Witness Name: Joanne Williams
Statement No.: 1
Exhibits: 0
Dated: 23 July 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JOANNE WILLIAMS

I, Joanne Williams, will say as follows: -

1. My full name is Joanne Williams.

2. I provide this statement in response to a request dated 4 July 2024 under Rule 9 of the Inquiry Rules 2006 ("the Rule 9 Request"). This statement is based on my personal recollection of events and a review of various documents, as referenced in this statement.

3. To assist the Inquiry to the best of my ability, I have addressed each question set out in the Rule 9 Request insofar as I am able to do so at this stage of the process.

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

4. I qualified as a registered children's nurse in 2006, having studied at Chester University. Whist studying, I undertook a variety of work-based placements with various specialisms within the area of my qualification.

5. Prior to starting work on the Neonatal Unit (NNU), I had worked as a Health Care Assistant in the hospital working on a variety of wards based on where staffing was needed or required.

6. Since qualifying in 2006 and whilst working on the NNU, I have completed a Northwest Induction Course for Neonatal Care, with placements at Liverpool Women's Hospital. I went on to complete the Neonatal High Dependency and Intensive Care Course in 2008 at Manchester University.

7. Between 2011 and 2015, I studied with Chester University to advance my Diploma in Higher Education Children's Nursing to a degree in Batchelor of Science. I was awarded a 2:1 in 2015. I also completed the Enhanced Neonatal Practitioner Course in 2015.

8. I became a Band 6 Neonatal Nurse in 2010.

9. In 2019, I took the position of Practice Development Nurse, Band 7.

10. In December 2021, I left the hospital in my role as Senior Neonatal Practitioner and Practice Development Nurse and joined the North West Neonatal Operational Delivery Network as a Care Coordinator.

11. In January 2023, I returned to the Countess of Chester Hospital as a Senior Neonatal Practitioner, Band 6.

12. Between 2015-2016, I was a Band 6 Neonatal Nurse. I had the responsibility of coordinating the shift if I was in charge or caring for the most vulnerable babies while supporting junior members of the team.

13. If I was allocated to be in charge, I had the responsibility of co-ordinating the following:

    a. Day to day running of the shift;

    b. Admissions and discharges;

    c. Allocation of staff; and

    d. Communication between medical staff and maternity services.

14. During that time, due to the acuity on the unit, the shift leader would also have a designated workload. My role involved the ability to prioritise, demonstrate good time management skills in a stressful environment and have the skills to remain calm and supportive to staff and families on the unit.

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

15. I have been asked to describe the quality of the management, supervision and/or support of nurses on the NNU between June 2015 and June 2016. I always felt supported within the nursing team. I was encouraged to further my qualifications and training and I had opportunities to develop and progress. The Deputy Manager and Practice Development Nurse were always visible on the unit and approachable.

16. I have been asked to 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. The relationships were professional across the different professions. The nursing team worked closely with the Registrars and Senior House Officers, who were present on the unit most of the time when acuity was high. The team strived to delivery high quality care.

17. I believe at times there was a reluctance from the medical team to call in Consultants.

18. Communication with maternity services could be challenging at times and I felt maternity staff did not always understand how busy NNU could be and offered very little support.

19. I was unaware at the time of support from senior management for the Trust, but at ward level management they were professional and consistently advocated for neonatal care.

Child A and Child B

20. I was the designated nurse for Child B for the day shift on 9th June 2015. Child B's twin, Child A, had died during the night shift on 8th June 2015 **[INQ0000727, p. 1].**

21. Letby was convicted of the murder of Child A and the attempted murder of Child B.

22. I have considered the following documents when making my statement in relation to Child A and Child B:

    a. Relevant medical records for Child B **[INQ0000698, p.22-31; p. 101-110];** and

    b. My witness statement to the police in relation to Child A and Child B dated 3rd October 2018 **[INQ0000727].**

23. In my statement to the police, I explain that at the start of each shift the incoming staff are briefed by the previous shift leader about events that occurred during that shift. I state: "*We discuss significant events, an overview of the babies on the unit, safety briefs, discharges, and anything else which is considered important*" **[INQ0000727, p. 1].**

24. In relation to Child A:

    a. There would have been a discussion in handover to make sure the team were aware of the passing of Child A to ensure sensitivity for the family and any staff

that had been present. Any death is extremely difficult. I cannot recall anything in detail about the handover. I cannot recall whether there was any discussion about whether this was sudden and unexpected.

b. I do not recall if there was a debrief, follow up or informal discussion involving nursing staff within the NNU team or between medical staff after Child A's death.

c. As I cannot recall if there was a debrief, I am unable to comment on whether it took place and who was present. A debrief should have been facilitated after any death, however those involved may not have been able to attend due to shifts or personal commitments.

25. In relation to Child B:

a. In my statement to the police, I discuss the care I provided to Child B during the day shift on 9th June 2015 **[INQ0000727].**

b. From reviewing the nursing notes I made on the 9th June 2015, Child B had been stable. I had given her a period of time off nasal CPAP where she had skin to skin with her mum. I was conscious after the events of Child A to maintain good observational skills with Child B.

c. The following day (10th June 2015) I noticed that Child B had been re-ventilated which came *"as a bit of a shock as she was doing so well"* but also that "*nothing really surprises me with neonatal babies anymore, as they can deteriorate quickly*" **[INQ0000727].** I have been asked to explain why it was "a bit of a shock". Babies can be unpredictable and can have sudden deteriorations. I felt shocked at the time as Child B had been stable during the day and I felt upset for the family.

d. I do not recall whether there was any discussion about any similarities between the discolouration seen on Child A (before his death) and Child B.

Child C

26. I was Child C's designated nurse during the day shift on 13th June 2015. Child C died on 14th June 2015, six days after the death of Child A and four days after the collapse of Child B.

27. I have considered the following documents when making my statement in relation to Child C:

    a. Relevant medical records for Child C **[INQ0000108, p. 20-24; p. 44-49];**

    b. My witness statement to the police in relation to Child C dated 26th February 2018 **[INQ0000134];** and

    c. My evidence at Letby's criminal trial in respect of Child C on 28th October 2022. A transcript of my evidence is at **[INQ0010271, p. 2-13].**

28. Letby was convicted of the murder of Child C.

29. In relation Child C:

    a. In my statement to the police, I discuss the care I provided to Child C during the day shift on 13th June 2015 **[INQ0000134].**

    b. Child C was a very vulnerable baby who was small for his gestation. It had been a difficult antenatal period for the family. On the day shift of 13th June 2015, Child C was unsettled and fractious at times, which could have been caused by nasal CPAP.

    c. I have written in my nursing notes that I had discussed with the Registrar to give Child C a period off NCPAP to have skin to skin with parents. Child C was very settled while enjoying skin to skin, which can be extremely beneficial for baby and their parents.

    d. Together with the medical team we decided to try Child C on a less invasive type of respiratory support, Optiflow (high flow), which Child C seemed more comfortable with. Baby C's blood gases were stable with a slight rise in PC02.

    e. I remember the shift being calm and spending much time in Nursery 1 with Child C and their parents.

    f. Child C was an intensive care baby who required one to one nursing and posed a high risk to a number of medical conditions. I had escalated any concerns I had to the medical team and felt Child C was stable at that time during the shift.

g. Babies of Child C's gestation and size are extremely vulnerable, and their Neonatal period can be unpredictable.

h. I was informed by telephone on 14th June 2015 that Child C had died during the night. Any death of a baby generally comes as a shock to me. I did find it unexpected that Child C deteriorated quickly, but this is not always unusual given the baby's gestation and risk factors – e.g. size, reversed end diastolic flow and infection risk.

i. I believe I would have talked to my nursing and medical colleagues about Child C's death, but I cannot recall details of with whom, or what was said.

j. To the best of my recollection, I believe there was a debrief involving nursing staff within the NNU team to discuss Child C's unexpected death, however I do not remember being in attendance.

k. As I do not believe I was part of any debrief for Child C I am unable to comment further on when it took place, who was present or what was discussed. It would be best practice for a debrief to take place following any death or traumatic event.

Child K

30. I was the designated nurse for Child K for the night shift on 16th to 17th February 2016.

31. I have considered the following documents when making my statement in relation to Child K:

a. Relevant medical records for Child K **[INQ0002287, p. 12-16; p. 18-22];**

b. My witness statements to the police in relation to Child K dated 10th April 2018 **[INQ0002325]** and 3rd October 2018 **[INQ0002324];** and

c. My evidence at Letby's first criminal trial in respect of Child K on 27th February 2003 and on 28th February 2023. Transcripts of my evidence are at **[INQ0010308, p. 39-44]** and **[INQ0010309, p.2-17].**

32. On 2nd July 2024, Letby was convicted of the attempted murder of Child K on 17th February 2016.

33. In relation to Child K:

    a. My recollection of Child K is based on my statement's given to the police in 2018. I explain that I had been present at the birth of Child K and then transferred Child K to the NNU. I was her designated nurse that night shift.

    b. The team stabilised Child K and I followed the process of ensuring Child K was cared for by administering medications she required, supporting thermoregulation, carrying out observations and preparing for transfer to a level three hospital for ongoing intensive care.

    c. I wrote in my statement and nursing notes that at approximately 03:30 hours I left the NNU to update the parents on Child K's condition. When I returned to the unit I saw and heard activity around Child K's incubator, and I was told Child K was suffering from apnoea and colour loss. Letby was present at the incubator. I cannot recall if other members of staff were present at that time.

    d. I remember being concerned about the collapses due to the fact we wanted to ensure Child K was optimally being ventilated and stable, ready for transfer. I wrote in my police statement that I had witnessed sudden drops in heart rate and apnoea which required neo-puffing and re-intubation. At the time I did not know what the cause was. I did not think anyone had intentionally displaced the baby's endotracheal tube.

    e. As detailed in my police statement and discussed in court, Dr Ravi Jayaram approached me on the night of 17th February 2016 in the equipment room and asked me '*what's happened, how has this happened*?'. I replied that I did not know as I was with the parents prior to the first collapse. At the time I was focused on providing the best care for Child K and there was a number of tasks/clinical duties that needed to be done prior to transfer.

    f. I do not recall whether any enquiries were made at the time regarding the displacement of Child K's endotracheal tube.

g. I do not recall if I attended any discussions or debriefs (formal or otherwise) in the case of Child K. If there was one held, I am sure I would have wanted to have been involved. It is very difficult to remember details of over eight years ago.

CQC visit to the hospital on 16th-19th February 2016

34. The CQC visited the hospital between 16th and 19th February 2016. Child K collapsed on the night of 17th February 2016:

a. I do not recall having any involvement with the CQC visit to the hospital on 16th-19th February 2016.

b. I have no recollection of speaking to the CQC team.

c. At the time I did not personally raise any concerns of increased mortality on NNU with the CQC as I was not involved with their visit to the hospital. I am unaware at the time if any other colleagues raised concerns.

d. At the time I am aware our immediate manager, Erian Powell, had advocated internally for increased staffing levels and escalated when we were in breach of staffing levels. I cannot recall if Erian raised staffing factors as being a link to the increased mortality.

Concerns or suspicions

35. I was aware and concerned about the increase in the number of deaths on the NNU. I cannot recall specifically when I became aware of the increase or what I thought. At the time the acuity on the unit was always high and we were caring for vulnerable patients. It was very difficult for the team dealing with numerous deaths, feeling overworked and at times under appreciated.

36. I personally did not have any concerns or suspicions that Letby was deliberately causing harm while I worked on the NNU, otherwise, I would have raised them.

37. It is difficult to remember whether any training was delivered in 2015/2016 on how to report concerns about fellow members of staff, but within my professional role I understand it is

my duty to raise any concerns. If I had any concerns, I felt I could escalate to the management team, and they would be listened to.

38. Following the collapse of Child K, on 17th February 2016, Dr Ravi Jayaram had asked me along the lines of '*how has this happened*'. After this, I thought he may have had concerns about Letby, however I did not personally have any concerns. Letby attended a number of collapses and deaths, she also worked full time and worked a number of extra shifts to cover staff shortness or sickness. It wasn't until the police became involved that I knew the extent to what was being suggested. For me it has been very difficult to comprehend anyone would cause intentional harm.

39. We have always been a very supportive team and one that I have felt privileged to be part of for several years since qualifying. We often had informal debriefs which offered a safe place to discuss traumatic events or deaths. We would always ensure those who had been involved felt supported. Formal debriefs were often arranged as soon as they could be facilitated, usually lead by the Consultants, but due to shifts or personal commitments, they wouldn't always include everyone who may have been involved.

Reflections

40. I have been asked whether I think there are any steps that could have been taken to identify earlier that Letby was harming babies on the NNU. I do not feel able to answer this question as I was unaware at the time.

41. I am unable to say whether CCTV could have prevented Letby's crimes. However, I do not think it would be appropriate for babies in any NNUs to be monitored by CCTV. The privacy for families is extremely important for them to develop close loving relationships with their babies.

42. I have been asked to comment on any recommendations I think this Inquiry should make to keep babies in NNUs safe from any criminal actions of staff. I feel it's very difficult to make recommendations, as if these are the actions of one person, it is very difficult to say what would make NNUs safer.

43. I do appreciate staffing is a main priority for all those in the NHS, having safe staffing levels to deliver high quality care is paramount.

44. General district hospitals with NNUs should ensure they understand the challenges/difficulties in working in such a specialist area and provide appropriate support.

45. Parents and primary carers should be able to be with their babies 24 hours if they wish to be, with NNUs designed to facilitate this.

46. I believe currently on the NNU we have an excellent culture to speak out and are encouraged to raise concerns and question practice. As a unit we have made great changes to improve, including being BPAM compliant (staffing ratios).

Request for documents

47. I do not have any documents or other 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: 23.07.2024 | 13:04:49 BST