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Witness Name: JANE EVANS

Statement Number: 1

Exhibits: JE01

Dated: 08 August 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF JANE MARGARET EVANS

I JANE MARGARET EVANS, will say as follows:

1. I am Jane Margaret Evans.

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

2. I first registered as a registered general nurse in 1990. I achieved my Diploma of Nursing from Birbeck College London in 1992 and my Degree in Nursing Professional Practice from Middlesex University in 1993.

3. I have worked in urgent and emergency care for most of my nursing career, mainly in North London, prior to moving back to North Wales. I was successfully appointed as a Clinical Manager in an Emergency Department in 2002.

4. I was appointed as Head of Nursing for the Urgent Care Division at the hospital in 2013. This was a Band 8c post. My duties were to professionally lead the nursing teams within:

    a. Medical wards.

    b. Emergency department.

    c. Paediatric ward NNU.

    d. Ellesmere Port hospital.

    e. Clinical co-ordinator team.

    f. Specialist nurses within Urgent Care.

    g. The medical outpatient department.

5. I remained Head of Nursing for the Urgent Care Division until 30th September 2015, when I retired.

6. On 14 April 2015 I wrote to Alison Kelly, Director of Nursing and Quality, to advise of my intention to flexibly retire as Head of Nursing for the Urgent Care Division effective from 30

September 2015 **(See Exhibit JE01).** I also advised of my intention to take two periods of annual leave from 03 August 2015 to 16 August 2015 (inclusive) and 07 September 2015 to 18 September 2015 (inclusive). I recall I was away from the Trust for about 6 weeks.

7. To enable me to receive flexible retirement, I accepted a post at Band 7 which commenced in November 2015. This post was to investigate complaints from across the hospital when allocated to me by Senior Managers.

8. I recall retiring from my post on 30 September 2015 and Karen Rees was successful in being appointed to Head of Nursing for the Urgent Care Division. Karen took up her post in August 2015 and a period of handover commenced. During this period of handover, I was finalising my work, and any decisions would been made by Karen rather than myself.

9. As I recall, risk assessments would be undertaken by the Risk team in conjunction with Unit/Ward managers. From memory, I recall risk training would cover how to assess and score that risk specifically, and how to put measures in place to reduce the risk.

10. To the best of my recollection, training specifically in relation to the safety of babies would be an additional part of mandatory training for all staff who had direct contact with children. Specific risk assessments for individual patients did not form part of my role as I recall, and therefore would not fall under my training.

11. As part of my role as Head of Nursing, I recall safeguarding training being part of mandatory training undertaken on a yearly basis. I am unable to recall any specifics in relation to that training.

Deaths on the neonatal unit (the "NNU")

12. I was aware of two of the babies who died in June 2015, but I cannot recall being advised of three deaths. I am unable to recall which two out of the three babies I was aware of (Baby A, Baby C or Baby D).

13. I am unable to recall who would have told me about the baby deaths but if a concern about risk was raised, the risk team would have notified me. However, this would not necessarily be immediately following a baby death.

14. My recollection is that I spoke to Eirian Powell, the Unit Manager, to ensure parents and staff were being supported. I recall the Unit Manager being aware that the babies were poorly, and sadly it was expected in some cases.

15. I cannot recall if I was made aware of the death of Baby E and Baby I in August 2015 and October 2015. I note I was on annual leave from 03 August 2015 to 16 August 2015 (inclusive) and I was not working at the Trust in October 2015.

16. The Inquiry have highlighted to me that Lorraine Burnett (Divisional Director of the Urgent Care Division at the hospital in 2015) says that I informed her of three deaths on the neonatal unit in late June 2015. She states that:

    "I was informed of each death separately and my recollection is that this was the day after each event. These were verbal updates as Jane and I were in the habit of meeting at 8am to review the previous day and plan for the day ahead. I discussed this with Jane to ensure that there were no issues I needed to be made aware of. I recall asking how the families and staff were coping and also whether there was anything we had not done correctly in each case. Jane assured me, each time, that there were no clinical concerns in relation to the deaths and that the family were in touch with the Trust's bereavement services and staff were being supported by the ward sister. Jane also assured me that the deaths were going through the internal governance process and that if anything of concern came out of those reviews it would be escalated to me as appropriate. To me this meant that there would be a review and report of each death by the clinical teams which would then be discussed at the corporate mortality review meeting if necessary. These meetings determined any actions, escalations or learning deemed necessary. I was therefore satisfied that no further action was required from me at that stage" **[INQ0102638, para. 25].**

17. Coordinators would have been responsible overnight for the overall hospital site and I would meet with them each morning for a handover, as I wanted to be briefed and have oversight on any issues which had arose.

18. My recollection is that I met with Lorraine Burnett daily on working days and would probably brief her of issues from the previous day and overnight. This was informal and as commitments allowed. I cannot recall the conversations, but I may have advised of these matters during that meeting.

19. I would not however have been able to reassure Lorraine the next morning whether there had been any clinical concerns. If I recall correctly, all deaths of children were reported via the Datix risk reporting system and then reviewed by senior clinicians. The coroner would also be informed. I vaguely recall there being a national reporting system for such events. I do not recall receiving any such reports of deaths on the NNU for June 2015.

20. I had a period of annual leave and was not in post for the period when several of the deaths occurred. When I returned into my part time role, I would not have been investigating these types of incidents.

21. I became aware of the deaths in the NNU in 2016 when I was asked to look at off duty rotas to identify who was on duty at various times. Alison Kelly and Sian Williams asked me to review the NNU off duty rota. I was told this was in connection with deaths on the unit.

22. I was unaware that any deaths were linked when I was employed as Head of Nursing.

23. I was a member of the Women and Children's Care Governance Board, and of the Quality, Safety and Patient Experience Committee until September 2015. I am noted as attending the Quality, Safety and Patient Experience Committee on Monday 15 June 2015 **[INQ0015008]** and Monday 20 July 2015 **[INQ0003211]**. In both groups, I attended in my capacity as Head of Nursing. I would not send a representative if unable to attend as the relevant Risk Lead would have provided the necessary information to the Committee.

24. I have been asked whether concerns about any increased mortality rate on the NNU at the hospital was ever discussed at any of those meetings. Due to the passage of time, I cannot recall what was specifically discussed, but I would have expected any concerns about the increased mortality rate to have been raised.

25. My membership on both groups ceased when Karen Rees took up her position as Head of Nursing on my retirement.

Concerns about Letby

26. I was not aware of concerns about Letby when I was working as Head of Nursing. When I returned to the Trust in my new role, I had no responsibility or involvement in staff or day to day operational management.

27. After the deaths of Babies O and P and the collapse of Baby Q at the end of June 2016, a decision was taken to redeploy Letby to the risk team. I would not have been involved in any decisions or consulted about the decision to redeploy Letby. This would not have been within the scope of my role as I was working in the complaints team. I was not involved in the decisions and unaware of the reasoning behind it.

Speak out Safely

28. I have been asked to detail my involvement with Speak Out Safely issues.

29. A Speak Out Safely Meeting took place on 18th April 2016 **[INQ0098686],** and one of the items discussed refers to me having been commissioned, in my new corporate role, to produce a report and action plan in relation to reports concerning a complex case and meetings with approximately 80 staff in different focus groups.

30. I recall being asked by Alison Kelly (Director of Nursing) and Sue Hodkinson (Director of HR) to pull together a report based on interviews they had conducted following a whistle blowing from some staff working in the Operating Theatre.

31. I produced and presented the report to Alison and Sue. They then asked me to produce an action plan from the report, this was also given to them.

32. I cannot recall the contents of the report or action plan.

The culture and atmosphere at the hospital in 2015-2016

33. I have been asked how I would 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 Countess of Chester hospital between June 2015 and June 2016.

34. In terms of the culture and atmosphere at the hospital, while in post as Head of Nursing, I do not recall that there were any problems or issues between clinicians and management.

35. I do not recall there being any significant concerns across teams.

36. As I do not recall any problem or issues regarding the quality of relationships on the NNU, I am unable to comment on whether relationships affected the quality of the care being given to the babies on the NNU.

37. If I correctly recall, all deaths of children should have been reported using the Datix reporting system as this was intrinsic to the risk/governance process and reviewed by the relevant senior clinicians. I believe they should also have been reported to the coroner. Mortality and Morbidity reviews were undertaken by senior clinicians of all deaths within the Trust any concerns should have been escalated to Directors as part of the Governance process and reports presented as I recall.

38. I do not feel the structures and processes for the management and governance of the hospital (as opposed to the people working within them) contributed to a failure to protect the babies on the neonatal unit from the actions of Letby in any way. From my recollection, I feel the structures and processes were robust, but I cannot comment on whether these were utilised effectively.

Reflections

39. My sympathy is with the families who have been deeply impacted. My support is provided to Baroness Thirlwall and her Inquiry to ensure that systems and process are interrogated, and improvements made as considered necessary following the recommendations of the Inquiry.

40. I am not well informed on the details of Letby's convictions, so I am unable to provide any personal reflections.

41. I have been asked if I feel CCTV on the babies would have prevented this crime. I do not feel able to answer this fully but would comment that this would require monitoring 24/7, and the CCTV controller knowing the difference between planned care and criminal activity. It may however, act as a deterrent and could be rapidly reviewed.

42. I do not feel able to provide any recommendations that I think this Inquiry should make to keep babies in neonatal units safe from any criminal actions of staff. However, I would support any recommendations which the Inquiry are able to make to prevent such a tragic event occurring again.

Any other matters

43. I have no other evidence which I can give from my knowledge and experience which is of relevance to the work of the Thirlwall Inquiry.

44. I have not given any interviews or otherwise made any public comments about the actions of Letby or the matters under investigation by the Inquiry.

Request for documents

45. 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.....

08.08.2024 | 11:54:10 BST

Dated: .....