash was, I thought it must have been related to sepsis. I do not know if I saw the same rash on another baby or if I was told or read about it in another baby's medical notes. I can recall wondering whether the rash had something to do with the previous leak through the ceiling in Nursey 1 near to where Child D was nursed. I cannot recall when the leak was but to the best of my knowledge, it contained soilage which made me wonder whether that had anything to do with causing the rash.

16. In my practice, if I have a concern about a symptom in a baby, I will discuss it with a nurse I am working with, and I will bleep the doctor to inform them of the situation.

18. I believe there was a general awareness of an unusual rash, but I do not know if it was discussed between medical professionals.

19. During the resuscitation attempts, I remember feeling shocked, confused, and upset. Mother D wrote in her statement dated 10 September 2018 which I exhibit as **Exhibit CO/12 [INQ0000792]** "*I remember reflecting at the time that whilst everyone else had*

been busy doing something she didn't seem at all panicked about what was going on. Everyone else had a sense of urgency and panic but this nurse, Lucy Letby, didn't". I have no memory of who was doing what during the resuscitation process and have no awareness of Lucy during this time either.

20. I felt Child D's death was unexpected because there were no clinical signs of a deterioration in her condition, and I remember feeling happy with her at the start of the shift too. I have put in my statement **[INQ0000808]** that the registrar, Dr Brunton, reviewed Child D at the start of his shift, and he was happy with her status too. I remember thinking she looked well.

21. I cannot recall the specifics of who I discussed the unexpectedness of Child D's death with or what was said. I did not understand what had happened and needed to try and process it. I didn't achieve this.

22. We did not, and do not, have a formal protocol for debriefs. The death of a baby usually merits a discussion and I presume there was one for Child D. Those who were on duty and cared for the baby who died would be invited to attend the debrief. I did not attend Child D's debrief for reasons I can't recall. I imagine I would have had a commitment I could not change as I would have chosen to be present if possible. If I was given feedback from the debrief, I cannot remember.

23. If a debrief was to take place, staff would be notified via email.

24. In my statement **[INQ0000808]** I have stated that, "*we are a close unit and we tend to get our support from each other*". We were quite a small team, and generally got on very well. There are some team members who were and still are friends out of work, and I imagine I chatted to them to enable reflection and processing of stressful events. I was not offered formal support, and I do not know if I would have wanted it.

Child E

25. I was the Shift Leader for the nightshift on 4 August 2015, and Lucy was Child E's designated nurse.

26. I do not recall if there was a debrief following Child E's death, and if there was one, I do not remember being present. I think it is difficult to organise a meeting in a timely manner and to accommodate within the constraints of the shift patterns for the staff who need to attend.

27. In my statement **[INQ0000228]** I say, "*I presume it was a learning experience*" in relation to a debrief. I only remember attending one debrief in relation to another child, and it was a review of what happened, and a discussion of points raised. To me, that is a learning experience.

28. Upon review of Lucy's entry in the nursing notes dated 4 August 2015 at 0451 hours which I exhibit as **Exhibit CO/13 [INQ0000187]**, I can confirm that I have not seen this entry before and I do not consider it to be particularly over detailed.

Child G

29. I was the day Shift Leader for 7 September 2015. I cannot recall the handover for Child G on the morning of 7 September 2015. However, standard practice during the day and night handovers would be for the Shift Leader to provide roughly a thirty-minute handover to all staff coming on shift, and this would include a summary of all the babies. Significant details such as collapses would be mentioned in the summary. Following handover, the Shift Leader would allocate each nurse a baby/babies to care for. The allocated nurse would then be provided with a detailed handover from the nurse who had been caring for that baby. This handover would take place at the cot side.

30. As Shift Leader, I would not have been present at the individual handovers. However, I would liaise with the nurses caring for the babies to ensure I was up to date with their clinical conditions, and I would prioritise visiting the babies who were poorly. I would also communicate with the doctors to ensure we were all aware of the management plan for each baby for the day following the medical morning ward round.

31. I cannot recall myself or anyone else present at the handover having any specific concerns about Child G's projectile vomiting and frequent collapses or later. I believe all the nurses would be concerned if a baby collapsed as we want our babies to improve and not deteriorate. Following a review of the medical records which I exhibit as **Exhibit CO/14 [INQ0000272],** I can see that Child G was stable and deteriorated overnight, appropriate interventions were taken to stabilise her and as such, this would not have caused me undue concern as this is the nature of neonatal nursing.

Child I

32. I worked the day shift on 22 October 2015 and was the designated nurse for Child I. There were no adverse events during my shift. I find it very difficult to speculate about Child I's collapses and death on 23 October 2015. I was shocked that she had died overnight; however, at the same time, it was not completely unexpected as I was aware she had been born at 27 weeks gestation and her neonatal journey over her 10 weeks of life had been complicated. I believed that a postmortem would identify a cause of death.

33. I have no memory of the handover from the night to day shift on the morning of 23 October 2015 or who was present. I would think that Child I's death would have been discussed briefly within the time constraints of the handover provided by the Shift Leader.

34. I have reviewed Child I's medical records, which I exhibit as **Exhibit CO/15 [INQ0000429].** Following the death of a baby, those involved in providing care would be invited to attend a debrief. Debriefs were not and are still not compulsory.

35. I have no memory of any informal discussion or any other type of meeting about Child I's death.

Child O and Child P

36. In my statement **[INQ0001401]** I stated that I was "*feeling godbsmacked*" in relation to Child O and Child P's deaths. I remember talking about Child O and Child P's death at work; however I cannot recall who I spoke to or what was said.

37. I do not remember whether there was a debrief, informal discussion or any other type of meeting at which Child O and Child P's deaths were discussed. In any event, as I was not present for their deaths, I would not have been invited to the debrief.

38. I did not notice any change in the way the nurses and doctors on the Neonatal Unit interacted with each other following Child O and Child P's death.

39. I did not think there might be a link between the unexpected collapses and deaths of the babies I cared for. I was aware that for a lot of the deaths Lucy had been present or caring for the babies, but I did not link her with the unexpected collapses or deaths.

Storage of drugs on the unit

40. Insulin was stored in a locked fridge in the equipment room on the Neonatal Unit. To the best of my knowledge, there were two bunches of keys which contained keys to various cupboards including the locked fridge which contained insulin. Any qualified member of staff could hold the keys. Other staff could request the keys if they needed to access one of the cupboards.

41. There was a controlled drug cupboard in Nursey 1 and there was a record book relating to how controlled drugs were kept. When a controlled drug was prescribed, two trained nurses would sign for this in the record book. When the door was open for controlled drugs, there was a red light, but I cannot recall where the red light was. There were security doors on the Neonatal Unit, and you could only gain access either by using your fob or visitors would use the intercom system and then would be given access by a member of staff once verified.

Concerns or suspicions

42. To the best of my knowledge I was not given any training on how to report concerns about fellow members of staff. As a senior member of the nursing team and depending on the nature of my concerns, I would either speak to the member of staff or escalate the issue to my manager.

43. I thought that Lucy was hard working and efficient and I did not have any concerns or suspicion about her or her conduct.

44. I was not aware of any suspicions or concerns of others about the conduct of Lucy.

45. Following the death of a baby, there was a debrief in which those who cared for the baby at their time of death would be invited to attend. Naturally, there would be discussion between nurses after the death of a baby as it is a very sad event and it helped us to process what had happened.

46. I was aware that 2015 to 2016 was a very busy year and we had more vulnerable babies coming in from the Labour Ward. I was aware of more deaths but due to the increase in the number of vulnerable babies we were caring for, I did not think it was an unnatural result that there were more deaths.

Reflections

47. I do not feel qualified to have an opinion on whether CCTV monitoring would have prevented the crimes of Lucy. I have no knowledge of CCTV and its efficacy in crime in general. I do not know how it would work in practice in healthcare.

48. I do not have any recommendations for the Inquiry on how to ensure babies are kept safe on Neonatal Units from any criminal actions of staff.

Request for documents

49. I do not have any documents or information which are potentially relevant to the Inquiry's Terms of Reference.

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: 30/4/24