Witness Name:
Nurse Y
Statement No: 1
Exhibits: NY01
Dated: 09 August 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Nurse Y

I, Nurse Y will say as follows: -

1. My full name is Nurse Y

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 General Nurse Part 1 (UKCC) Irrelevant & Sensitive

Irrelevant & Sensitive

5. Irrelevant & Sensitive

6. Irrelevant & Sensitive

7. Irrelevant & Sensitive

8. The qualifications I have gained since becoming a Registered Nurse to support my role are:

   a. "Ethics and Ethical Standards" N60 in I&S

   b. "Teaching and Assessing in Clinical Practice" ENB 998 course in I&S which allowed me to become a mentor.

   c. "Management of Care" NM 2508 course in I&S.

   d. "Foundations in Leadership and Management" NM 6009 course in I&S I&S

   e. "Infection Prevention and Control" NM 6153 in I&S

   f. R23 "Enhanced Neonatal Nursing Practice" FHEQ (L3) in I&S

   g. "Advanced Resuscitation of the Newborn Infant" course set by the Resuscitation Council UK in I&S

   h. I am an NLS provider (Newborn Life Support, Resuscitation Council UK) and complete training every 4 years to maintain and update my skills.

9. I I&S employed on the NNU at the hospital I&S I was a Senior Neonatal Practitioner in 2015 I&S

10. As a Band 6 Neonatal Practitioner during 2015-2016, my duties and responsibilities were extensive. The unit was Level 2 at this point. When allocated patients, I care for

infants requiring all levels of support, ranging from those in special care, to the sickest infants requiring intensive care. Some of my responsibilities are as follows –

a. I care for infants requiring respiratory support – those intubated and ventilated, requiring CPAP or Hi Flow, or those dependent on low flow oxygen via nasal cannula.

b. I care for infants undergoing cooling, CFAM monitoring (cerebral function analysing monitor) or have chest drains in place due to pneumothorax.

c. Infants may have a peripheral cannula, longline or UVC/UAC (umbilical venous catheter/umbilical arterial catheter) for fluid infusion, depending on their condition. I administer medications via oral or nasogastric tube route, intravenous stat doses or infusion via peripheral line, longline or UVC, depending on the infants' available access.

d. I stabilise sick infants who require transfer out to a Level 3 Unit or a surgical unit for ongoing specialist care.

e. I administer blood transfusions (if prescribed) for infants in my care, following policy to ensure the infant's safety during the procedure.

f. I assist in infection screens and lumbar punctures with doctors when indicated, supporting the infants' wellbeing during the procedure. I also assist doctors while they carry out other procedures such as central line insertion or insertion of chest drains.

g. I can cannulate infants if they require intravenous access and can complete an infection screen by obtaining bloods as instructed by a doctor.

h. As I hold the R23 qualification, I can also obtain blood samples via UAC or radial arterial line for analysis. I am also able to remove longlines or UVC/UAC's with this enhanced role.

i. I support mothers in their breastfeeding or bottle-feeding journey, helping them in all aspects to aid a positive outcome, encouraging and helping them gain confidence.

11. It is important to support families during their infant's stay on the NNU, particularly during the difficult time following admission to the unit when parents and the infant may initially be separated. Communication with midwives and parents is of high importance so that we can promote their understanding and relieve their anxiety. Communication with parents must be maintained throughout their stay whilst also caring for the sick infant.

12. Throughout the stay on NNU, it is our job to prepare parents for their infant's discharge. This involves completing preparations and supporting them to enable them to care for their infant independently. It is invaluable to give parents time and involve them in the planning and implementation of care to their infant to assist bonding and promote developmental care.

13. In my role as a registered nurse, it is my responsibility to remain up to date on all mandatory training, either online or in person. I must maintain my own personal development by completing annual appraisals, documenting my achievements and completing reflections for Revalidation as per NMC requirements. It is necessary to remain updated on new policies to ensure safe and best practice is given and to attend relevant study days to remain updated on current research.

14. Completing mentorship requirements and triennial review enabled me to teach and assess students when allocated to me. Within my role, I use my experience and specialist knowledge in teaching and supporting junior staff members, new doctors and students to enhance their experience, as well as orientating new staff.

15. Accurate and up to date patient records must be completed, unit policies must be adhered to, and any child or adult safeguarding concerns encountered must be highlighted to the Safeguarding team.

16. As shift leader I assist in the management and organisation of the clinical area on a day-to-day basis, ensuring appropriate care is delivered to patients. Some of my responsibilities as shift leader are as follows –

    a. I work collaboratively with other professionals to maintain effective communication to deliver the highest standards of care, involving other health care professionals such as social workers, pharmacists, physiotherapists, dieticians, speech and

language therapists and community midwives, to provide a multidisciplinary approach to ongoing care needs and discharge arrangements.

b. It is my duty as shift leader to make appropriate decisions regarding allocation of patients according to acuity and staff skills. I manage change effectively if re-allocation is required due to further admissions or patient deterioration. The unit must meet BAPM guidance of patient/staff ratio. We endeavour to source extra staff when acuity/numbers increase or to cover sickness as necessary via telephone calls, in the absence of management, whilst also running the busy unit.

c. I liaise with the cot bureau to update them on cot occupancy and levels of care twice daily via telephone. I also deal with enquiries throughout the day either by phone or in person.

d. I liaise with the shift leader on the central labour ward to gain updates on antenatal patients or potential admissions.

e. I am responsible for reviewing BAPM compliance and escalating concerns, or the need to close the unit if appropriate, to higher management or the bed co-ordinator when out of office hours.

f. I deliver effective time management of staff and resources, co-ordinating to ensure staff have breaks and attending ward rounds so that I am updated on any changes made to patient care daily.

g. BadgerNet is to be updated daily for each patient by staff and it is the role of shift leader to enforce this.

h. There are daily jobs and checks to be completed and it is the duty of the shift leader to delegate tasks not yet completed to ensure compliance.

i. It is my responsibility to deal with any concerns or conflict if raised by parents, to demonstrate an understanding or providing explanation, directing them for further support if required. Concerns would be directed to the unit manager or matron if available.

j. Completing Datix reports following incidents or reporting faulty equipment for evaluation or risk management, whilst also recognising and responding appropriately to urgent or emergency situations, assessing and responding with appropriate clinical judgement.

k. Communicating clearly with colleagues throughout the shift, gaining updates and liaising with Transitional Care (TC) staff regarding infants being cared for next to their mother on TC, located on postnatal ward. It was not always possible to leave the unit to visit TC personally when the unit was busy.

l. As shift leader, it is my responsibility to ensure all medications have been administered as prescribed to the infants on both NNU and TC. This would include any infants from the postnatal ward who may require antibiotics after having undergone an infection screen (these babies were transported down to the NNU by midwives or their parents for antibiotics to be administered by neonatal practitioners). The shift leader contacts the pharmacist with any queries regarding medications to be sourced or stores when extra supplies are required.

m. In 2015-2016, there was no bleep held by the neonatal practitioners in case of emergency on the labour ward or postnatal ward. Midwives would run down the corridor and open the door to the unit to shout for help with a newborn when needed and a Band 5 or 6 neonatal practitioner would run through to assist. There was no prior allocation of who would attend.

Mentorship of Lucy Letby ("Letby")

17. In this part of my statement, I refer to the period 2010 - 2011.

18. I was allocated as a mentor to Letby during her 2010 student nurse placement. This placement was between 31 May 2010 – 5 July 2010, based on the NNU. The Practice Development Practitioner at the time made the allocation.

19. I also worked some shifts between 27 October 2011 and 16 November 2011 with Letby, during her 2011 placement. I am unsure if I was a mentor during that time and am unable to clarify this as all previous off duty and personal files were removed by the police during the investigation.

20. I was able to mentor students, having completed the ENB 998 course and meeting the NMC's (Nursing & Midwifery Council) standards by attending annual mentorship workshops to update myself on current practices and changes within the students training or documentation. Mentoring at least two students over a three-year period enabled me to adhere to the mentorship requirements. These requirements were assessed during triennial review which ensured I maintained my own professional development and met the values and standards set by The NMC's Code.

21. As a mentor, my key responsibilities were to support Letby during her allocation, by helping her reach her potential in gaining as much knowledge and experience in the speciality as possible, whilst meeting her learning objectives set by the university. I supported her by involving her in daily tasks and caring for allocated patients, explaining their conditions and discussing their current care.

22. Some of my responsibilities as a mentor are as follows -

    a. I teach students activities and support them as they learn the required skills and gain experience and confidence.

    b. I organise learning opportunities for them within the clinical area encouraging them to observe or assist, if possible, to enhance learning.

    c. Whilst attending planned or emergency deliveries resulting in neonatal input or admission the student would accompany me to observe. I would explain what care is being delivered during the interventions. I reflect on such incidents afterwards to help the students' understanding.

    d. As a mentor, it is important that students understand what medications infants require, as well as how to draw up and administer them safely.

    e. I observe a student's practice throughout the shift and offer advice and support when required. I encourage them to ask questions to assist in their understanding and provide teaching about conditions we encounter to enhance their development, whilst guiding them to any beneficial resources.

f. I complete the student's paperwork during their initial, midway and final assessments. This gives them the opportunity to complete any outstanding objectives.

g. I ensure I increase a student's responsibilities as their placement progresses and competence allows, whilst always supervising them. As their training progresses, I encourage them to promote decision making, plan their patients' care, work more independently, encouraging communication skills with parents and other members of the multidisciplinary team.

h. As a mentor, I may not always be on shift with my allocated student so I would discuss their performance with the colleagues they worked with in my absence to gain feedback.

i. It is my responsibility to assist students in their documentation of patient notes. This would involve ensuring they include all aspects of care, and depending on the stage of their training, help them develop skills to handover the care they have given to the next member of staff on duty.

j. I would provide feedback to the Practice Development Practitioner during the placement.

k. At the final assessment, I would discuss if the student felt they had met their personal outcomes set at the beginning, completed their objectives and help them to reflect on the placement.

23. As a mentee, it was Letby's responsibility to ensure –

a. She completed the number of hours on placement as set by the university.

b. Student documentation was in her possession, and it was Letby's responsibility to always bring this with her to be updated regularly or allow the mentor to view it when necessary.

c. The student must share any difficulties they encounter with the mentor or if they had not met any learning objectives on previous placements.

d. It was Letby's responsibility to be punctual, professional and adhere to the dress code.

e. As a mentee, Letby was to seek opportunities to learn and inform us if there were any particular procedures she wished to participate in to enhance her learning or meet outstanding objectives.

f. She was to ensure assessments were completed timely and paperwork signed, to gain as much experience as possible in this specialised area and participate with the multidisciplinary team to achieve this.

24. I monitored and assessed Letby's performance throughout each shift on which we worked together. Monitoring and assessment was undertaken in a manner as described above.

25. Any comments regarding Letby's performance would have been documented in her student workbook. I do not recall what I wrote. Workbooks were handwritten at this time and remained in the students' possession. I am therefore unable to review this.

26. I do not recall having any concerns about Letby during my time as her allocated mentor. I did not need to seek any guidance from the Practice Development Practitioner or Practice Education Facilitators during her neonatal placement, nor did I have any suspicions about her in my role as mentor.

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

27. I have been asked how I would describe the quality of the management, supervision and/or support of nurses on the NNU between June 2015 and June 2016.

28. During the period between June 2015 and June 2016, the unit had a full-time unit manager and full-time deputy manager. The manager was office based, working weekdays. The deputy manager would also work clinical shifts and provide support on the unit, helping if necessary.

29. Matron for the Women and Children's department was based on the paediatric ward and would attend the NNU each morning to meet with the manager. They were always contactable and supportive in the absence of management on the NNU.

30. The NNU was often busy. The intensive care and high dependency care cots were occupied on a regular basis, with the total number of patients on the unit meeting capacity or sometimes exceeding it during that particular year (which would then breach BAPM guidance due to lack of appropriate numbers of staff).

31. If management was present, they would endeavour to accrue extra bank staff to assist. They would also plan during busier times so that we had sufficient cover on the unit with either bank staff, or additional cover with permanent staff agreeing to do overtime shifts where possible.

32. When there was no management on shift in the evenings or at weekends, this task would fall to the shift leader who would be running the unit, whilst also managing a patient workload. The next port of call to escalate any concerns when management was absent would be to the hospital co-ordinators who covered the whole of the hospital. There was always a neonatal consultant on call with whom the shift leader could discuss acuity/capacity. They would make decisions together regarding unit closure if necessary. This would then be escalated to the hospital site co-ordinator.

33. At a unit meeting held on 26th July 2016, according to minutes which I have in my personal profile, staffing and recruitment were mentioned by the unit manager **(See Exhibit NY01).** We were informed of the unit being downgraded to a Level 1 and an external review was to be undertaken following the increase in baby deaths. The five Band 5 posts that were due to go to advert had been deferred as it was deemed our staffing complement was appropriate for a Level 1 NNU. At this point staff were tired as the unit had been so busy and moral was running low.

34. As far as I recollect, this was the first time that the Band 6 staff and grades below were made aware of the pending review and downgrade. It had been kept confidential between management, consultants and the executive team. This information concerned the team and affected morale. We did not know what to expect following the review. I was not aware at my level of banding what was being discussed.

35. I do not recall senior management attending the unit very often. I only recall the executive team visiting the unit for specific reasons such as Christmas or when a particular important visitor attended. Once the review had taken place and during the time the investigation commenced, higher management and members of the executive team would attend the unit more regularly.

36. 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 hospital between June 2015 and June 2016.

37. I am not aware of the relationships between clinicians and managers during this time. Any meetings or discussions held were above my Band 6 grading. I was therefore not included.

38. I believe the relationship between the midwifery team and the neonatal nursing team was not particularly good during this time. There was often poor communication from midwives, and I felt some were often unwelcoming and not helpful.

39. The rapport between the maternity management and neonatal shift leaders was not particularly good either. I felt they were often not considerate of the unit's' acuity and the difficulties we faced with further admissions when the unit was already stretched.

40. During busy periods on the unit, when shift leaders had to liaise with the midwifery department regarding potential preterm deliveries, I recall one or two obstetricians being dismissive and obstructive of our concerns of the unit's acuity or if closed to admissions. They would be adamant they were going to deliver a lady when I felt it was necessary to transfer the women with their unborn in-utero, out to another unit with cot availability. I felt that was the safest option and in the best interests of the unborn infant.

41. On these occasions, it would be necessary to involve the on-call neonatal consultant to intervene and discuss options with the obstetricians.

42. The cot capacity of the unit at that time was 16 cots (3 ITU cots, 3 HDU cots and 10 SC). Although we often reached full capacity of 16 babies, admissions would not stop. If an admission presented it was necessary to accept the infant, which then resulted in

the unit being beyond our numbers and staff workload exceeded. I recall occasions when an infant would be transferred out to another unit with cot availability, but this was not done regularly enough, and we would struggle for incubator space in Nursery 1 to accommodate the infants. Infants admitted beyond the 16 cot spaces should have been transferred out and only repatriated once our NNU capacity allowed.

43. On exceptionally busy shifts staff would often leave the shift late as we would inevitably have to document patient notes after handing the infant over to the next shift, as we had been too busy during the shift to have opportunity to sit at the computer.

44. Appropriate antenatal management of transfer out in-utero, where possible, was not always maintained, which consequently put further pressure on NNU and on occasions we then struggled for equipment for admissions.

45. The registrars allocated to the unit were very experienced and appeared to have good a rapport with the nurses.

46. I have worked on the unit for a long time. From a personal point of view, I feel I have a good rapport with consultants. I cannot comment on the relationships of other medical professionals together.

47. Members of the obstetric, midwifery and neonatal team would meet if requested for a Level 1 review as part of the "Each Baby Counts" National Quality Improvement Programme. This was led by the Risk and Patient Safety Lead if the team were involved in a difficult term delivery or resuscitation, with potential consequences which may have resulted in stillbirth, risk of severe disability or early neonatal death.

Child D, Child H, Child I, Child K and Child Q

48. In this part of my statement, I detail my involvement or knowledge of the care of Child D, Child H, Child I, Child K and Child Q. I gave the following statements to the police:

    a. Statement dated 6th January 2023 in relation to Child F **[INQ0000913];**

    b. Statement dated 17th April 2019 in relation to Child I **[INQ0000532];**

    c. Statement dated 15th March 2018 in relation to Child H **[INQ0001015];**

d. Statement dated 23rd July 2018 in relation to Child K **[INQ0002332];**

e. Statement dated 26th March 2018 in relation to Child P **[INQ0001479];** and

f. Statement dated 5th June 2020 in relation to Child Q **[INQ0001559].**

49. In relation to Child D, Child H, Child I, Child K and Child Q:

a. Letby was found guilty of the murder of Child D on 22nd June 2015.

b. Letby was charged with two counts of attempted murder of Child H: one relating to 26th September 2015 at 03:22 hours (the jury returned a not guilty verdict) and one to an incident on 27th September 2015 at 00:55 hours (the jury could not reach a verdict).

c. Letby was alleged to have attacked Child I on 30th September 2015, 13th October 2015, 14th October 2015 and 23rd October 2015. Letby was found guilty of the murder of Child I on 23rd October 2015.

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

e. Letby was charged with the attempted murder of Child Q on 25th June 2016 in relation to which the jury were unable to agree a verdict.

50. I was not on duty when Child D, Child H, Child I, Child K and Child Q collapsed and/or died.

51. As I was not on shift and therefore not involved in any of the deaths or collapses, I would not have attended any debriefs or discussions following these events. I expect there would have been debriefs but I was not involved. The consultant attending the incident would generally set up a suitable time for the members of staff involved to meet for a debrief if they wished to be involved.

52. I did not have any discussions with others regarding the safety of the babies on the unit during the period of June 2015 – June 2016. I was aware of how busy the unit was

with sick infants at that time, but this was a regular occurrence for the unit. Towards the end of that period, the unit was understaffed. The five outstanding Band 5 posts were then deferred due to the downgrading of the unit to Level 1, as staffing was deemed appropriate for that level.

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

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

54. During the CQC visit to the hospital between 16th and 19th February 2016, I was on duty on day shifts on the 17th and 19th February.

55. I do not recall if I was interviewed by the inspectors on these dates, but I am aware the unit was very busy once again during that period.

56. I do not recall who was chosen to be interviewed by the CQC inspectors during their visit or if any of my colleague's raised concerns regarding the increased mortality on the unit. These conversations take place in private, and staff are spoken to individually, so I would not be aware of what was discussed.

Concerns or suspicions

57. I was aware of the number of deaths on the NNU. The sad loss of an infant would be mentioned informally by colleagues when I attended for my shift, or I would enquire about the infants whereabouts on my return to duty.

58. In 2015 - 2016 I had a link role. This link role has always solely been referred to as "statistics". I was to collect data and compile statistics for the unit, so I was aware of the number of deaths when I retrieved the information monthly, between January to December. The completed annual statistics were then forwarded to a senior consultant who would later present them at the Women and Children's department Rolling Half Day meeting. This data was also inputted by other units within the Network. The BadgerNet system also compiles unit reports for individual neonatal units. BadgerNet forms a single record of care for all babies within neonatal services. Information included in the statistics regarding admissions were:

a. infants' gestation at birth,
b. birthweight,
c. ITU, HDU, SC status,
d. respiratory support information,
e. cot occupancy,
f. oxygen dependency,
g. transfers out of the unit/transfers in from other units,
h. deaths,
i. number of multiple births admissions, and
j. any stages of ROP (retinopathy of prematurity) identified or treated on eye examination.

59. I had no concerns regarding Letby's conduct whilst I worked with her on the NNU.

60. As part of mandatory training, staff complete Information Governance training online annually. We also had some sessions in person, although I do not remember how regular the face-to-face training was. This teaches attendees how to deal with personal and sensitive information relating to patients and employees, highlighting how to deal with confidential information to ensure safe practice and adhering to correct procedures. As a senior member of staff, if I had concerns regarding another member of staff, I would report this to my line manager in confidence or raise my concerns via e-mail if they were not available at that time.

61. As a Registered Nurse, it would be my responsibility to escalate any concerns about patient safety to the unit manager, or matron in her absence. This is the ethically correct course of action and follows the standards set by the NMC Code of Conduct.

62. I was not aware of any concerns or suspicions regarding Letby's conduct at my band 6 level or below.

63. As a full time Band 5 neonatal practitioner, who also worked regular overtime shifts, with the relevant qualifications to care for intensive and high dependency care patients, Letby was regularly allocated the sicker infants on shift. Band 5 nurses do not take charge of the NNU. I remember her being taken off night shifts to work only day shifts at some point. I had presumed this was to protect her own wellbeing as she had been present for a number of deaths on the unit.

64. I have been asked what discussion or debrief there was (formal or otherwise) with or between nurses, or between nurses and doctors, after the death of a baby. I expect there would have been discussions between the team involved in the care of an infant following a death, but I do not recall these specifically at this stage.

Reflections

65. I do not believe CCTV is appropriate in an NNU environment. New mothers may be performing skin to skin contact with their infant, expressing milk or breast feeding. I think CCTV would be an invasion of their privacy and could make them feel uncomfortable. I do not feel it is dignified for parents to have someone observe them in a semi dressed position.

66. It is also inappropriate to have cameras observing infants during procedures or examination when their private areas may be visible. It concerns me who would have access to these images and if DBS checks would be required for those individuals.

67. As a practitioner, I would strongly object to CCTV monitoring as I feel it is an intrusion. It is not used in general nursing wards or in paediatric care so I feel it would be unnecessary and inappropriate.

68. I have been asked whether if the babies had been monitored by CCTV the crimes of Letby could have been prevented. I do not believe there has been physical evidence to prove criminality by Letby and although incubators were in close proximity to each other, it appears there were no crimes observed.

69. As a Band 6 practitioner I was not aware there were any concerns regarding Letby's practice until we were informed as a team about the external review. I do not have any recommendations that could have been taken to identify if Letby was harming infants.

70. I strongly believe all babies are safe in the NNU. I do not feel the infants are at risk from criminal actions, therefore I have no recommendations for the Inquiry.

Request for documents

71. 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 to the best of my knowledge and belief. 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 of its truth.

Signed: Personal Data

Dated: 09.08.2024 | 23:48:27 BST