Witness Name: Belinda Williamson
Statement No: 1
Exhibits: 0
Dated: 19 August 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF BELINDA WILLIAMSON

I, Belinda Williamson, will say as follows: -

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

1. I qualified in December 2000 as a registered nurse from Western Sydney University. I was first registered by the NMC-UK in 2004.

2. My nursing qualifications are as follows:

    a. Bachelor of Nursing, obtained in 2000.

    b. Graduate Certificate in Neonatal Intensive Care Nursing, obtained in February 2004.

    c. Learning and Assessment in Practice, obtained in 2012 / 2013.

    d. Examination and Assessment of the Newborn, obtained in 2015 / 2016.

3. Details of my previous and current employment are as follows:

    a. Registered nurse overseas in Australia, February 2001 - October 2004.

    b. Staff nurse (Band E) at Jessop Wing Sheffield Teaching Hospital, November 2004 – October 2005.

    c. Registered nurse overseas in Australia, March 2006 – January 2008.

    d. Acting clinical nurse educator in Australia, February 2008 - July 2008.

    e. Clinical Nurse Educator in Australia, July 2008 – October 2011.

    f. Band 6 nurse at Countess of Chester Hospital February 2012 to present.

4. My duties and responsibilities as a nurse at the hospital in 2015 and 2016 were, but not limited to -

    a. In charge of a shift as and when allocated.

b. Link nurse for resuscitation and transport.

c. Student mentor.

d. Supporting junior staff to develop their skills.

e. Caring for Intensive Care Unit, High Dependency Unit and Special Care Unit infants within the unit.

f. Administering IV antibiotics for infants on Post Natal Ward and Central Labour Suite.

g. Performing cannulation and venepuncture.

h. Liaising with Central Labour Suite regarding potential deliveries and admissions.

i. Working within the Multidisciplinary teams to deliver patient care.

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

5. 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.

6. The Unit Manager, Eirian Powell, was generally very supportive and fair. If I had a problem, she was approachable and would generally work with me to solve the problem. She would often ask for the problem to be put in writing if she felt it was necessary to have a record of the issue. She encouraged the team to actively fill out Datix. Eirian supported us with trying to ensure we had adequate staffing levels and often asked us to enter a Datix if staffing levels were insufficient.

7. Yvonne Griffiths (Deputy Manager) and Eirian worked well as a team. They balanced each other out and appeared to work well together.

8. I felt Yvonne Farmer (Practice Development Nurse) seemed out of her depth at times and was not always up to date with current practices and development within the field of neonates or education. For example, I queried the level of my learning and assessment qualification, as I was not familiar with the UK education system. She was insistent I could only do level 6. Halfway through the course I was issued an apology as I should have been completing it at a level 7.

9. At times it did feel that some staff were given opportunities based on who they were, not their abilities and / or experience.

10. Staff were encouraged to improve their knowledge and skills through further training and education, as well as secondments at tertiary centres.

11. At times, it felt staff were allocated infants above their capabilities due to the workloads occurring within the unit, relying on the nurse in charge or senior nurses to oversee their work.

12. 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.

    a. Overall, I think the clinical relationships seemed reasonable.

    b. Relationships between midwives and nurses seemed okay. Although as a shift leader it could be difficult finding a midwife at times to get a brief handover, as they could be very busy and unavailable for a quick update.

    c. There was some tension at times between the Central Labour Suite (CLS) and NNU, especially if we were full and they wished to deliver a preterm infant. I felt at times the team on CLS did not like to be told no and would apply pressure so that we would accept more infants, even if we were at capacity. At times, the obstetricians would go above the NNU shift leader and talk directly to the NNU consultant or NNU ward manager, trying to apply pressure to accept infants. This worked at times as the NNU consultants would accept, without consulting the nursing team to discuss our reasons for refusal or without being aware of staffing issues.

    d. There was frustration with the medical team at times due to lack of cover for neonates, especially overnight, or if the team became busy on A&E or on the paediatrics unit.

Child A, Child B, Child E, Child F, Child L, Child M, Child N, Child O and Child P

13. In this part of my statement, I detail my involvement or knowledge of the care of Child A, Child B, Child E, Child F, Child L, Child M, Child N, Child O and Child P.

14. A copy of the following statements I gave to the police were enclosed with my Rule 9 Request:

    a. statement dated 17th July 2018 in relation to Child A and Child B: **[INQ0013962];**

b. statement dated 26th March 2018 in relation to Child E: **[INQ0000229];**

c. statement dated 31st October 2018 in relation to Child E and Child F: **[INQ0000901];**

d. statement dated 21st September 2021 in relation to Child F: **[INQ0000916];**

e. statements dated 17th December 2018 and 8th February 2023 in relation to Child L: **[INQ0001212] and [INQ0001265];**

f. statement dated 16th February 2018 in relation to Child M: **[INQ0001211];**

g. statement dated 26th September 2018 in relation to Child N: **[INQ0000649];** and

h. statement dated 26th September 2018 in relation to Child O and Child P: **[INQ0001411].**

15. I gave evidence at Letby's criminal trial. Transcripts of my evidence were enclosed with my Rule 9 Request:

a. **[INQ0010279, p. 32]** in relation to Child E;

b. **[INQ0010282, p.27]** in relation to Child F;

c. **[INQ0010304, p. 20]** in relation to Child L; and

d. **[INQ0010306, p. 2]** in relation to Child M.

16. I have reviewed the statements I provided for the police investigation and the transcripts of my evidence at the criminal trial. **INQ0000229** does contain spelling errors and my name is incorrectly spelled.

17. In relation to Child A, Child B, Child E, Child F, Child L, Child M, Child N, Child O and Child P:

a. Letby was convicted of the murder of Child A on 8th June 2015 and the attempted murder of his twin sister, Child B, on 9th / 10th June 2015.

b. Letby was convicted of the murder of Child E on 4th August 2015 and the attempted murder of his twin brother, Child F, on 5th August 2015.

c. Letby was convicted of the attempted murder of Child L and his twin brother, Child M, on 9th April 2016.

d. Letby was charged with three counts of attempted murder of Child N: one count on 3rd June 2016 for which she was found guilty and two counts on 15th June 2016 (at about 07:15 - 07:30 hours and at 15:00 hours) for which the jury were unable to agree verdicts.

e. Letby was convicted of the murder of triplets, Child O and Child P, on 23rd June 2016 and 24th June 2016 respectively.

18. I was not on duty when Child A and Child B collapsed or when Child A died. I had not been involved with their care when I worked long day shifts on 8th, 9th and 10th June 2015 **[INQ0013962, p. 1-2].**

a. As explained in my police statement, I would have been made aware of Child A's death when I came back on shift on the 9th June 2015.

b. I am unaware of any debrief, meeting or discussion regarding the collapse/death of Child A and Child B.

19. In relation to twins, Child E and Child F, the Inquiry have informed me that I was the shift leader for three consecutive night shifts on 3rd to 4th, 4th to 5th and 5th to 6th August 2015. Despite being listed in the medical records as being present at the scene of Child E's collapse, I do not recall anything regarding Child E's collapse. I noted that my involvement in his care is not described in the medical records apart from my signature in respect of medication. Having looked at Child E's medical records, I commented in my statement to the police that Child E was *"pretty stable prior to his collapse"* **[INQ0000229, p. 6].**

a. According to my police statement on 26th March 2018 **[INQ0000229],** I cannot remember if I was the nurse in charge during the shift which Child E passed away, or whether this was Caroline Oakley. However, my police statement on 31 October 2018 states that according to the off duty I was allocated in charge for all three shifts **[INQ0000901].**

b. I have been asked whether Child E's collapse and death was an unexpected event. Any child being cared for in an NNU is at risk of a collapse, as if they were well, they would not be on an NNU. I did not feel that Child E's collapse and death was an unexpected event as during my career I have seen infants who appear stable collapse and die very quickly.

c. Child E's death would have been discussed at the handover from the night to the day shift on the morning of 4th August 2015. It would have been mentioned in

handover to the entire nursing team coming on shift that we had a death overnight, and that the parents were currently within the unit. I do not recall who was present or what was exactly said. I would have allocated someone to care for the parents and Child E, and to finalise any paperwork that needed completing.

d. As shift leader, usual practice would have been to inform the ward manager of any sudden and unexpected death of a baby on the unit if it was a weekday, as she was usually on the ward and present from 7am. The other members of the nursing team would have been informed during handover when a quick safety huddle of the unit was held.

e. A Datix would have also been completed.

f. The nurse caring for the infant would have given an individual handover to the staff member coming onto the following shift. This would include what was complete and what needed completing in relation to notifications and paperwork.

g. It is recorded in the medical records that I attended a de-brief following Child E's collapse. I said in my statement to the police on 26th March 2018 that I have no recollection of this debrief **[INQ0000229, p. 2-4].**

h. I have been asked whether there was any informal discussion or any other type of meeting at which Child E's death was discussed. According to my police statement on 31 October 2018 **[INQ0000901]:**

"I can't really recall any discussion surrounding; Child E's cause of death but I believe staff were querying Sepsis, as he had suffered bleeding and staff were unsure if his tummy was the issue or NEC."

i. I do not remember any further details regarding who was present at any discussion, or what was exactly said.

20. I took over the care of Child F from Letby in the early hours on 4th August 2015 following Child E's collapse. During the following night shift (4th to 5th August 2015) I was made aware of a drop in Child F's blood sugars and a subsequent increase in Child F's heart rate. As a result of the rise in Child F's heart rate and temperature he was screened for sepsis **[INQ0000901, p.2-4].**

a. I would have been made aware of Child F's first CRP at the time the result was reported by the lab. I would have been made aware of the second CRP on the night of the 5th to the 6th August 2015 when again the results were reported. The results of blood culture and line cultures would not have been available on my shift as they take up to 36 hours to report on.

b. The CRP had risen to 40 which is an indication of infection.

c. I was not surprised by the results. Neonates are susceptible to infections particularly when central lines are in place.

d. I do not recall discussing Child F's blood sugar readings with anyone between 4th and 6th August 2015. I would assume that I discussed them with the nurse who was looking after the infant and the medical team. I would also assume it would have been mentioned during handover between staff.

e. I do not recall any informal discussions, debriefs and/or or any other type of meeting regarding Child F's persistent low blood sugar readings on 5th or 6th August 2015.

f. I do not recall being aware of any concerns regarding the care of Child F and in particular the concerns about him receiving insulin.

21. In relation to twins, Child L and Child M, on 9th April 2016 I was working a long day shift when I heard the alarm sound on Child M's monitor and saw on the monitor that Child M's heart rate had dropped.

a. At the beginning when the alarm sounded, Child M's collapse was not an unexpected event as far as I was concerned. It is normal for premature infants to have episodes of bradycardia and apnoea that trigger the alarms.

b. It became unexpected when it progressed further, and Child M did not immediately respond.

c. In my police statement on 16th February 2018, I state that I did not attend a debrief in respect of this incident **[INQ0001211, p. 7].** I also say that I did not have any

concerns about how the incident was dealt with and do not recall any conversations of note regarding Child M's collapse. I have no recollection of a debrief concerning Child M's collapse on 9th April 2016.

22. In my statement to the police on 17th December 2018, I confirm that *"I have virtually no memory of Child L"* **[INQ0001212, p. 1].** Having reviewed his medical records, I noted that my only involvement with Child L's care on 9th April 2016 was immediately following Child M's collapse when I took over from Nurse Mary Griffith and Letby who at the time were in the process of making up a dextrose infusion for Child L. I did not consider Child L's low blood sugar to be unusual **[INQ0001212, p. 2].**

    a. I do not recall discussing Child L's blood sugar readings with anyone at the time. I would assume that Mary informed me of Child L's problem when I was talking to her and Letby about what they were doing prior to the collapse of Child M.

    b. I am not aware whether there was a debrief, meeting or discussion (whether formal or informal) involving nursing staff or other medical staff within the NNU team to discuss Child L's persistent low blood sugar readings on 9th April 2016.

23. I had a brief involvement with Child N during the night shift on 14th to 15th June 2016. I do not remember the shift and therefore my account is based on my reading of Child N's medical records. I do not recall Child N's collapse at 07:15 hours on 15th June 2016 and have no recollection of being involved with his resuscitation **[INQ0000649, p. 1].**

    a. I do not recall whether there was a discussion about Child N's sudden collapse at the morning handover.

    b. My police statement does not state if I was in charge or not. If I was in charge, I would have discussed the matter with the oncoming nurse in charge.

    c. I would not have been present for the handover regarding Child N as he was not my patient.

24. In relation to Child O, I was the shift leader for the night shift on 23rd to 24th June 2016. Child O had died prior to the start of my shift at about 17:47 hours on 23rd June 2016. In my statement to the police, I said: *"I was surprised especially given the good condition that he had been in when I left my shift on the 21st June"* **[INQ0001411, p. 2].**

a. I cannot recall when and by whom I was informed of the death of Child O. I would assume I was informed by the shift leader of the previous shift (Nurse Melanie Taylor) during the safety huddle. I assume she would have told me what had occurred and what the doctors may have thought had caused the death. I assume she would also have updated me on the relevant paperwork and where the infant was currently.

b. I cannot recall whether Child O's collapse and death was discussed at any meeting or debrief, although this probably would have occurred.

c. There was some informal discussion amongst staff nursing staff as to the causes of the deaths, for example an infection or something genetically we didn't know about. I cannot recall specifics of who was present or what was exactly said.

d. I asked Letby if she wanted to look after Child P and Child R during the day shift on 24th June 2016 **[INQ0001411, p. 3].** As shift leader the allocation of staff for the oncoming shift was one of my duties

e. I have been asked to explain my reasons for allocating the surviving triplets, Child P and R, to Letby. I allocated the triplets to Letby for continuity of care as she knew the infants and family and had cared for them the day before.

f. I had checked on Letby's welfare and whether she felt able to interact and continue with the family given the events of the 23rd June. I would do the same for any colleague who was in the same situation, if possible, taking into account staffing levels and patient acuity. It would be unfair to place a staff member in a situation they would find difficult especially after their previous shift, if it was avoidable.

g. I also considered the parents, as seeing a familiar face who knows what they have been through the previous day can be reassuring, as they do not feel they have to explain what has occurred and how they are feeling, as the nurse was with them through it all.

25. On 24th June 2016, at around 06:00 hours, I recall Child P *"shouting his little head off"* because he was hungry. I describe this as *"a good sign."* I note that he appeared *"alert, active, pink and was already prescribed antibiotics"* **[INQ0001411, p. 3].** At the end of my

night shift (23rd to 24th June 2016) I completed the handover to the day staff and had no concerns to raise. I returned later that evening to work the night shift (24th to 25th June 2016). In my statement I say, *"I remember thinking this is ridiculous, something's gone wrong and I was informed that [Child R] had been transferred out, as I am led to believe that he too had started to misbehave"* **[INQ0001411, p. 3].**

a. I would have been informed of the death of Child P during handover or on my arrival to the unit at the commencement of my shift. I do not recall who informed me. I would have been informed as shift leader regarding what still needed to be done for Child O and Child P and any outstanding paperwork. I would have been given a brief outline as to the time of the collapse and what had occurred by the previous shift leader.

b. I cannot recall if I was involved in any discussions about the similarity of the circumstances surrounding the deaths of Child O and Child P and their unexpected nature with anyone. I would assume there would have been a discussion with fellow night shift nurses while having a break, if the ward allowed, about the two deaths.

c. I have been asked to expand on what I meant by, "*I remember thinking "this is ridiculous, something's gone wrong*". I thought we had missed or not treated something in the infant's care, such as an infection or a genetic condition.

d. I do not recall whether there was a formal debrief, meeting or discussion involving nursing staff within the NNU team to discuss the unexpected death of Child P, but I would assume this did occur.

CQC visit to the Hospital 16th-19th February 2016

26. In relation to the CQC visit to the hospital between 16th-19th February 2016:

a. I cannot recall the extent of my involvement with the CQC visit to the hospital on 16th-19th February 2016. I do not know if I was on shift on these dates.

b. I cannot recall if I was spoken to by the CQC team.

c. I am not aware if other colleagues raised any issues of increased mortality on the neonatal unit with the CQC.

d. I am not aware if other colleagues raised the issue of patient safety and/or concerns that staffing factors (whether incompetence or deliberate harm) may have a link to the increased mortality raised with the CQC.

e. The lack of qualified speciality nurses and/or staff was listed on our risk register. If we had time, we submitted a Datix when our shift was short of staff. This would have been available for review by the CQC, as well as the nursing off duty.

f. The lack of space and inadequate plumbing that caused issues frequently was also known to the hospital. Money was being raised for a new unit to meet BAPM standards.

Concerns or suspicions

27. I was aware of the increase in numbers of deaths on the NNU. However, having worked in other NICU units I was aware the death rate can vary year to year, month to month, depending on a number of factors including the mothers age and co-morbidities, the infant's gestation and condition at birth and where they are born.

28. I never had any concerns or suspicions about the conduct of Letby while I worked on the NNU. I found she was very conscientious and if she was concerned about an infant she would come and discuss the matter with me if I was in charge of the shift.

29. Due to my previous role as a Clinical Nurse Educator, I was aware of the ways in which to raise concerns relating to fellow members of staff. If it was something that could be dealt with as a shift leader I would speak to the person individually. If it was a patient safety issue it would generally be reported to the manager verbally, with an email to follow up the conversation. If the situation required, a Datix would also be submitted.

30. I was not aware of any suspicions or concerns of others about the conduct of Letby until all the nursing staff received an email from the ward manager stating that Letby was being given a secondment elsewhere, and the unit was temporarily being downgraded.

31. I have been asked what discussion or debrief (formal or otherwise) occurred between nurses, or between nurses and doctors, after the death of a baby. It depended on the circumstances of the death as to when or if a debrief occurred. It was voluntary for nursing staff to attend. If the ward manager or medical staff wanted us to attend, it was generally arranged for a day when we were back on shift and available to attend.

32. As a member of staff, you could ask for a debrief with the medical team and raise any questions you had regarding the event, even if the medical team did not necessarily know the answer. We could also ask verbally for the postmortem results once they were completed. Nurses tended to discuss the events amongst colleagues if we felt we needed to.

Reflections

33. I do not think there are any steps that could have been taken to identify earlier that Letby was harming babies on the NNU.

34. CCTV will not prevent anyone from committing a crime if they are determined to commit a crime. CCTV does not stop other murders from occurring where it is in place.

35. I feel strongly that you cannot have CCTV in a clinical area. This is equivalent to having CCTV in a toilet as we frequently have mothers undressed while teaching breastfeeding or helping the parents with skin to skin. Some mothers at present are hesitant enough to breastfeed or have skin to skin with male team members present.

36. If we informed mothers that there was CCTV present, we would prevent vital opportunities for family integrated care from occurring. This would be detrimental to both infants and their parents.

37. I think this Inquiry should make the following recommendations to keep babies in NNUs safe from any criminal actions of staff -

    a. Adequate staffing levels both medical and nursing.

    b. The provision for family integrated care and the facilities for a parent to remain beside the infant 24 hours a day.

Request for documents

38. I am not aware of any documents or other information which are potentially relevant to the Inquiry's terms of reference.

39. I have noted that the police transcripts provided have spelling errors in them and were not seen by me prior to attending court for the criminal investigation. I was informed at the time of the recording the recordings were to jog the police officer's memory in typing up the statement. I was not informed they would be used in the criminal trial. At the time, a lot of the transcripts were recorded when it was an investigation, and no crime had yet been determined.

40. I have also noted that the court transcripts which I have been provided contain some spelling errors, which may affect the context of my evidence given in the criminal trial.

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: PD

Dated: 19.08.2024 | 12:22:57 BST