

Monday, 16 September 2024

(10.04 am)

LADY JUSTICE THIRLWALL: Good morning.

Mother A&B, I know I'm going to refer to you by that description, but I do know that underneath that description is a real person, and I won't forget that.

Thank you very much indeed for coming to give evidence this morning. I know you'll be nervous, and I think the best way of dealing with that is just to get on with it, so that's what we'll do.

THE WITNESS: Yeah.

LADY JUSTICE THIRLWALL: First of all, then, I'll ask Tim Suter to do the affirmation with you.

THE WITNESS: Okay, thank you.

MOTHER A&B (affirmed)

Questioned by MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you. Ms Langdale.

MS LANGDALE: Mother A&B, as you know, I'm Counsel to the Inquiry, and I'm going to be asking you questions. If at any time the wi-fi or signal means that you can't hear me, or I can't hear you, please just put your hand up, and we'll know straight way.

A. Okay.

Q. If you want a break at any point, put your hand up, and we will know straight way.

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are traumatised that it won't let us remember most of the night where you killed our child. What should have been the happiest time of our lives had become our worst nightmare.

"After losing Child A, not only were we absolutely traumatised at what had happened, we were riddled with fear for our baby girl, Child B. We weren't there when Child A collapsed, and by the time I was brought through to him, he was gone, despite all the efforts to revive him. You had been successful in your quest to cause maximum pain and suffering. We are so thankful that we had that fear for Child B as it saved her life, not allowing you to fully do the same to her as you did to Child A.

"After losing Child A, we made sure that there was always a member of family at her side watching. However, we made a mistake. We started to believe that what happened to Child A was a tragic event that we couldn't have stopped. We trusted that Child B would be given extra special care. It had certainly appeared that way. Little did we know that you were waiting for us to leave so you could attack the one thing that gave us a reason to keep going on in life. We are forever grateful that you wasn't able to take Child B away from us that night.

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You provided a statement to the Inquiry dated 17 July 2024. Can you tell the Chair whether the contents are true and accurate, as far as you're concerned?

A. Yes.

Q. I'm going to take you through that statement, and I'm also going to take you to some documents. I know you would prefer me to read those documents, rather than you finding those electronically, and I'll do that or read parts of it as we go through your evidence.

The first thing I'm going to do at your request is to read your victim impact statement that you gave at the end of the criminal trial.

A. Okay.

Q. And you said this:

"2015 was going to be the best year of our lives. We were going to become parents to a little boy and a little girl. Everything was perfect. Our babies were doing well in the neonatal unit. We were told that Child B needed a little bit of extra help but was doing well, and that Child A was very strong and doing really well. Never could we have imagined that the most precious things in our lives were placed under the care of an evil monster. We never got to hold our little boy while he was alive because you took him away. Our minds

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"Although our family has a gaping hole where Child A should be, there is a constant shining light in Child B. You tried to take everything away from us. You thought it was your right to play God with our children's lives.

"Our lives are tough. We struggle with anxiety, depression and PTSD and sometimes we almost want to give up, but we never will. We have a duty to our children. We have a duty to keep Child A's memory alive for generations to come, and we have a duty to give Child B the best life possible, and we will spend our lives doing that.

"You thought that you could enter our lives and turn it upside down, but you will never win. We hope you live a very long life and spend every single day suffering for what you have done. Maybe you thought by doing this you would be remembered forever, but I want you to know my family will never think of you again. From this day, you are nothing. I hope they lock you up and throw away the key."

Q. I'm going to move to paragraph 7 of your statement and begin to ask you about your experiences at the Countess of Chester Hospital.

So you tell us in these paragraphs, and perhaps tell us in your own words now, what treatment you received when you were pregnant at the Countess and moving

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1 towards when you had your caesarean section and the
 2 birth. What was it like, your antenatal care and
 3 generally? How did you feel?
 4 **A.** The antenatal care was -- I mean, I had a couple of
 5 specialists who realised it was a high-risk pregnancy,
 6 so the antenatal care was good. I was being looked
 7 after by another consultant at a different hospital for
 8 my condition.
 9 **Q.** Yes. And do you --
 10 **A.** But the antenatal care with the consultant was good.
 11 **Q.** And you had some care at the Countess, didn't you, and
 12 some consultant care, so split care type of arrangement.
 13 And how did you feel, knowing you were expecting
 14 twins?
 15 **A.** Really excited. Even more so when I found out it was
 16 a boy and a girl, and I sort of got one of each.
 17 **Q.** And you actually spent some time in the Countess of
 18 Chester before the caesarean section, didn't you?
 19 **A.** Yeah.
 20 **Q.** And how was that, that period of care?
 21 **A.** The only time that I didn't feel very comfortable was
 22 the day that I was admitted, and somebody from the
 23 neonatal unit came and told me about -- that they were
 24 going to show me around and things and basically how
 25 high risk it was and how, you know -- because, at the

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1 **A.** One of the nurses actually told my partner that she'd
 2 never seen a pre-term baby doing as well as he was.
 3 **Q.** And you'd had a general anaesthetic, so what happened to
 4 you after you had had the babies?
 5 **A.** Well, it was in the evening, so I was just encouraged to
 6 rest.
 7 **Q.** So --
 8 **A.** I remember being really thirsty, but I was on low
 9 [fluid?] restriction, so I was kind of only allowed to
 10 have a certain amount of fluid per hour. So I was
 11 sleeping and then waking up at every hour to have the
 12 amount of fluid that I was allowed. The neonatal unit
 13 brought through, because I asked -- because obviously
 14 I was going to be under a general anaesthetic, I did ask
 15 to have photos taken so that I could see them as soon as
 16 I woke up. So they brought through, like, two little
 17 cards with a photo of each.
 18 **Q.** So did you see them in person that first night or not?
 19 **A.** No.
 20 **Q.** But you tell us your partner went into the unit and had
 21 taken some photos and you saw them?
 22 **A. (Witness nodded)**
 23 Yeah, on the photos, yeah, but not physically saw
 24 them.
 25 **Q.** The next morning, you asked if you could go and see your

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1 time, I was 29 weeks and basically put the fear of God
 2 in me.
 3 **Q.** You actually --
 4 **A.** But other than that, the actual care on the maternity
 5 ward was really good.
 6 **Q.** And you had -- you tell us at paragraph 20 of your
 7 statement you had -- you were 31 plus two weeks, and you
 8 had a caesarean section; yes?
 9 **A.** Yeah.
 10 **Q.** And Child B and Child A were delivered at 8.30 and 8.31
 11 pm. Child A weighed 3 lbs 12 ounces, and Child B
 12 weighed 3 lbs 11 ounces; yes?
 13 **A.** Yes, that's correct.
 14 **Q.** And when you came round, what do you remember? You set
 15 out from paragraph 21 what you were told about the
 16 babies and how you felt. How was it?
 17 **A.** That Child A needed a little bit of extra -- no,
 18 Child B, sorry. I'm getting them mixed up. Child B
 19 needed a little bit of extra help.
 20 **Q.** Yes.
 21 **A.** But that Child A was doing really well for a premature
 22 baby. Really well.
 23 **Q.** And you'd had a general --
 24 **A.** In fact one of the nurses -- sorry.
 25 **Q.** No, no. Go.

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1 babies first thing. Were you aware able to do that?
 2 **A.** No.
 3 **Q.** Why not?
 4 **A.** Because they told me that they were trying to insert
 5 long lines and that I would need to wait. I also asked
 6 several times throughout the day and was told that exact
 7 same thing. I was only allowed to go through when the
 8 consultant that was looking after me came through, and
 9 I actually complained to her and told her that I hadn't
 10 seen them yet and that I really wanted to, and it was
 11 quite distressing that I wasn't allowed to go through.
 12 And that was only then that that consultant went through
 13 and told them that I was able to go through and see
 14 them, but even then, I had to wait about two hours.
 15 **Q.** At paragraph 26 of your statement, you say this:
 16 "When I first went to the neonatal unit, I went to
 17 see Child B because I'd been told she'd had breathing
 18 difficulties at birth and had needed medical assistance
 19 to start her breathing. I was told by a nurse that she
 20 needed a little bit extra help. I took the nurse's
 21 comments to mean that there was now nothing to be
 22 concerned about."
 23 Do you remember that?
 24 **A.** Yeah, that's true.
 25 **Q.** You tell us in your statement, from paragraph 30

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1 onwards, later that day you were in your room, and you
 2 heard nurses discussing Child A, or you -- or
 3 Father A&B --
 4 **A.** My partner.
 5 **Q.** Yes, father heard. And what are you aware that he heard
 6 being said, then?
 7 **A.** He heard them say there's something wrong with Child A,
 8 and discussing whether they should come and get me and
 9 my partner.
 10 **Q.** Did someone come and get you? And what happened next?
 11 **A.** They came to get me when he'd already crashed and there
 12 was nothing more that could be done.
 13 **Q.** You say you were wheeled down to the unit by a staff
 14 member or Father A&B -- you can't remember now -- but
 15 what scene did you come across? What did you arrive to?
 16 **A.** It was chaos. Absolute chaos. I couldn't even
 17 actually -- there was that many people, I couldn't even
 18 actually see Child A.
 19 **Q.** You say there were many people around his cot, and one
 20 nurse asked if you were religious and if you'd like her
 21 to say a prayer. Do you remember that now?
 22 **A.** Yeah, I do.
 23 **Q.** What did you make of that? What did you think of that?
 24 **A.** Well, I'm not religious myself. My partner is. So
 25 I felt like I sort of had to say yes, even though

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1 answer. I was told that: we had to stop CPR because he
 2 was gone, and even if they managed bring him back, he
 3 could have been severely disabled, although I wouldn't
 4 have cared. I would have preferred to have him,
 5 disabled or not. But they still said that they needed
 6 to stop.
 7 **Q.** Shortly afterwards, you were told they'd need to take
 8 Child A to Alder Hey Hospital for a post-mortem, "and he
 9 had to stay in a hot cot while we waited for transport
 10 to take him there."
 11 You say you were asked, at that time, to speak to
 12 the coroner. Were you asked to do that, and how did you
 13 feel about having to do that?
 14 **A.** So the -- the time that it happened to Child A, it was
 15 the evening, and my concern went straight away to
 16 Child B, and I didn't want to leave her. I didn't want
 17 to talk to anybody. I just wanted to be there with my
 18 child. I'd already been told for nearly 12 hours, maybe
 19 even longer, that I couldn't see them. I got to see
 20 them for maybe half an hour, so if he'd been alive -- so
 21 half an hour is all I got to see my child before he
 22 died. And there was no way that I wanted to leave
 23 Child B. Why would I want to leave her? I only got
 24 half an hour with my other child. But they kept coming
 25 through: "You need to talk to the coroner. You need to

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1 I wasn't ready for -- to let go. So she was asking me
 2 to say a prayer, and I had got to accept that my child
 3 died before I even got to know what was going -- what
 4 was happening, or anything like that. And I understand
 5 she was probably just trying to make me feel better, but
 6 it made me feel so much worse. Sorry.
 7 **Q.** Dr Jayaram spoke to you and said he needed permission to
 8 stop CPR. Was it him who asked you about that or spoke
 9 to you?
 10 **A.** Yes.
 11 **Q.** At this point, had you ever had a chance to hold
 12 Child A?
 13 **A.** No. No. The only contact that I had with him before he
 14 died was -- he was crying when I went into the neonatal
 15 unit, so I went over, and I put my hand in and put my
 16 hand on his stomach, and that's the only time.
 17 **Q.** Shortly afterwards, you were asked if you wanted the
 18 hospital chaplain to come to see you. What in fact was
 19 your need at that time? What did you want to do?
 20 **A.** To find out what had happened. I'd been told that my
 21 baby, for a pre-term baby, was in one of the best
 22 conditions that they'd ever seen, and then hours later,
 23 he died.

24 And I was told I need to go and get rest because I'd
 25 had major surgery, when what I actually needed was an

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1 talk to the coroner," and it was the last thing I wanted
 2 to do. And in the end, my partner got so sick of them
 3 pestering us, that he went and spoke to the coroner,
 4 just so that they would leave us alone.
 5 **Q.** Father A&B remembers that it was Letby who brought
 6 Child A in to you.
 7 **A.** Yes, I --
 8 **Q.** Do you remember anything --
 9 **A.** Yes, I remember vividly that it was her. I didn't
 10 remember at the time when I was first -- when the police
 11 were brought in and I was told her name, but as soon as
 12 I saw the picture of her face, I remembered straight
 13 away.
 14 **Q.** We have seen the medical records and the conversations
 15 that Dr Brearey, Dr Saladi and others are having in the
 16 next few days, and to quote, for example -- my Lady,
 17 it's page 63 -- Dr Saladi: "cause of death is unknown",
 18 and Dr Brearey also saying to you -- sorry, it's
 19 Dr Saladi: "We don't have an explanation for the cause
 20 of death of Child A. We're waiting for the full
 21 post-mortem report."
 22 Is that what they were saying to you? They did not
 23 know why --
 24 **A.** Yeah.
 25 **Q.** -- he had died?

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1 A. Not only did they not know, they didn't expect it.
 2 Q. They didn't know, and they didn't expect it. And we see
 3 that in the medical records, that they didn't know and
 4 they didn't expect it.

5 The Inquiry also has the Datix form, it's called
 6 a Datix form, which is filled in around Serious
 7 Incidents or deaths, or should be. Were you ever shown
 8 that Datix form before it was sent to you by the
 9 Inquiry?

10 A. No, never. I wasn't even aware that a Datix form had
 11 been completed.

12 Q. And we know -- and my Lady, it's page 28 -- the Datix
 13 form says:

14 "Sudden and unexpected deterioration and death of
 15 a patient on the neonatal unit after full resuscitation
 16 requiring post-mortem."

17 So it sets it out. And there's also a section,
 18 "Duty of Candour, Assessment, Patient and Family", and
 19 "How the Patient and Family Have Been Treated" that has
 20 to be completed.

21 You hadn't seen the Datix form, but had Dr Brearey,
 22 Dr Saladi -- you'd understand that it was unknown or
 23 unexplained, from their point of view, at this point?

24 A. Yes.

25 Q. Child B -- you set out in your statements how you wanted

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1 you heard the question, but it was: how you were feeling
 2 at that time, sitting with Child B.

3 A. The only time that I felt relaxed or comfortable was sat
 4 by Child B. And every time I had -- because I'd just
 5 had major surgery, so moving around was not easy, you
 6 know. It took me a while to get out of bed to get into
 7 the room when they were resuscitating Child A. So
 8 I didn't want to leave the room with Child B because it
 9 might take me too long to get back. And it was the only
 10 time that I felt comfortable.

11 I actually had -- my consultant came on to the unit
 12 to check my blood pressure, and it was the only time
 13 that it was stable, was when I was there with Child B.
 14 But they kept telling me that I needed to rest.

15 Q. And you say: during the night, you set your alarm on
 16 your phone for every two hours, and you'd call the unit.

17 A. I would, yeah.

18 Q. One night, you rang at about 4.00 am, and there was
 19 a bit of a confusion about whether the call -- well, do
 20 you want to tell us what happened?

21 A. So I called every two hours, and me and my partner would
 22 sort of take it in turns, but most of the time it would
 23 be me because I couldn't sleep properly. I called, and
 24 I said: I'm just calling to check on Child B, which is
 25 what I did every night every 2 hours, from when I left

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1 to be with Child B afterwards, and was that -- was it
 2 possible? Were you able to do that? Could you sit with
 3 her?

4 A. Yes. Yeah. The night that it happened, they were very
 5 good at letting us stay and letting us sit there, but
 6 towards the afternoon of the second day was when they
 7 were telling us that they would allow it for now, but we
 8 would need to go back to the rules, basically.

9 Q. You say also in your statement -- how did hearing alarms
 10 on the ward generally make you feel, having lost Child A
 11 and when you were with Child B? What was that time like
 12 for you on the ward?

13 A. Unbearable. Even now, if I visit family or anybody in
 14 hospital and I hear those beeps, it makes me want to
 15 cry. It is something that we -- both myself and my
 16 partner -- we cannot deal with, hearing that noise,
 17 because that's obviously the noise that indicates
 18 something is wrong.

19 Q. You also tell us at paragraph 57 that the nurses would
 20 try and encourage you to go and rest when you were sat
 21 with Child B, but unless the father was there -- or you
 22 found that really difficult to do.

23 I think the screen is frozen.

24 A. -- and when I was sat by -- oh, sorry.

25 Q. That's okay. We lost you for a moment. I don't know if

14

1 the hospital. Normally, they would just put me through
 2 to the nurse, so they told me: "I'll put you through,"
 3 and the next thing, I was on the phone to -- I don't
 4 know whether it was a consultant or a registrar, but it
 5 wasn't a nurse, and there was a child crashing, and he
 6 asked me -- he told me he'd given them a certain CCs of
 7 adrenaline, am I coming in? So naturally, panic,
 8 because in my brain: why hadn't they rang me if
 9 something was happening with my child, like I asked them
 10 to do every night? Even though I called every
 11 two hours, I asked them to call me if there was
 12 anything.

13 Q. Then the next day, was it explained to you that that
 14 should have been a conversation with somebody else?

15 A. It was, but I was made to feel like I'd done something
 16 wrong. When I walked in that unit, everybody turned
 17 their head to look at me, and I was taken off into
 18 a room to be explained that to. They did apologise, but
 19 the atmosphere when I walked into that unit was as if
 20 I'd done something wrong.

21 Q. Turning now to the cause of the death of A and the
 22 deterioration of B. I'm going to read some documents
 23 here to help remind you of what they say, rather than
 24 you have to turn them up, if I can.

25 The first one is a letter, it's at page 25 in our

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1 bundle, and it's a letter dated 29 January 2016 to
2 Yvonne Williams at the Countess of Chester, and it's
3 from you, Mother A&B, and you wrote this:

4 "Hi Yvonne. Sorry for the delay in getting this to
5 you. Here's the issues regarding Child A's care that we
6 have.

7 "1. As we were told Child A was so well, why was
8 his long line not put in straight away?

9 "2. While myself and my partner were on the unit,
10 we noticed the SATS monitors are not checked straight
11 away by a nurse or doctor when they beep, so how many
12 times was Child A's monitor allowed to beep without
13 being checked? How long was it beeping before the
14 medical staff attended to him?

15 "3. Why, when we were told the doctors were
16 struggling to put his long line in, was a more senior
17 doctor not called to assist?

18 "4. Why were we allowed to believe Child A's
19 initial post-mortem showed nothing, when in actual fact
20 he had a condition?

21 "5. Why were we not informed straight away that his
22 long line had been put through his liver? We were told
23 it was taken out straight away. Is this the case? And
24 if not, why not, and why were we not informed of this?"

25 So this is you writing in January 2016. What was it

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1 "I'm not sure who fed back the PM results to you,
2 but having read the report, the only abnormality
3 described by the pathologist was a crossed pulmonary
4 artery. This is a rare variant where the left pulmonary
5 artery that carries blood from the heart to the left
6 lung starts to the right-hand side of the right
7 pulmonary artery. However this should not cause any
8 problems with the function of the heart and lungs and
9 the post-mortem report suggests that there was no issue
10 with the heart and lungs as a result of crossed
11 pulmonary arteries."

12 What did you make of that? Did you think he was
13 saying that there was a condition or no condition that
14 was relevant to the death of A?

15 **A.** To be honest, that part of the reply made me feel
16 better, because we thought if he'd had this condition,
17 that could have possibly contributed to it. And as
18 I explained, I'm very nervous -- was very, very nervous
19 about Child B, and I have been -- even now, I'm still
20 very nervous about Child B and her health. So for me,
21 the fact that it was sort of insignificant made me feel
22 better.

23 **Q.** And similarly, when he's talking about the long line:
24 "Why were we not informed straight away?" you'd asked;
25 that it had been put through his liver, he makes the

19

1 that made you write that letter to Yvonne Williams?

2 **A.** Because we had no answers. Nobody had told us. And
3 I understand that they were -- when we were on the
4 neonatal unit, they were telling us they didn't know and
5 they'd never seen anything like this before, but that
6 doesn't help us as parents. And why was nobody looking
7 for an answer?

8 So I was trying to get some clarification as to what
9 happened, because as I said to you, I was only brought
10 into the room when it was too late, so I didn't see what
11 they actually did or what had happened beforehand, or
12 anything like that. I was brought into the room when it
13 was too late. So I was trying to get some answers as to
14 what had led for, in one of the nurse's own words,
15 a perfectly well pre-term baby to suddenly die.

16 **Q.** We've got in our bundle at 26 and 27, my Lady,
17 a two-page letter from Dr Jayaram dated
18 10 February 2016. And he has taken all your questions,
19 and they have been answered. I'm not going to read all
20 of the answers to the various points out now, but at
21 paragraph 4, where you had said:

22 "Why were we allowed to believe Child A's initial
23 post-mortem showed nothing, when in actual fact he had
24 a condition?"

25 Dr Jayaram replied:

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1 points that he would not normally expect paediatricians
2 to keep parents informed at every stage of the
3 procedure, but he does also say:

4 "The UVC entered one of the liver veins but did not
5 puncture the vein or enter the liver itself. The PM
6 showed a tiny clot on the end of the line which would be
7 expected, but the liver itself was normal, suggesting
8 that the UVC did not cause any damage to the liver. As
9 above, this is not an uncommon event in UVC insertion."

10 So how did that make you feel about the long line
11 point?

12 **A.** Well, to be honest, it didn't really -- he's put that he
13 didn't expect to inform parents of everything, but it
14 took him all day, so you would have thought that
15 somebody would have given a bit more of an explanation
16 because I was desperate to see my children but I had to
17 wait because of these long lines. So I would have
18 expected that it was more than normal for somebody to
19 come and explain to me that maybe they're difficult to
20 place, because I don't even know what -- at the time,
21 I didn't even know what a long line was. So if they'd
22 have come and told me what it was, what the function
23 important that it would stop me from seeing my children?
24 So I understand maybe that he doesn't feel that he needs
25 to explain every detail to parents, but when something

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1 is taking that long and a parent is missing out on
 2 meeting their children for the first time ever and
 3 they've been born the night before, to me, that's just
 4 something that you should do. Because if I hadn't --
 5 you know, if I'd have had a caesarean and I was awake, I
 6 would have saw them there and then, but I didn't because
 7 I was under general anaesthetic, so that was going to be
 8 my first chance to see them. And that was what we were
 9 told was causing the delay in us going through, was the
 10 long line insertion. It should have been better
 11 explained to us.

12 **Q.** You then had instructed solicitors, hadn't you, and we
 13 have seen a letter written on your behalf by solicitors
 14 dated 28 September, and it was sent to coroner
 15 Mr Nicholas Rheinberg. My Lady, it's page 37 of our
 16 bundle. And the letter is dated, as I've said,
 17 28 September, Mother A&B, and what it says is:
 18 "Dear Mr Rheinberg. Inquest concerning the death of
 19 Child A. I write further to the disclosure of the
 20 one-page summary regarding Child A's death which was
 21 today provided by the Countess of Chester Hospital. We
 22 were of the understanding that a full investigation was
 23 taking place at the Trust regarding Child A's death
 24 which would result in a report detailing the chronology
 25 of events, the issues involved, whether any errors were

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1 report can be disclosed as a matter of urgency, if
 2 indeed that investigation is yet complete."
 3 We also know, Mother A&B -- it's at page 66 -- what
 4 that one-page report was that was signed by S Brearey
 5 and dated 1 July 2015, contained a summary of your case,
 6 and learning from these changes. And underneath
 7 "Learning from these cases", it said:
 8 "There was notable excellence in practice and
 9 record-keeping, [it says in all three cases] although
 10 the following points are unlikely to have influenced the
 11 outcome, the following points for discussion improvement
 12 in practice were noted: no record of capnograph used
 13 following intubation. However, doctor recorded see ETT
 14 pass clearly through cords and good chest movement,
 15 verified by consultant. ETT left in for PM - no comment
 16 that was incorrectly placed on preliminary PM report.
 17 Delay in debrief."

18 Do you remember that one-page report that you were
 19 sent, a one-page typed report, or not now?

20 **A.** To be honest, I don't, no.

21 **Q.** Fair enough.

22 **A.** I don't remember that.

23 **Q.** What we know -- and, my Lady, we see at page 38 in our
 24 bundle -- the reply from the coroner to your solicitors:

25 "Thank you for your letter which arrived whilst I

23

1 made, whether such errors could have caused or
 2 contributed to Child A's death, and the lessons learned.
 3 "We were told in August 2016 that this investigation
 4 was ongoing and we would be provided with a Serious
 5 Untoward Incident Report. We therefore expected to
 6 receive prior to the inquest hearing a fairly lengthy
 7 and comprehensive document dated August or
 8 September 2016. We are therefore very surprised that
 9 the Trust has now provided such a short document
 10 describing only the most superficial investigation and
 11 one that bears the date 1 July 2015. Clearly, this
 12 document is not the result of the major and detailed
 13 investigation we were told was still ongoing only a few
 14 weeks ago.

15 "We are very concerned that, with less than two
 16 weeks until the inquest hearing, no proper investigation
 17 report has been provided which is arguably the most
 18 crucial piece of evidence in the inquest. Without it,
 19 we and the Family's counsel are quite simply unable to
 20 prepare sufficiently for the inquest. If we do not have
 21 such a report by Monday 3rd October, we will very
 22 regretfully have to ask you to adjourn the hearing until
 23 the report has been provided and all parties have had a
 24 chance to consider it. We therefore respectfully invite
 25 you to revert to the Trust to see whether the full SUI

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1 was attending a conference. I too was disappointed with
 2 the brevity of the report which I received. However, I
 3 have no power to order a hospital to conduct an
 4 investigation and still less give directions as to the
 5 nature and extent of any investigation that is
 6 undertaken."

7 Later on, it continues:

8 "I'll not be adjourning the inquest next week; it
 9 would be inappropriate for me to do so. As you know,
 10 the Consultant Paediatric Pathologist was unable to
 11 determine the cause of death. It is to be hoped that
 12 the Pathologist with the benefit of hearing the clinical
 13 evidence may be able to give an opinion as to the cause
 14 of death, although we will have to wait and see whether
 15 this turns out to be the case."

16 You attended the inquest, didn't you?

17 **A.** I did, yes.

18 **Q.** And we've got your solicitors -- there's no publicly
 19 available record now, my Lady, of the whole hearing, but
 20 we do have a detailed file note from your solicitors,
 21 page 49 onwards in our bundle, of that inquest.

22 What are your -- before -- I'm going to take you to
 23 a couple of extracts of it, but just standing back,
 24 what's your memory of that inquest? What did you learn
 25 from it? How did you feel when you left it? What was

24

1 the impression that you had gained from it?
 2 **A.** Well, it was -- the whole day was an absolute nightmare.
 3 It started off with a big crash on the motorway, so we
 4 were running really late, which was like mass panic for
 5 us that they would start without us. It was very
 6 uncomfortable. Again, it was a situation where there
 7 was people from the hospital and everything like that,
 8 and when we walked into the room, it was that feeling
 9 of: we've done something wrong. I felt like it was
 10 a waste of time, if I was being completely honest,
 11 because nothing came of it.

12 I don't feel it was sort of thorough as it should
 13 have been. It seems to have been -- it was just a case
 14 of: this was unexplained, and that's that. And as hard
 15 as it is to take, me and my partner on that day,
 16 although we were very upset, what else could we do?

17 It just seems to be that throughout this whole
 18 process, it's been forgotten by the Countess that we are
 19 people and they're our children. And it just -- that's
 20 how it feels.

21 **Q.** I'm going to read to you now from page 49, the first
 22 one, some of the evidence that Dr Saladi and Dr Jayaram
 23 gave and ask you if you remembered that.

24 If we look at page 49 of our bundle:

25 "Mr Rheinberg asked [that's the coroner] Dr Saladi
 25

1 death in neonates is the end point in a cause of events
 2 and normally they can be resuscitated. He confirmed
 3 that there had been similar cases of neonates dying in
 4 similar circumstances on the unit which they've not been
 5 able to explain. He confirmed that they have therefore
 6 downgraded the unit so that they do not care currently
 7 for preterm babies, and they have also requested an
 8 independent review, and they are still awaiting the
 9 formal report.

10 "However, the initial feedback from this is that
 11 nothing can be found that is wrong with any of the
 12 training, any of the practices, or any of the equipment.
 13 However there is a potential issue with staffing. As
 14 far as Dr Jayaram is aware this report is then to go
 15 back to the Executive Board, and they decide whether or
 16 not to release it to the public. Mr Rheinberg asked
 17 whether or not it would be possible for the family to
 18 receive a copy. Dr Jayaram said he's of the personal
 19 view that it should be made available for the public and
 20 he would have no issue with a copy of it being provided
 21 to the family, however as he pointed out it is the
 22 Executive Board's decision. He has to confirm however
 23 that the events that happened to Child A do not make any
 24 clinical sense to him at all."

25 Do you remember Dr Jayaram giving evidence?
 27

1 whether he had any worries about Child A, and Dr Saladi
 2 confirmed he had no worries at all. After his breathing
 3 had become regularised immediately following birth, all
 4 was looking well, and he would not have anticipated any
 5 complications. Mr Rheinberg then touched briefly on
 6 Mother A&B's condition, and Dr Saladi confirmed that
 7 this would not have had any impact on Child A."

8 Do you remember him giving that evidence?

9 **A.** Not really, to be honest.

10 **Q.** Fair enough. Then if we go to page 53, Mr Rheinberg
 11 moved on to questioning Dr Jayaram. He confirmed that
 12 he was handed over to from Dr Saladi:

13 "Child A was very stable when he came on shift, and
 14 he knew about the need for gaining central access."

15 If we go over the page, 54:

16 "Dr Jayaram saw the X-ray after the line had been
 17 removed, and [in his opinion] the line again was in an
 18 acceptable position. He did not think the tip of the
 19 line was in a position which would have caused
 20 problems."

21 And if we go over the page to page 56:

22 "Dr Jayaram was then brought in to try and assist
 23 with his paediatric knowledge of the circumstances...
 24 Mr Rheinberg asked Dr Jayaram whether or not he'd seen
 25 anything similar. Dr Jayaram confirmed that normally
 26

1 **A.** I remember him being called, because obviously he was
 2 the one that was there on the night, so we were quite
 3 interested to see what he had to say. And I remember
 4 him saying that he couldn't understand and that there
 5 was -- he couldn't find a reason.

6 **Q.** So Dr Jayaram was clear about that with the coroner or
 7 in the hearing. I've read that note of the evidence,
 8 but you remember him saying he couldn't understand it
 9 and didn't have a reason for it?

10 **A.** Well, I don't know the exact words, but that was what he
 11 alluded to, yeah.

12 **Q.** We now know, of course, the report they're talking about
 13 there that they'd gone to get is this RCPCH report. Did
 14 you understand at the time of the inquest about that
 15 report or what that meant?

16 **A.** We thought the report was going to give us some answers,
 17 and we were very, very disappointed when we were given
 18 a copy of it because it left us no better off. There
 19 was no answers in it at all.

20 **Q.** Moving forward in the chronology, it looks as though you
 21 phoned and spoke to a Sian Williams in February 2017,
 22 can you remember that, trying to follow up the report?
 23 We've got notes, they're her notes, of conversations
 24 about the report and whether people had it. Do you
 25 remember that or not, or do you think you did speak
 28

1 to --

2 **A.** I remember trying -- I remember trying to get our copy
3 and find out when we would get it, but I couldn't tell
4 you who I spoke to.

5 **Q.** Right; so you did phone the Countess. You had
6 solicitors, as well. So you remember that, trying to
7 get hold of that report?

8 **A.** Yeah.

9 **Q.** There's a letter -- again, it's in the bundle, my Lady,
10 at page 40 -- 8 February 2017, from a Mr Harvey. And
11 you tell us you don't remember receiving that letter.
12 This letter says, I'll read it to you, 8 February:
13 "Following on from your conversation with our Deputy
14 Director of Nursing Sian Williams on Friday, please find
15 enclosed a copy of our report. During this telephone
16 conversation, it was explained to you that we asked for
17 this external assessment from the Royal College of
18 Paediatrics and Child Health and the Royal College of
19 Nursing. This step was taken because we wanted to
20 better understand why there had been a greater number of
21 deaths than we would normally expect on our neonatal
22 unit between January 2015 and July 2016. In the report,
23 it describes no single cause or factor to explain the
24 increase we have seen in our mortality numbers. The
25 review makes a total of 24 recommendations across

29

1 **Q.** There's also a letter, 28 April 2017 -- page 46, my
2 Lady -- to Mother A&B, writing to pass on the results of
3 the independent external review regarding the care of
4 your baby.

5 Do you think that's the one that was sent, that you
6 got -- the report -- in April, or did it get it before
7 then, or you can't remember now?

8 **A.** I can't -- I remember we received it, but I couldn't
9 tell you when, to be honest.

10 **Q.** What appears -- and again, do you remember this or not,
11 say if you don't -- attached to that letter is
12 a one-page typed notes of Child A and with cause of
13 death unascertained. Do you remember getting that,
14 a summary --

15 **A.** No.

16 **Q.** -- in any report?

17 **A.** No.

18 **Q.** And it may be that you did, you just don't remember now.

19 **A.** It may be that I did, but I don't remember.

20 **Q.** You were, we can see, with the instruction of your
21 solicitor and your attendance at the inquest, trying to
22 find answers as to why Child A died. Did you feel at
23 any of these moments getting the report or communicating
24 with the hospital you got any answers?

25 **A.** No. It feels as if the more they tried to sort of --

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1 a range of areas, including compliance with standards,
2 staffing, competencies, leadership, team working and
3 culture. We are already working to implement these
4 recommendations."

5 And it continues. And it says at the end:
6 "We would really encourage you and your family to
7 have a meeting with us to discuss anything from the
8 report that you need further clarity on."

9 Do you remember getting any correspondence from
10 Mr Harvey or not?

11 **A.** I don't. I remember that we were supposed to have
12 a meeting with him but that it didn't happen. And
13 I think that was because that -- the police were brought
14 in and he was then not allowed to talk to us.

15 **Q.** So how did you get that report? Because you did get
16 that report in the end, didn't you?

17 **A.** Yeah. I got it through the post.

18 **Q.** So you were going to have a meeting but you couldn't
19 have. Why did you not have one, as far as you were
20 aware?

21 **A.** Because the police were called in, and we don't think he
22 was allowed to talk to us after that. I'm not certain
23 that that's the reason, but --

24 **Q.** You didn't have one?

25 **A.** No, we didn't have one.

30

1 like I say, with Dr Jayaram's reply to me and
2 everything, it just felt really half-hearted, and that's
3 why I wanted to say: we are human beings, and we'd lost
4 our child, and at no point did I think that anybody was
5 trying. I think it was just a case of: he was
6 a patient. He died. That's the end of it. Move on. I
7 don't think that they ever tried to understand how it
8 was affecting us, and the fact that we never had
9 a reason -- to me, it was really important for them to
10 try and do everything they could to give us a reason,
11 and to me, they just didn't care. They just did not
12 care. We weren't even -- I just didn't even feel like
13 they thought of us as people, that they thought of
14 Child A as an actual baby that had died. It was just
15 a patient.

16 **Q.** When you say "they didn't care", you obviously spoke to
17 Dr Saladi, Dr Brearey and Dr Jayaram at the inquest.
18 When you say "they", who do you mean by "they"? Do you
19 think -- do you include everyone at the hospital, or do
20 you think the doctors were talking with you and showed
21 care?

22 **A.** At the inquest, Dr Jayaram was -- approached us and was
23 very nice, and, you know, but just, in general, when we
24 were on -- I mean, what you have to understand is: I had
25 to walk through them doors and sit there all day every

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1 day to visit my child who was still alive. That was
 2 also the same place that I had to walk past where my
 3 other child had died. And I remember we were in the
 4 nursery once, and a new baby had been put in the
 5 incubator space where my little boy had been, and you
 6 can't help but look. You can't help it because there's
 7 now -- and he's a little boy. You can't help but look,
 8 and one of the nurses basically sort of said, "What are
 9 you looking at?" You know, it's just -- we are human
 10 beings, and we were looking because that is the space
 11 where our child was. And it's a human reaction,
 12 I think.

13 I had to go on to that unit for four weeks after I'd
 14 lost my child to try and care for my other child, and
 15 I don't think that they understood that. I just think
 16 that they just thought, like a conveyor belt, we're just
 17 a patient; we're not a person.

18 **Q.** Did any of the nurses have a conversation with you about
 19 how that felt?

20 **A.** A few of the nurses were brilliant. I can't lie. A few
 21 of them were brilliant. But I was being told to rest
 22 all the time. And I remember there was an incident
 23 where I actually shouted at one of the nurses because
 24 she'd -- every night when I would leave -- so I would
 25 wait until the night shift took over so I would know who

33

1 staff had witnessed blotching/mottling, travelling
 2 across Child A's chest and body. I was not aware of
 3 this at the time of Child A's death. When Child B
 4 collapsed, I saw mottling/blotching on her, as did the
 5 doctor, but I was not told, either then or subsequently,
 6 that the same or similar had been seen on Child A."

7 Can you tell us a bit more --

8 **A.** No, so I was told that he -- that she collapsed in the
 9 same way that he did.

10 **Q.** Right. So do you --

11 **A.** But not as -- [audio disruption]

12 Sorry, can you repeat that? I didn't catch that.

13 Did I see ...?

14 **Q.** You say there, you saw mottling/blotching on her. Did
 15 you see that? Can you remember that for Child B?

16 **A.** Yes. I even took a photo of it a day later, and you
 17 could see -- not as -- it wasn't as prominent, but I did
 18 take a photo the next day, and it was still there
 19 slightly --

20 **Q.** Did anyone ever discuss that with you at any stage, the
 21 rashes?

22 **A.** No. Well, at the time, the on-call consultant asked me
 23 if she could take a photograph of it because they hadn't
 24 seen it before. So I said yes. And by the time the
 25 nurse had gone to get the camera to take the photo, it

35

1 was looking after Child B. And every night, they would
 2 say, "Why don't you try and sleep tonight?" And as I --
 3 I just would sort of say, "I'll see. I'll see."

4 But then there was one night -- I can't remember
 5 even what had happened that day, but I was obviously not
 6 feeling good, and the nurse said to me, "Why don't you
 7 just sleep tonight?" And I turn around, and I shouted
 8 at her, and I said, "If I had my baby at home, I'd be
 9 awake every two hours. I need to do what I feel is
 10 right." And to me, to call and check on my child when I
 11 would have been awake feeding her, if she was at home
 12 with me, is the least I can do. And just because she's
 13 in hospital doesn't mean I'm not her mother.

14 But it was hard having people tell me what I should
 15 do. It was as if people forgot that they are my
 16 children. That's my child. And I know what's best for
 17 my child. But I was constantly being told what I should
 18 do, what I shouldn't do. There was just so many things,
 19 and you were made to feel -- you're not -- so we were
 20 told that we're the parents. We're the parents. It's
 21 up to us. But they were just words. We were never
 22 actually given any respect as the parents.

23 **Q.** You mention in your statement -- it's paragraph 44, my
 24 Lady:

25 "At Child A's inquest, I heard for the first time

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1 was resolving, so they didn't bother, which to me is
 2 only half a job because they should have taken a photo
 3 of it, especially knowing what we know now.

4 That could have been anything. That rash could have
 5 been absolutely anything. It could have been a deadly
 6 virus that was going to spread throughout the whole
 7 hospital, and it was just a case of: oh, it's gone now.
 8 Never mind. Which is why I took the photo the next day
 9 when I could still see it a bit.

10 **Q.** Moving on now to suspicions and concerns regarding
 11 Letby. When did you first know or have any indication
 12 there was suspicions about either deaths at the hospital
 13 or Letby's care of children?

14 **A.** When the police called me.

15 **Q.** And what did they tell you when they called you?

16 **A.** That they were brought in to investigate the number of
 17 deaths over the neonatal unit. They didn't tell us that
 18 they suspected a person. We thought that they were
 19 being called in because there'd been, you know,
 20 negligence, not enough staff or something wrong with the
 21 equipment, or ...

22 **Q.** And then --

23 **A.** They just told us they were going to investigate.

24 **Q.** You say in your statement at paragraph 91 -- that was
 25 December 2017 time that they first contacted you.

36

- 1 A. No, they contacted me before that.
 2 Q. Right, okay, so it was earlier.
 3 A. Yeah, it was earlier.
 4 Q. And were you assigned a police liaison officer?
 5 A. Yeah.
 6 Q. From that point onwards, did you ever have any
 7 correspondence from the hospital or not, when the police
 8 were involved?
 9 A. No.
 10 Q. Right. Did you --
 11 A. The only time that I had anything to do with the
 12 hospital was: Child B had to have follow-up
 13 appointments, as pre-term babies do, up to two years.
 14 Q. Yeah.
 15 A. But that was the only time. And while I was there,
 16 I would visit the nurses because, as I say, some of the
 17 nurses were absolutely brilliant. So I would take her
 18 in to see them so they could see how she was doing.
 19 Q. Bereavement counselling and support now. You tell us in
 20 your statement you were asked shortly after Child A's
 21 death if you wanted to speak to a bereavement
 22 counsellor, but your full focus was on the health of
 23 Child B. You told us that earlier as well.
 24 A. That's right.
 25 Q. Do you want to expand on that? What was the role, as

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- 1 I understand that Child A was the first one, and
 2 maybe they couldn't have stopped her for that one, but
 3 they most certainly could have for the rest of them, if
 4 they'd have had that CCTV in place.
 5 Q. You also give thought to the distressing situation when,
 6 effectively, you were phoning up about Child B and got
 7 information about another child's collapse, and you
 8 speak about the pragmatics of phone lines. How do you
 9 think that could be improved?
 10 A. It needs to be a separate number. It was the same phone
 11 number for consultants, for staff, for parents. And we
 12 were given the number -- it was called the parent line,
 13 which was supposed to be a separate line. But if that
 14 one wasn't answered, it would go straight to the other
 15 line. And that's how the mix-up with putting me on the
 16 phone to -- in a distressing situation with a child
 17 collapsing happened. It should be something completely
 18 separate.
 19 Q. You also mention that you always spoke to clinical
 20 registrars about your babies. We know you had some
 21 conversations with consultants, we've seen them in the
 22 notes.
 23 A. **(Witness nodded).**
 24 Q. But having more time with consultants --
 25 A. They only came because we caused a scene, and we

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- 1 far as you were concerned, of counselling at that point
 2 for you in your specific circumstances?
 3 A. To me, counselling just -- I couldn't even -- I couldn't
 4 be away from Child B, so how could I go and leave and
 5 have counselling? And if I opened the floodgates as to
 6 what happened Child A, I would be no good to Child B.
 7 I needed to be there for Child B. She was my main focus
 8 at that point. And that's the only reason that I kept
 9 going, was because of Child B.
 10 Q. And did you find yourself more anxious about her health,
 11 given what had happened?
 12 A. Very. Very, very, very anxious. Even now, I'm still
 13 very anxious about her health.
 14 Q. The Inquiry has asked you about your views on
 15 recommendations or what might have prevented crimes of
 16 Letby being committed. You refer to CCTV, and you say
 17 you'd like to see it used. What's your thinking about
 18 that? How could that have assisted you?
 19 A. Well, I think that it would have been a bit of
 20 a deterrent, or if not, we would have had a much clearer
 21 view of who was there and what happened at the time,
 22 without just people's statements or things like that.
 23 You would be able to see it for yourself who was there
 24 and what was happening, and it might never have happened
 25 again.

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- 1 shouldn't have to do that. You could never imagine what
 2 we were dealing with. We'd just lost one of our
 3 children, and nobody was telling us why, and then very
 4 shortly after, we very nearly lost our second child.
 5 And to me, the least that they could have done was set
 6 up a separate room for me and my partner and our child's
 7 consultant to sit down while we threw as many questions
 8 as we needed to them. And they didn't do that. It
 9 would be a case of: we would catch them on rounds, and
 10 it would always be the registrar. And it was only after
 11 I think they got sick of us that we managed to speak to
 12 a consultant.
 13 Q. You have already mentioned the mottling on the baby's
 14 skin never seen before. You say:
 15 "If it was an unprecedented presentation, it should
 16 have been investigated more thoroughly earlier on."
 17 A. Well, when I think about it, if you look at what
 18 happened with Covid, Covid spread worldwide, and lots of
 19 people lost their lives because of it. Nobody knew that
 20 that wasn't a disease that was going to kill thousands
 21 and thousands of people. And it seems like nobody
 22 cared. It should have -- the amount that came through,
 23 sitting through the trial, I know that there was -- I
 24 don't think there was a single member of staff that was
 25 called in the trial that said they'd seen it before,

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1 apart from other children related to this case. So why
2 was that not treated as something urgent that needed to
3 be looked into? It could have been something wrong with
4 the hospital equipment that was poisoning them, but
5 nobody checked. And for everybody to be so shocked and
6 never ever seen this before, why was something more not
7 done about it? Because it wasn't just Child A and
8 Child B.

9 **Q.** You --

10 **A.** They could have maybe stopped this sooner if they did
11 look into it properly.

12 **Q.** You also comment that the approach of staff on the unit
13 was to ask for your input on simple things like if they
14 could give your babies a dummy, but when it was bigger
15 issues such as the condition when they were born, or
16 cause and collapse, you didn't feel there was proper
17 consultation or discussion?

18 **A.** No, there wasn't. We -- as I said to you, they
19 explained to us: "Well, you're the parents, you know.
20 These are your babies," but it never once felt like
21 that. It was almost as if we were sort of -- they were
22 in control, and we were just there to visit.

23 **Q.** One of the recommendations you suggest, you say:

24 "I would hope psychological screening process is
25 implemented to assess any staff treating vulnerable

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1 up sooner.

2 **Q.** You mention you'd like to see better reporting on the
3 administration of medication; at least one child harmed
4 by unapproved administration of insulin.

5 **A.** Yeah.

6 **Q.** So that concerns you, the access to that drug and how it
7 can be used?

8 **A.** Well, it's not -- it's not necessarily just that. Like,
9 through sitting through the criminal trial, it came up
10 that there was -- one would sign and one would
11 administer, but they didn't necessarily go and stand
12 there while it was administered. And I understand that
13 that is supposed the rule, but it needs to be more -- it
14 needs to be better policed. It needs to be made sure
15 that that happens in a hundred per cent of cases. And,
16 again, that might have stopped what was happening,
17 because nobody could have done anything to a child if
18 there was another person stood there right next to them
19 while they were doing it.

20 **Q.** And finally, you say in your statement:

21 "I'd hoped that a formal process is implemented to
22 thoroughly investigate any unexplained death" carried
23 out by independent professionals not associated with the
24 staff involved.

25 Why do you think it's important that they're

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1 patients in the future. This would be screen of their
2 mental state to confirm they are fit to be treating
3 patients."

4 **A.** Yes, I agree with that.

5 **Q.** You suggested that. Why do you think it's important to
6 know something about the psychology or wellbeing of
7 people dealing with patients?

8 **A.** Well, because if there was an assessment done, or if
9 counselling was mandatory, whoever was talking to these
10 staff might have seen some red flags. Something might
11 have shown up in a discussion with these people, or in
12 an evaluation, that might have needed more monitoring or
13 maybe further assessment.

14 **Q.** You remember from the criminal trial learning that Letby
15 had texted her friends stating that Father A&B had
16 collapsed to the floor when she had taken Child A for
17 the post-mortem. Was that true, that that had happened?

18 **A.** No, it's not true. And this is what -- this is why my
19 point about psychological evaluation is very valid.
20 That's not normal. It was -- there was several text
21 messages that came out through the trial that were lies,
22 and it was -- to me, it was attention seeking, and
23 I think that that would have -- that should really have
24 been a red flag. And if somebody had been checking in
25 with her and assessing her, maybe that would have come

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1 independent and not from the same hospital if they're
2 investigating something at the hospital?

3 **A.** Well, because the staff at the hospital have
4 a relationship with each other. And obviously, it's
5 going to -- as it did with the criminal trial, it took
6 a long time before people even suspected because she was
7 their friend. And if you're an independent person,
8 you've got nothing to do with any of the people,
9 including the bosses. The bosses could be covering.
10 Friends cover for each other. If you're an independent
11 person, you don't care about any of that; you're just
12 looking at facts and finding out what really happened.
13 And if somebody impartial who had nothing to do with
14 anybody on that unit had have come in sooner, who knows.

15 **Q.** Mother A&B, they are all my --

16 **A.** I just think it needs to be -- sorry?

17 **Q.** Finish what you were saying. You think it needs to be
18 someone...?

19 **A.** Independent, who's not associated. I mean, I'm not
20 saying that it's somebody from completely outside of the
21 hospital, necessarily, but the doctors and nurses and
22 consultants on the neonatal unit work with each other;
23 they have relationships. And I just think if it's
24 somebody that is not involved in that, there's no
25 emotion to it. It's just strictly looking at what

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1 happened.

2 **Q.** They are all the questions I have for you, Mother A&B.

3 Is there anything you would like to add that I perhaps

4 haven't asked you about, or something else that you

5 would like the judge to know about?

6 **A.** Just on the -- you know how I was saying about the

7 independent review, I also think that there needs to be

8 given more information to the parents, because as I've

9 stressed the whole time, we are people, and that is our

10 child. That's our world. And I was never given an

11 opportunity to sit in an official setting and ask

12 questions that I wanted answered. It was almost -- and

13 they didn't -- they didn't roll their eyes, but you know

14 that's how I felt. Like: "Here comes this woman again

15 asking the same questions that we can't answer" and

16 never even tried to answer. And we were just supposed

17 to accept that one of the most important things in the

18 world to us was gone, and that's it.

19 So I think, in hindsight, there needs to be more

20 emphasis on treating parents as individuals. As I said,

21 some of the parents on the neonatal unit probably had

22 a great experience, but I didn't. I lost a child on

23 that unit. And there was never any thought given, when

24 I walked through them doors every day, that I had lost

25 a child on that unit, you know. There was never any

45

1 a person, and they are my babies, and I've lost one of

2 them, and I very nearly lost one of the others. And

3 that's what needs to be at the focus of everything, not

4 Lucy Letby. Why is anybody talking or thinking about

5 her? We're human beings, and that's how we should have

6 always been treated.

7 **Q.** That concludes your evidence from my perspective. What

8 we're going to do is, we're going to stop now, the Chair

9 is going to leave the room, your lawyers will have

10 a conversation and may have some more questions or may

11 not. But if you maybe go and have a cup of tea or

12 something and come back in ten minutes, the link will

13 still be here, and we'll know if there's more questions

14 or if we will be concluding. Does that work for you?

15 **A.** Okay.

16 **Q.** Does that work for you?

17 **A.** Yeah. I'll go and grab a drink and have a walk around

18 the house.

19 **Q.** Yes, exactly. Okay, see you shortly.

20 **A.** Okay, thank you.

21 (11.17 am)

22 (A short break)

23 (11.40 am)

24 **LADY JUSTICE THIRLWALL:** Welcome back Mother A&B.

25 I understand there are going to be some more questions

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1 thought given to that. And I just think, instead of

2 treating me as this hysterical woman, put yourself in my

3 shoes. How you would feel if you had to walk into the

4 place every day where your child died. And I would have

5 done it because obviously Child B was there, so nothing

6 would have kept me out of that unit, but it was hard.

7 It was really hard.

8 And I just think, treat us as people because that's

9 what we are. And not everybody is under the same

10 circumstances. And if I'm asking a question over and

11 over again, it's because I need an answer. I need you

12 to -- I need to know that you care. I need you to know

13 that Child B and Child A are people. They're the most

14 important people in my life. And I just think that that

15 is something that's been overlooked through this whole

16 process, in the press, in the trial. We had to act a

17 certain way in the trial. We couldn't just be the

18 parents of these babies. And all we want to do -- all

19 we want to do is find out what happened, and we never

20 ever want it to happen again.

21 And it just feels like we have been given no power

22 throughout this whole process, throughout all this time.

23 We've got no power. And I just think that this Inquiry

24 is finally the chance that we are listened to, and we

25 can give our side of things. And my side of it is: I am

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1 for you, so I hope you've had a drink and a chance to

2 relax insofar as anyone can do that.

3 **A.** Okay, thank you.

4 **LADY JUSTICE THIRLWALL:** Now, Mr Skelton?

5 **Questioned by MR SKELTON**

6 **MR SKELTON:** Mother A&B, may I ask you just briefly about

7 Child B again.

8 In your statement, you describe wanting to stay with

9 her after Child A had died.

10 **A.** Yes.

11 **Q.** And could you describe what happened the first time you

12 left her.

13 **A.** She collapsed and had to be resuscitated and was

14 attempted to be murdered.

15 **Q.** What did you feel about the fact that that occurred the

16 only time you weren't there?

17 **A.** It was an absolute nightmare. I just -- my brain -- my

18 first thought was: "Not again", and that night,

19 I refused to leave the bedside all night. And the whole

20 time that Child B was in hospital, that is the best

21 night's sleep I'd ever got because I was right there

22 with her.

23 **Q.** You mention in the statement at paragraph 52, and you

24 have mentioned in evidence in answer to Ms Langdale,

25 that you recall her having a particular rash that you

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1 took a photograph of.
 2 **A.** Yes.
 3 **Q.** What had you been told about Child A and whether or not
 4 he had had a rash of a similar type?
 5 **A.** I was -- all I was told in the similarities between
 6 Child A and Child B was the way that they collapsed.
 7 The only difference between Child A and Child B's
 8 collapse was her -- I can't remember if it was her
 9 oxygen rate or her heart rate didn't drop as rapidly, so
 10 they were able to bring her back --
 11 **Q.** If you --
 12 **A.** -- but I was not told about Child A's rash.
 13 **Q.** If you had been told about the similar-type rash, what
 14 would you have done?
 15 **A.** Well, I would have demanded that something was done.
 16 I understand that there was a lot of discussion about my
 17 condition, but for some -- a consultant to tell me they
 18 had never seen this before, that indicates that
 19 something is seriously wrong. Seriously wrong. And for
 20 it -- it wasn't just a one-off; it happened with Child A
 21 and then the very next day with Child B.
 22 **Q.** So would it be --
 23 **A.** That, to me, indicates that something is wrong and it
 24 should have been looked into.
 25 **Q.** I'm going to turn now to a wider issue. When did you

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1 into those deaths specifically; it was a review into the
 2 neonatal unit, and there should have been a review of
 3 those deaths.
 4 **Q.** Over time in --
 5 **A.** Not just of the unit. Sorry.
 6 **Q.** It's quite all right. Over time in 2015, the doctors
 7 begin to suspect that one member of staff is connected
 8 to the deaths and collapses, and as you now know, that's
 9 Letby. Would you have wanted to know about their
 10 suspicions about that connection sooner than when you
 11 were first contacted by the police?
 12 **A.** Definitely.
 13 **Q.** Again, if you had been told that they thought a member
 14 of staff was responsible and possibly even harming the
 15 babies deliberately, what would you have done?
 16 **A.** I'd have been on the phone to the police every day
 17 asking what was happening. When was somebody going to
 18 be charged? You have to understand, we have been
 19 told -- we were told and made to believe that there
 20 was -- it was unexpected and unexplained. But it wasn't
 21 unexpected or unexplained. It was a person. And I have
 22 lived with guilt that it could have been my fault or
 23 that we should have done more for years. And it wasn't
 24 until we were told it is -- somebody is responsible. As
 25 heartbreaking as that is, it's an answer, which is

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1 first become aware that there had been an unexpected
 2 increase in mortality in the neonatal unit?
 3 **A.** When the police were called.
 4 **Q.** Would you have wanted to know about that increase in
 5 mortality much sooner?
 6 **A.** Yes, because maybe then it would have been easier for us
 7 as parents to push for something more to be done.
 8 **Q.** Would you have expected to have been told about it in
 9 2015 when it became a concern internally within the
 10 hospital?
 11 **A.** Well, we attended an inquest in 2016, and it was not
 12 even mentioned then, and it had clearly -- it clearly
 13 had been an increase of a lot by then, and it still was
 14 not mentioned.
 15 **Q.** I'll come on to the inquest in a minute, but just
 16 focusing on 2015, if you had been told that there'd been
 17 an unusual spike in the deaths on the unit in 2015, what
 18 would you have wanted to have happen?
 19 **A.** The same as I would have wanted to have happened as soon
 20 as it happened with -- twice with Child A and Child B:
 21 an investigation. A thorough investigation. Not just
 22 looking into the unit as a whole; looking into those
 23 deaths.

24 I understand that there was a report given to us
 25 that was an independent review, but it was not a review

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1 something that we were never given.
 2 **Q.** Many months after those suspicions arose, the inquest
 3 took place into Child A's death on 10 October 2016. Are
 4 you surprised now that that -- the concerns that the
 5 consultants had about a particular member of staff, Lucy
 6 Letby, weren't raised with the coroner?
 7 **A.** Very concerned. Very, very concerned. At the inquest,
 8 we had no idea, and from the trial we know that by that
 9 time they did suspect her, but nobody mentioned it, not
 10 once, and they should have.
 11 **Q.** The note that's made of the inquest records that
 12 Dr Jayaram mentioned an independent review. Was that
 13 the first you'd heard about that?
 14 **A.** Yes.
 15 **Q.** Again, and I know I'm repeating this question, but had
 16 you been told the hospital were conducting or asked for
 17 an independent review to have been conducted, what would
 18 you have wanted to have said or done?
 19 **A.** I'd like to have been more involved. I'd like them to
 20 have spoken to us. Because maybe we could have shed
 21 some more light on it. We could have brought [audio
 22 disruption] just would have liked to have been more
 23 involved, rather than -- as I say, there's records of me
 24 trying to chase up the review and was just told: well,
 25 that's important document that I would have got some

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1 answers as to what would have happened to Child A.
 2 **Q.** Can you remember when you first got a copy of the report
 3 from that review, which was undertaken by the Royal
 4 College of Paediatrics and Child Health?
 5 **A.** I can't remember the exact date, to be honest.
 6 **Q.** It might have been in about February 2017. Do you
 7 remember seeing that document?
 8 **A.** I do remember seeing it, yeah. It was like a booklet.
 9 **Q.** Did it make any mention of concerns or suspicions about
 10 any particular member of staff?
 11 **A.** No.
 12 **Q.** Have you since --
 13 **A.** The only concern that was raised was staffing levels.
 14 **Q.** Did you subsequently become aware that there was another
 15 version of the report that did have a section on those
 16 concerns about that member of staff?
 17 **A.** No.
 18 **Q.** How do you feel about the fact that there were two
 19 versions of the report, one of which was given to you
 20 and others parents which didn't mention concerns about
 21 Nurse L, as she is termed in the report, and then
 22 another version which does deal with those concerns?
 23 **A.** We had a right to know. As I explained before, they are
 24 our babies. We had a right to know. And we were
 25 being -- well, I was made to believe that that report

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1 though, because towards the end of your evidence you
 2 said that you and he felt powerless during the whole of
 3 the experiences you have described, and that's a very
 4 interesting and I'm sure accurate observation.
 5 But what I'd like you to know is that your evidence
 6 today is amongst the most powerful I have ever heard.
 7 I'll just say a little bit more because you caused
 8 me to reflect a bit.
 9 Obviously, the love that you and your partner have
 10 for your children shines through, as is your -- as does
 11 your determination to make a difference to people in the
 12 future. And you've really reflected on what happened to
 13 you and how it could and should have been very
 14 different. The expression you used was: "They should
 15 have put themselves in our shoes". And that obviously
 16 is an insightful observation and one which I thought
 17 I would consider as people explain to me in due course
 18 how they behaved at various stages.
 19 I'll give very careful consideration to all your
 20 practical and thoughtful suggestions for change that
 21 already you have made a difference and you will achieve
 22 change. Thank you very much indeed.

23 (11.52 am)

(The Short Adjournment)

24 (2.00 pm)

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1 was the report. I never knew that there was another
 2 version of it that explained concerns.
 3 **Q.** The report that you didn't see contains a section, as
 4 I've mentioned, on Nurse L in which it's said that the
 5 consultants had made allegations about her resulting in
 6 her being removed from the unit and that they had a gut
 7 feeling that she was involved with, and linked to, the
 8 deaths, but they hadn't found evidence to demonstrate
 9 that. What's your response to that?
 10 **A.** It's mixed feelings, because I'm forever grateful
 11 because the consultants did speak up and did say
 12 something, but it's also very sad that nothing was ever
 13 shared with us.
 14 **Q.** Thank you, Mother A&B. Is there anything you'd like to
 15 add or ask arising from the questions that I've just
 16 asked you?
 17 **A.** No.
 18 **MR SKELTON:** Thank you, my Lady.
 19 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
 20 Mother A&B, that's the end of your evidence.
 21 I can't thank you enough for coming and giving your
 22 evidence today. And you've helped me really begin to
 23 get to profoundly understand your experiences and that
 24 of your partner.
 25 There is just something I'd like to say to you,

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1 **MS LANGDALE:** May I call Mother C.
 2 **LADY JUSTICE THIRLWALL:** Yes, please.
 3 **MS LANGDALE:** And may the witness be sworn.
 4 **MOTHER C (affirmed)**
 5 **Questioned by MS LANGDALE**
 6 **LADY JUSTICE THIRLWALL:** Thank you very much indeed. Just
 7 before we begin, I am conscious that there is an audio
 8 link this afternoon, so I just want to make one thing
 9 very clear. The accredited media and the Core
 10 Participants have an audio link to this afternoon's
 11 hearings. There is no delay on the link. As a result,
 12 we must all be scrupulous to avoid any reference and any
 13 inadvertent breach of the orders of the Crown Court.
 14 The media knows which people must not be identified, and
 15 if there is any breach the information which has been
 16 referred to in error must not be reported. This
 17 includes, of course, information which may lead to
 18 a jigsaw identification of the people named in the
 19 orders. All such information will be removed from the
 20 transcript before it goes up on to the website.
 21 Thank you.
 22 Ms Langdale.
 23 **MS LANGDALE:** Mother C, you have prepared a statement dated
 24 4 July 2024 for the Inquiry, and can you confirm the
 25 contents are true and accurate, as far as you are

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1 concerned?

2 **A.** Yes, they are.

3 **Q.** I am going to take you now, if I may, through that
4 statement and take you to some other documents that you
5 refer to in the statement as well.

6 **A.** Okay.

7 **Q.** You begin by setting out your baby's delivery and your
8 pregnancy. Can you tell us about the circumstances of
9 your pregnancy, how it was going, and the care you
10 received there?

11 **A.** Yeah, so my pregnancy with Child C was my first
12 pregnancy, and it wasn't going very well, unfortunately.
13 I went for my routine 20-week scan at the Countess of
14 Chester Hospital, and we were told at that scan that my
15 baby was measuring much smaller than would be expected,
16 and so from that point on, we were very closely
17 monitored under the care of foetal medicine, that was
18 predominantly Jim McCormack, and the foetal medicine
19 midwife at the time was Jill Ellis. They saw us very
20 regularly and gave us really excellent support, we were
21 very grateful for that, but the pregnancy was very
22 precarious, really. The scans were to monitor growth
23 but also to monitor blood flow to weight, up until the
24 point where the situation was critical and the baby
25 would need delivery. So it was made very clear that my

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1 necessary. He said that he would monitor things closely
2 and that if that changed then we would change the plan,
3 and I completely trusted him and his judgment.

4 **Q.** When Child C was delivered by caesarean, when did you
5 see him, and where did you go next?

6 **A.** So when he was delivered, I heard him cry, so I knew
7 that he'd been born, you know, breathing and screaming,
8 like I had hoped. But I didn't see him when I was in
9 theatre. He was sort of whisked off to the neonatal
10 unit. And my caesarean was completed, and then I was
11 taken up to the postnatal ward where I was told that
12 I was not allowed to go down and see him until I was
13 able to stand unassisted. I'd had an anaesthetic into
14 my spine, so my legs were numb, and I was in pain and
15 recovering.

16 I hadn't anticipated that I wasn't going to be able
17 to see him, so this was really upsetting. My husband
18 was up and down to the neonatal unit sort of seeing him
19 and taking photographs and bringing the photographs up,
20 but it was quite a difficult kind of disconnecting
21 experience to be not allowed to see him in person for
22 some hours. So it was later on that day, I would
23 estimate maybe six or seven hours after his birth,
24 that I forced myself to stand because I needed to go and
25 see him. The neonatal unit was on a different floor of

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1 baby was going to be born early and that that would have
2 to be by caesarean section. So I felt the communication
3 and the support was really excellent, to be honest, but
4 it was a very scary time.

5 **Q.** And it was a day in June 2015 when you'd been in for a
6 scan, in fact, with Mr McCormack that the delivery
7 ensued; is that right?

8 **A.** Yes. So I -- in these kind of routine -- well, in these
9 monitoring appointments that I was having -- I'd been
10 for one on 5 June -- Mr McCormack was actually on
11 holiday. It was Sara Brigham that I saw that day, and
12 she felt that I needed admission to hospital for the
13 remainder of my pregnancy because some of the parameters
14 had worsened. So I was admitted on that day, and it was
15 the following week that things had become critical.
16 Mr McCormack was seeing me daily, things had become
17 critical, and he said that delivery needed to happen
18 that day.

19 **Q.** Was there any discussion about where the delivery should
20 take place, which hospital, and why?

21 **A.** So prior to my admission to hospital -- so I couldn't
22 tell you exactly when, but during that pregnancy, I did
23 ask Mr McCormack at one point whether I needed
24 a transfer to somewhere like Liverpool Women's or
25 a different unit, but he didn't feel that that was

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1 the hospital, so it did represent some challenge with
2 that.

3 **Q.** And how did you hear how your son was in those few
4 hours? Via his father, or via a doctor, or did anyone
5 talk to you about how he was?

6 **A.** Yeah, so my husband was up and down, so he was kind of
7 updating me a little bit, but we had some updates from
8 Dr Sally Ogden, who was the registrar, so she came and
9 spoke to me in theatre a couple of times to sort of say
10 where things were up to, and she let me know that he was
11 doing really well, he was born in good condition, and
12 that he had had a brief period where he was ventilated
13 so that he could have surfactant, which helps the lung
14 development, but that he was fighting it so much and
15 that he was so lively that they didn't feel that
16 ventilating him was necessary, so this was only for
17 a brief period, so he was breathing by himself.

18 **Q.** You say in paragraph 6 of your statement that Dr Gibbs
19 was present a lot on the ward and spoke to you a number
20 of times over Child C's short life. What did he say to
21 you about how he was?

22 **A.** So I don't recall seeing Dr Gibbs on the day that he was
23 born, but in subsequent days, certainly we saw him a
24 number of times on the ward, and we felt that he was
25 very open and honest with us, that Child C was very

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1 small for his gestation and that that represented
2 certain risks such as an increased risk of developing
3 infection and an increased risk of a particular bowel
4 complication called necrotising enterocolitis, but that
5 he was born in very good condition, he was making good
6 progress, and he was doing well.

7 He expressed to us that although babies of that
8 gestation and that -- well, that size at that
9 gestation -- were at risk of these complications that
10 his prognosis was good and that he was not expected to
11 die, certainly, and he made that very clear to us.

12 **Q.** I think it was on the second day of his life that you
13 were able to hold him for the first time?

14 **A.** Yes.

15 **Q.** How was he, and how was that?

16 **A.** We've got sort of videos and photographs of that day.
17 It was -- it was really overwhelming, actually, to hold
18 him in. We'd had a very difficult pregnancy, and there
19 were times in that pregnancy that I didn't know whether
20 he would be born alive, you know, so to hold him was
21 a really big thing for us. It was very emotional, and
22 I -- you know, I hadn't had a baby before, and I didn't
23 really anticipate all the feelings that I would have
24 when I held him, and that immediate bond that you feel
25 that, you know, I couldn't describe now but I certainly

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1 back up to go to bed. You know, I was actually quite
2 exhausted. We'd spent all day on the unit, and I was
3 still recovering from my surgery. So I would estimate
4 I went up to bed shortly after ten o'clock, maybe half
5 past ten, and I was asleep. And shortly after
6 11 o'clock, the door to my room was flung open by
7 a midwife on the postnatal ward who was really panicked
8 and was telling me that I needed to come immediately
9 because my son had become unwell really quickly.

10 And I remember the absolute shock that I felt at
11 that time. I was really disoriented. I'd been woken up
12 from my first sleep. I assumed -- my first assumption
13 was that perhaps she'd got the wrong room because this
14 was so out of the blue, so unexpected. I was kind of
15 trying to get my bearings. I remember saying to her,
16 you know: "Do you mean me? Are you sure you're talking
17 about my baby?" And she said, "Yes," and that I needed
18 to come. So we made our way down to the unit. I was in
19 a lot of pain, but the adrenaline sort of took over at
20 that point.

21 **Q.** And when you went back to the unit, you say you walked
22 straight into the intensive care room where Child C was.
23 What did you find there?

24 **A.** I'd phoned my husband on the way to the unit, but when
25 I walked in, I think -- I didn't really know what to

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1 didn't anticipate. It was a really amazing feeling.

2 **Q.** Was there a time when it was decided he was able to have
3 his first milk feed?

4 **A.** Yes. So we'd had a few days where he was nil by mouth
5 and receiving nutrition via his lines. Because of his
6 sort of size and gestation, they felt that they needed
7 to rest the bowel to reduce his risk of complications.

8 So it was on 13 June so his (*redacted*) -- (*redacted*) day
9 of life that he was given his first milk feed. We'd had
10 a really good day that day. We'd spent a lot of time
11 holding him. My parents had come in to visit, which --
12 we'd not had anybody in to visit until that point
13 because we wanted to kind of settle in ourselves, and we
14 wanted our privacy, but because things were going so
15 well, they'd come to visit that day. John Gibbs had
16 come to see us and had said, you know, if this day
17 continues to go well, then we'll give him his first milk
18 feed this evening, which is what happened.

19 **Q.** And then on the evening of 13 June, your husband set off
20 home, and you went to express some milk.

21 **A.** Yeah.

22 **Q.** What happened later that evening?

23 **A.** So I'd been expressing since he was born, so I'd gone to
24 express before going to bed. So having expressed the
25 milk, I went down to say goodnight to him, and then went

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1 expect because I'd had this sort of panicked midwife
2 waking me up from sleep, but what I was faced with
3 was -- it just -- it was awful, and it took me
4 completely by surprise, you know. There were medical
5 personnel everywhere. There were numerous doctors and
6 nurses. Where Child C had been, in an incubator with
7 the glass sides up the whole time that we'd visited him,
8 the sides were down. They were doing CPR on him. And
9 it was extremely -- it was extremely busy, you know.
10 Alarms were going off. And I really struggled to take
11 it in.

12 So I was ushered to a seat several feet away but
13 within the same room by a nurse, and I sort of sat down
14 there because I was aware that I was in a lot of pain as
15 well.

16 **Q.** When you went down and were met with that scene, you say
17 a nurse came and asked you if you wanted the priest.

18 **A.** Yeah.

19 **Q.** Tell us about that.

20 **A.** So when I was sat on this chair several feet away, a
21 nurse I hadn't seen before, who I'd had no previous
22 interaction with, just asked me, you know, "Would you
23 like me to call a priest?" And even though I was faced
24 with a situation where my son was having CPR, I was
25 still quite confused and disorientated as to what was

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1 going on, and until I was asked that question, it really
 2 didn't hit me that there was a chance he was going to
 3 die, which sounds probably quite strange, but I just --
 4 my thoughts hadn't kind of caught up yet. So I asked
 5 her. I said, you know, "Do you think he's going to
 6 die?" And she said, "Yes, I think so." And at the
 7 time -- you know, as I say, I didn't know this nurse's
 8 name, I hadn't seen her before, but I believe this was
 9 Lucy Letby.

10 **Q.** And when she said, "I think so", how did you feel?

11 **A.** I completely shut down, to be honest, at that point.
 12 From then on, that evening, I struggled to absorb a lot
 13 of what was going on, you know. I just went into
 14 complete panic mode, you know, I couldn't -- I just
 15 couldn't take things in properly. None of the medical
 16 personnel there, apart from John Gibbs, were people that
 17 we'd met before, you know. We hadn't been on the unit
 18 for very long, and at this point, I was still waiting
 19 for my husband to arrive, so I was on my own. It wasn't
 20 a question that I'd ever thought about being asked, so
 21 I struggled to know how to really answer it. So the
 22 rest of the evening really is fractions of memory, and
 23 then lots of blurred feelings of panic, really.

24 **Q.** After Child C was baptised, resuscitation efforts
 25 ceased, didn't they?

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1 that there'd been such a significant amount of time
 2 where he hadn't had any oxygen that, you know, we just
 3 wanted him to be kept comfortable at this point.

4 **Q.** And did -- was he made more comfortable?

5 **A.** Well, we contacted our parents, who came in and sat with
 6 us. We were sent to a family room, and we were all
 7 getting quite upset, obviously, because of the situation
 8 anyway, but because Child C was making some kind of
 9 noises, some distressed, whimpering noises that were
 10 really difficult to witness and to hear, so I went to
 11 the nurses' station and asked the registrar, Dr Davies,
 12 whether something could be given to settle him because
 13 I felt that he was in pain. You know, he'd had
 14 resuscitation for around an hour, you know. That would
 15 be painful for anybody. And I was told that that isn't
 16 something that they usually do for neonates. And I sort
 17 of felt I had to push it a little bit because I didn't
 18 want my son to die in pain, and I felt that he was in
 19 pain, and there was no -- there was nobody that was
 20 going to tell me that he wasn't. You know, that's how
 21 I felt as his mother. So she said she would speak to
 22 Dr Gibbs, and shortly after, one of the nurses came and
 23 gave him some morphine, and that did work, and that did
 24 settle him.

25 **Q.** You're in a family room at this point --

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1 **A.** Yes.

2 **Q.** Tell us about what happened then.

3 **A.** So there was quite a long wait, actually, for the
 4 baptism, and during this time, the type of resuscitation
 5 that was being performed was sort of slowed down so that
 6 it was more what John Gibbs has described as a token
 7 resuscitation, which I would agree with. It wasn't
 8 something that was actually meant to resuscitate him any
 9 more because they'd tried everything that they could up
 10 until that point.

11 And after he'd been baptised, he was handed to us,
 12 and I remember my husband holding him, and I sort of put
 13 my hand on his arm, and I could feel a pulse at his
 14 elbow, and I thought, you know, he's not -- he's not
 15 died, you know. He's still alive. But he was obviously
 16 not the same baby that he'd been some hours before. He
 17 was, you know, floppy and grey and not responding in any
 18 way.

19 And John Gibbs had a conversation with us about, you
 20 know, what we would like for him. What would be our
 21 thoughts and feelings about what happens next. And we'd
 22 had this very difficult pregnancy, followed by this
 23 really sudden, awful situation, and we'd witnessed this
 24 very long period of attempts at resuscitation, and we
 25 all felt that everything reasonable had been done and

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1 **A.** Yes.

2 **Q.** -- are you, together, and you say:

3 "Two nurses were in and out to see us, one called
 4 Melanie Taylor, and the other being Lucy Letby."

5 **A.** Yeah.

6 **Q.** What were they doing?

7 **A.** So there were various things that they were involved
 8 with, so one of them being the administration of
 9 morphine when it was needed, another being creating
 10 things for a memory box. So taking Child C's hand and
 11 footprints, taking a bit of his hair, and checking on
 12 us. So my understanding at that time was that they were
 13 designated to do that, and it was only at the criminal
 14 trial that I realised that that was not the case, that
 15 Lucy Letby was specifically designated not to do that,
 16 and she was supposed to be somewhere else and was
 17 repeatedly told to be looking after a different child.
 18 So that's been quite a difficult thing to learn through
 19 this process that, you know, that was something that was
 20 not supposed to be happening at that time.

21 **Q.** Had you seen Melanie Taylor before, either of the nurses
 22 before, or not?

23 **A.** I don't believe we had met Melanie Taylor before that
 24 night. I don't think we had, no.

25 **Q.** Was that the first time you heard that, at the criminal

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1 trial, that she wasn't supposed to be looking after
 2 Child C?
 3 **A.** Yes.
 4 **Q.** Your husband has said in your joint statement:
 5 "At some point while Child C was dying, I remember
 6 a nurse plugging in a 'cold cot', a ventilated Moses
 7 basket, in the corner of the room ..."
 8 And he said this:
 9 "I vividly remember when Lucy Letby prompted me to
 10 place Child C in the cold cot. At the time, I reacted
 11 curtly to her suggestion, and she promptly removed
 12 herself from the family room. My mother-in-law also
 13 recalls this incident. Reflecting on it now, I believe
 14 she wanted to savour my son's dying moments for herself,
 15 which fills me with both emotion and anger. Had I not
 16 challenged her, she would have further intruded on our
 17 private goodbye to Child C."
 18 **A.** Yeah.
 19 **Q.** Do you have any recollection now of her presence and
 20 doing that?
 21 **A.** I do. It's not something that I recollected at the time
 22 of my police statement spontaneously, but when I read
 23 Father C's police statement, I do have memories of that.
 24 They are not as clear as his. I remember the cold cot
 25 being plugged in, and it was actually next to my

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1 **Q.** You say at paragraph 16 of your statement:
 2 "During the events of this night Dr Gibbs had
 3 advised us of the need for a post-mortem examination due
 4 to the sudden, unexpected and inexplicable nature of
 5 Child C's collapse, and that we would hear from the
 6 coroner's office with regards to this."
 7 **A.** Yes.
 8 **Q.** So Dr Gibbs told you that immediately, in effect?
 9 **A.** Yes. Yes, he did. One thing that I remember that night
 10 was him sort of running through a list of causes of
 11 collapse out loud and sort of stating each one that
 12 wasn't applicable, and he sort of ran out of things in
 13 the list. So he was very, very clear on that night that
 14 this was not something that had been expected, and that
 15 he had no explanation, and that he was perplexed as to
 16 how Child C hadn't responded at all to very vigorous
 17 resuscitation and then had these signs of life later.
 18 **Q.** Well, he wrote to you, didn't he? If we look at page 23
 19 in this bundle, on the 20 July 2015, Dr Gibbs writes to
 20 Mother and Father C. It says at the beginning:
 21 "I expect you are still coming to terms with
 22 Child C's sad death ..."
 23 And invites a meeting.
 24 **A.** Yes.
 25 **Q.** If we go over the page at 24, three paragraphs down, he

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1 mother's legs, and she complained about it because it
 2 sort of makes a noise, and it's very cold, and we were
 3 in this really difficult situation where, you know, our
 4 son was dying, and it was certainly jumping the gun to
 5 bring that in and plug it in. And I remember snapping
 6 at one of the nurses, but I couldn't give any more
 7 specific detail than that. I do know that my mother
 8 made a complaint to the Bereavement Office, I think just
 9 a verbal one by phone call, to say that that must never
 10 happen to anybody else, that, you know, when a child is
 11 dying, you shouldn't come in and plug in a basket for
 12 when they are deceased to put them in it.
 13 **Q.** After Child C died, you were given a memory box. Tell
 14 us about the memory box and how that was put together,
 15 what was in it, and who was doing that.
 16 **A.** Yeah, so that memory box was put together by Melanie
 17 Taylor and Lucy Letby, and it consisted of hand and
 18 footprints that were sort of ink on paper. It had some
 19 clay hand and footprints. It had a little box with some
 20 of Child C's hair and some water from the baptism. It
 21 had a teddy with it, as well, and the blankets that had
 22 been used during that evening, a hat and a little dummy.
 23 **Q.** So all of the physical memories of your son in that.
 24 **A.** Yes, so I haven't got any physical memories of my son
 25 that were not packed in that box by Lucy Letby.

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1 explains:
 2 "You might be aware that in addition to any sudden
 3 and unexpected death needing to be reported to the
 4 Coroner, there is also a separate investigative process
 5 that needs to be undertaken for every sudden unexpected
 6 death in infancy. This is known as the SUDI (Sudden
 7 Unexpected Death in Infancy) process."
 8 He sets out:
 9 "I'm afraid that one important aspect of the SUDI
 10 process is to consider whether an infant's (or older
 11 child's) death could possibly have been due to child
 12 abuse and also whether there are safeguarding
 13 implications for any other children in the family.
 14 Clearly, there are no child protection or safeguarding
 15 concerns related to Child C's death, but the SUDI
 16 process, albeit in an abbreviated version, has to be
 17 followed for every sudden and unexpected death in an
 18 infant."
 19 And he goes on to say at the end of that page that
 20 it was a sudden and unexpected death, again.
 21 **A.** Yes.
 22 **Q.** So when you read this letter, what messages did you take
 23 from this? It was the invitation to the meeting, but
 24 what was being said in this letter, as far as you were
 25 concerned?

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- 1 A. I was still very much deep in grief when receiving any
2 of the correspondence, really, that we're going to talk
3 about. But this supported what we'd been told in
4 person, you know, that this was unexpected and
5 unexplained. So I just took from this that this was the
6 process that was kind of expected following that,
7 really, just the meetings that were going to happen that
8 were sort of standard meetings in these kind of
9 circumstances. So I didn't think too deeply, really,
10 about the fact that these -- what sounded like fairly
11 standard routine meetings for unexpected events were
12 going to happen.
- 13 Q. And we know from your statement that in fact you had two
14 meetings on 21 August 2015. One was with Dr McCormack,
15 and another one with Dr Gibbs.
- 16 A. Yeah.
- 17 Q. You set out at paragraph 17 the one with Dr McCormack,
18 and if you want to -- I'm not suggesting you need to --
19 the notes of that meeting are at 27 and 28 in the
20 bundle. But what did Dr McCormack say to you in that
21 meeting?
- 22 A. So as I've alluded to already earlier on, you know, he
23 was always a great support to us, and when we met with
24 him at this point, it was no different. He expressed
25 his shock at what had happened and his surprise, really,

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- 1 unexpected when he experienced a cardiorespiratory
2 arrest at the end of the (*redacted*) day of life."
- 3 In the paragraph above that, he refers to what you
4 referred to earlier and says that when the resuscitation
5 efforts were being made, he says:
- 6 "By that stage, a little surprisingly, Child C did
7 have a weak pulse and was making gasping respiratory
8 efforts."
- 9 A. Yes.
- 10 Q. What did you make of that at the time? You know now of
11 the significance of that. When you read that, what did
12 you understand by that?
- 13 A. I wasn't really in a position to consider anything we
14 were being told in great depth at that point because
15 I was trying very much to deal with this intense grief.
16 I felt that Dr Gibbs was quite perplexed as to what had
17 happened and why. I feel this letter reflects that,
18 reflects the fact that he couldn't explain or didn't
19 understand why Child C had collapsed in the first place
20 but also then didn't respond as expected but then showed
21 signs of life later. He made it very clear to us that
22 he found that very unusual, but I didn't really think
23 anything deeper than that at the time.
- 24 Q. On page 32, the last paragraph, he refers to this and
25 says:

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- 1 that this had been what had occurred, that Child C had
2 collapsed and died very suddenly. He was much more
3 concerned with, you know, what had happened in pregnancy
4 and why Child C had been born prematurely, so that was
5 very much his focus of that meeting, was to understand
6 the pathology that had caused that and to look at ways
7 of preventing that problem in a future pregnancy.
- 8 But he was very supportive. He offered to refer us
9 for some counselling. He made a plan for any future
10 pregnancy. And, yeah, we knew we could contact him at
11 any stage if we needed to or wanted to discuss things
12 further. He had a very approachable manner.
- 13 Q. And then you saw Dr Gibbs, and a summary of that meeting
14 we see at page 30. Thirty onwards is Dr Gibbs's letter
15 to you.
- 16 A. Yeah.
- 17 Q. He sets out a number of things in that letter. It's
18 a fairly lengthy letter.
- 19 A. Yeah.
- 20 Q. But if we look at page 2, he sets out at paragraph 2:
21 "Although there were several risk factors in
22 Child C, that increased the probability of death
23 following his delivery, it still was not expected that
24 he would die (at least until a severe complications,
25 such as NEC had developed), and it certainly was

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- 1 "I was sorry to learn of your negative experience
2 with the Bereavement Office at Alder Hey Children's
3 Hospital. I do hope you're able to go ahead, as
4 intended, to feed back on your experience to the staff
5 in that office."
- 6 What was the experience that you had there?
- 7 A. So when Child C was having his post-mortem over at Alder
8 Hey, I received a phone call from the Bereavement
9 Office, and the lady that spoke to me was obviously
10 trying to be lovely and supportive and kind, but she
11 made a comment about how they had dressed Child C and
12 that he looked beautiful. I found this comment
13 particularly difficult because in his life he had never
14 been dressed and he had never been dressed by me. And
15 if anyone was going to dress him, it should have been
16 me, as his mother. So at that time, you know, I know
17 that there was no malice in that at all, but I found
18 that really difficult, that my son was elsewhere, and
19 he'd been dressed by somebody, and it wasn't me.
- 20 Q. In the conversations you had with Dr Gibbs around that
21 time about Child C, did you know if there had been any
22 other deaths or unexpected deaths recently, or not?
- 23 A. No, I didn't. He did sort of mention that. I remember
24 him making a comment about how it's very rare that they
25 had unexpected or unexplained things happening on the

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1 ward, but there was certainly no talk about numbers of
2 deaths that year or anything of that nature, no.

3 **Q.** You say at paragraph 21 in your statement, after
4 meetings in August you were:

5 " ... trying to process everything that had happened
6 and looking towards the future as best as [you] could."

7 In November 2015 while you were at work, you
8 received a phone call from the Coroner's Office. Can
9 you tell us about that.

10 **A.** Yeah. So when we had met with John Gibbs, he had said
11 that he had had discussion with the Coroner's Office
12 about the cause of death, so we were expecting a phone
13 call at some point or a letter to say what the
14 post-mortem had concluded. This was several months
15 after Child C's death, and that would enable us to then
16 go and register the death. So it was a kind of -- it
17 was a shock on the day that it actually happened
18 because, as I say, I was in work when I received the
19 phone call. But the Coroner's Office has said that the
20 cause of death had been concluded as diffuse myocardial
21 ischaemia and that we should now go and register the
22 death and that I would be getting a letter with the
23 relevant details on it.

24 **Q.** And did you go and try and get the death certificate,
25 and what was that experience?

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1 **Q.** Paragraph 22. You refer to a friend of your husband
2 sending him a WhatsApp message. What was that about?

3 **A.** So I'm fairly sure now that it was July 2016 that my
4 husband's friend sent him a WhatsApp message which
5 contained a picture of an article from the Chester
6 Chronicle, and the message was to ask whether we were
7 involved in the investigation that was going on at the
8 Countess of Chester, which covered the period of time
9 during which Child C had died, and it was relating to an
10 investigation of increased deaths on the neonatal unit.
11 And up until this point, we had absolutely no idea that
12 there was any kind of concern or investigation taking
13 place, or even that there had been an increased number
14 of deaths, so this was extremely distressing to find
15 out, and especially to find out in this way.

16 **Q.** Would you have been easy to contact?

17 **A.** Yes. I was -- at that time, I was a patient of the
18 hospital. I was heavily pregnant. I was being seen
19 regularly at foetal medicine. We had not moved house.
20 I had not changed my mobile phone number. I had not
21 changed my email address. So I would have been
22 extremely easy to contact.

23 **Q.** You say you were furious, distressed and anxious in your
24 statement.

25 **A.** Yeah.

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1 **A.** Yeah, I did go and get the death certificate, and it was
2 another upsetting and difficult experience for anybody
3 to go and register the death of their child. I chose to
4 go on my own because I didn't want to put anybody else
5 through having to do something so awful. And when I got
6 there and I'd gone through all of the paperwork with the
7 registrar, she asked me if I would like a copy of the
8 death certificate, which of course I did want a copy
9 of it because it's a formal document, I felt it was
10 important to have, and she told me that there was
11 a charge of £4, which I didn't have. I hadn't taken any
12 money with me. I wasn't expecting to be charged for
13 anything. And this certainly set me into a panic at the
14 time because I thought: I can't face coming back here to
15 do this all again just to pay £4 for something that's so
16 important. So I got quite upset because it was a big
17 thing in my life going and doing that, and the thought
18 of leaving without one was unbearable. So she did
19 actually waive the charge, but I was quite shocked that
20 there was a charge for something of that nature, to be
21 honest.

22 **Q.** Indeed, it's one of the things you mention at the end,
23 when you suggest recommendations -- you don't think
24 there should be a charge for something like that.

25 **A.** No, not for something so essential.

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1 **Q.** And you turned up unannounced at the Bereavement Office
2 at the Countess of Chester Hospital, having read the
3 article.

4 **A.** Yeah.

5 **Q.** What happened when you did that?

6 **A.** So when I turned up, I didn't really know who I was
7 asking for or what to do. So I remember knocking on the
8 door of the Bereavement Office and being met by
9 presumably one of the clerical workers from the
10 Bereavement Office, and I said that I needed to speak to
11 somebody as a matter of urgency about the article that
12 had gone in the Chester Chronicle, and the first
13 question that I was asked was whether I was from the
14 press, which was an awful question to be asked at that
15 point. And I said no, that I was a bereaved parent, and
16 I wasn't leaving until somebody had the decency to talk
17 to me about the article that had gone in the newspaper.

18 So this lady went and got Sian Williams and Alison
19 Kelly, who came down and spoke to me. It was a fairly
20 short meeting, to my recollection, where I was told by
21 them that there was an investigation being done by the
22 Royal College that was more of a formality because
23 there'd been a very small increase in number of deaths,
24 that it was looking at various sort of logistical things
25 like staffing levels and that sort of thing, and that

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1 they weren't really expecting anything to come from it,
 2 that they had tried to contact me, which I challenged
 3 because, you know, I'd gone in there and said, "How can
 4 you let me read this in the newspaper? I think that's
 5 absolutely outrageous." I was really upset. They said
 6 that they had tried me on my landline once, and
 7 I challenged this as well. I said, you know, "Do you
 8 really think that that is acceptable to just try
 9 somebody once?" And the response was that they didn't
 10 know whether parents would want to know, so they didn't
 11 know how far to take the attempts to contact parents to
 12 let them know that this was happening.

13 And I was quite taken aback. I didn't see any sort
 14 of malice in the way that they'd behaved, but I saw
 15 absolute breathtaking ignorance. And I said, you know,
 16 "That is not your choice to make, who would want to
 17 know, when you're talking about the death of people's
 18 children."

19 I asked them if they knew that I was a patient under
 20 Foetal Medicine, and they knew that I was one of Jim
 21 McCormack's patients and actually used this as further
 22 justification for not contacting me. They said that if
 23 I had any questions, they knew that I could ask Jim
 24 McCormack. And, again, I challenged this, and I said,
 25 "Well, how on earth could I ask him about something that

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1 you know, he was not very happy that we had had to learn
 2 it in that way.

3 **Q.** You then heard nothing from the Countess until
 4 January 2017, you say, when you received a phone call on
 5 holiday. Can you tell us about that?

6 **A.** Yeah. So several months had passed, and in this time,
 7 we had welcomed a baby, and we were very much trying to
 8 look forward. Although we were very disappointed by the
 9 lack of communication, we felt in some ways reassured
 10 that nothing could have been found that, you know, the
 11 report must have been done or, you know, that there was
 12 nothing of note, why we hadn't heard anything. So we
 13 didn't contact to push for anything.

14 And then out of the blue, I got a phone call,
 15 I think it was a Friday evening -- it was into the
 16 evening, anyway -- from Sian Williams, telling me that
 17 the Royal College review had been done and the report
 18 had been leaked. She said that the Sunday Times was
 19 going to print something, and she just wanted to let me
 20 know.

21 So obviously this prompted lots of questions, you
 22 know. What on earth were the Sunday Times
 23 interested in? What had the report shown that would
 24 interest the media? What is this leak? And she said
 25 she couldn't tell me. So I pushed her again, and

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1 I didn't know was going on?" I don't remember them
 2 having an answer to that, but they were apologetic at
 3 the lack of information that we'd been given. They said
 4 that they had nothing really that they could tell me
 5 until the report had been done that was expected to be
 6 a few months down the line, but that they would keep me
 7 informed from that point.

8 **Q.** You say in your written evidence:

9 "They did apologise and said that they would ensure
 10 better communication in future."

11 **A.** Yes.

12 **Q.** So when you left there, what was your expectation around
 13 communication?

14 **A.** I expected that when the report had been done by the
 15 Royal College that somebody would contact me to discuss
 16 that with me.

17 **Q.** You also spoke to Mr McCormack about it, didn't you?
 18 Told him?

19 **A.** Yes, I did. So as I've mentioned, I was having regular
 20 appointments with him at that time, and when I had my
 21 next appointment with him, I told him how distressed I'd
 22 been to read this in the newspaper and how let down
 23 I felt and how upset I was. And then he advised me that
 24 the consultants had been told that all patients had been
 25 informed, which obviously was not the case at all. So,

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1 I said, you know, "Well, what has the report shown?"
 2 And she said, you know, "Well, there was some mention
 3 about staffing levels, but, you know, I can't discuss
 4 the report with you, but you can have a copy of it."

5 So I asked her to email it to me because we were
 6 abroad at the time, and she said she couldn't. So she
 7 gave me the option of collecting it when we returned
 8 from holiday, so that's what I did. But in the
 9 meantime, we were expected to just wait and see if
 10 something went in the newspaper about it, once again,
 11 without knowing what to expect or what had been found.

12 **Q.** Can you have a look at page 54 in the bundle, please.
 13 These are Sian Williams's notes to be confirmed in
 14 evidence, but that's what they appear to be. If you
 15 look at 6 February 2017:

16 "Call from Father and Mother C enquiring about the
 17 two cases unexplained."

18 Did you turn up and collect the report on
 19 6 February?

20 **A.** Yes.

21 **Q.** Do you think this might be then?

22 **A.** Yes, so I'd been on 6 February and collected that
 23 report. I don't recall ringing Sian that evening, but
 24 I obviously did, because the report threw up a number of
 25 new questions, that being one of them -- you know, was

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1 this the end of the investigations for us, or was there
 2 something further that was going to happen?
 3 **Q.** So you physically collected the report.
 4 **A.** Yes.
 5 **Q.** There's a note -- if you look above "Actions agreed",
 6 "Send report in the post".
 7 **A.** Yeah.
 8 **Q.** Is that a conversation you had?
 9 **A.** I remember asking Sian if she could email it to me
 10 because I was away. Now, from memory, I think the day
 11 that she rang me was a Friday. We were returning from
 12 holiday on the Sunday, and so I went to collect the
 13 report on the Monday. It may have been -- because I've
 14 thought about this, I've read these notes -- it may have
 15 been that she had offered to post it but that it was
 16 going to be quicker for me to collect it in person if
 17 she wasn't going to post it until the Monday, so I think
 18 that's possibly what's happened there, because as soon
 19 as I was told that there was a leak to the press,
 20 I wanted to know what on earth was so interesting about
 21 it that people were not telling me. So I wasn't willing
 22 to wait a second longer than I needed to.
 23 **Q.** If you look at paragraph 26, going back to your
 24 statement, you say there, as you just have, that Sian
 25 Williams, when you collected it, advised you that:

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1 which are followed by everyone."
 2 Did you see just that piece underneath there?
 3 **A.** So I don't remember reading that particular paragraph,
 4 and that doesn't fit with my recollection of being told
 5 that there were two that required further investigation.
 6 So I couldn't be a hundred per cent sure, but I don't
 7 believe that that paragraph was in the report that I was
 8 given, because I think that would have made me realise
 9 that there had been, you know, a recommendation of
 10 further investigation into our son's death.
 11 **Q.** If you go to page 76 in the bundle, this is
 12 a confidential copy of the RCPCH report.
 13 **A.** Yes.
 14 **Q.** At paragraph 4, "Findings: the individual nurse" --
 15 I'm not going to read them now -- it'll be available
 16 later on in the evidence -- but if you look at those
 17 paragraphs, three large paragraphs, and over the page?
 18 **A.** Yeah, that was definitely not in the report that I was
 19 sent. There was no mention of any individual of concern
 20 at all. All of that had been removed from the report.
 21 **Q.** So any allegations about Nurse L or being moved to an
 22 alternative position, that wasn't shared with you?
 23 **A.** No.
 24 **Q.** Or the comment:
 25 "In the light of information shared with the Review

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1 "Some parts of the report had been removed as it
 2 contained information about the babies and that a plan
 3 was going to be made to meet families individually to
 4 discuss each case".
 5 **A.** Yes.
 6 **Q.** Did she tell you that some babies needed further
 7 investigation but she had been told that Child C was
 8 probably not one of them?
 9 **A.** That's correct, yes.
 10 **Q.** That's what you were told.
 11 When you were sent the RCPCH report, if you look in
 12 the bundle, there's a copy that's grandly described as
 13 "Final copy for dissemination" at page 101. Is this the
 14 copy you had at paragraph 4 -- if you go to page 109 --
 15 where at paragraph 4, "Findings", it simply has
 16 underneath it:
 17 "Recommendation: Conduct a thorough external,
 18 independent review of each neonatal death between
 19 January 2015 and July 2016 to determine any factors
 20 which could have changed the outcomes. Include
 21 obstetric and pathology/post-mortem indicators, nursing
 22 care and pharmacy input."
 23 And then "Recommendation":
 24 "Ensure there are clear, swift, and equitable Trust
 25 processes for investigating allegations or concerns

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1 team, the RCPCH advised the Trust to follow corporate
 2 processes in responding to allegations of misconduct by
 3 opening an investigation. It was also recommended a
 4 full and detailed independent casenote review was
 5 required on the deaths, prioritising those that were
 6 unexpected."
 7 So that bit was not in the material that was sent to
 8 you?
 9 **A.** No, it wasn't. No.
 10 **Q.** And what do you make of that now?
 11 **A.** I think, you know, we were in a very vulnerable position
 12 as bereaved parents who were very much being kept in the
 13 dark about what had happened to our child. We were
 14 being given no information whatsoever without being --
 15 without finding it out almost by accident, and these are
 16 serious suggestions in that report, that there was
 17 serious concern about this nurse, that were being hidden
 18 from us. They were deliberately removed from the report
 19 that we were given.
 20 **Q.** Going back to what you knew at the time, we see at
 21 page 37 of the bundle a letter you wrote to Mr Harvey as
 22 Medical Director on 7 February 2017.
 23 **A.** Yeah.
 24 **Q.** Would you like to read that letter in now, either all of
 25 it or parts of it --

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1 A. Yeah.

2 Q. -- which set out clearly what your views were at the
3 time and what you were thinking.

4 A. Yeah, I will read it. So I wrote this letter the day
5 after receiving the copy of the report that we were
6 given, which as we mentioned, did not contain
7 everything:

8 "Dear Mr Harvey. I am writing as a bereaved parent
9 following the recent Royal College review of the
10 neonatal services at The Countess of Chester Hospital.
11 I suffered a complicated pregnancy in 2015 and was under
12 the care of Mr McCormack in Fetal Medicine. Due to
13 problems with my son's growth, I had a caesarean section
14 at 30 weeks on (*redacted*) June 2015 and our son,
15 Child C, was transferred to the NICU for support.

16 "He was born in good condition (all things
17 considered), although very small, having suffered severe
18 IUGR due to placental insufficiency. It was felt by the
19 paediatric team that he was high risk but had a very
20 good chance of survival. On 13th June whilst on the
21 postnatal ward I was called down to the Neonatal Unit
22 urgently as Child C had suffered a very sudden and
23 unexpected cardiac arrest. Although an output was
24 regained after what I understand to be around 50 minutes
25 of resuscitation it was clear to us that Child C was not

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1 would have the happiness that we have found since having
2 our baby, who is now six months old.

3 "Jo Gwinn provided me with counselling for several
4 months, which got me through this stressful pregnancy
5 and helped tremendously with my grief. In amongst the
6 things that went wrong, I feel it is important to
7 acknowledge those things that went right. Mr McCormack,
8 Jill Ellis and Jo Gwinn deserve high praise and we will
9 forever be grateful to them for what they did for us.

10 "Although my pregnancy was progressing well, we were
11 truly horrified when, in July 2016, we read an article
12 in the Chester Chronicle detailing that an investigation
13 was taking place into deaths on the Neonatal Unit
14 covering the period during which we lost our son. This
15 article stated that support was being offered to the
16 families involved. At no point had anyone contacted
17 myself or my husband to inform us of this investigation
18 into our son's death - the only way we knew about it was
19 to read it in the newspaper. I am sure you would agree
20 that this is a significant failure of the Trust and,
21 quite frankly, a disgrace.

22 "I met with Sian Williams and Alison Kelly when
23 I turned up at the Bereavement Office really quite
24 distressed following this publication. It was explained
25 to me that an attempt had been made to contact us on our

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1 going to survive. With our families we spent several
2 hours holding him as he died in the early hours of
3 14th June 2015.

4 "Due to the unexpected nature of his death, he was
5 referred for a post-mortem, the results of which took
6 five and a half months to come to us. I am aware that
7 this was a delay at the coroner's office. It was a very
8 difficult wait for us. It was concluded that Child C
9 died of severe myocardial ischaemia despite normal
10 coronary arteries - a rare cause of death in a neonate
11 for which there was no explanation.

12 "It is very hard to explain what this tragedy has
13 done to us and our family. The effect it had at the
14 time was devastating and the impact it will have forever
15 is impossible to put into words. Losing Child C changed
16 our perspectives on almost every part of life.

17 "Six months later, in December 2015, I was
18 re-referred to Foetal Medicine with a positive pregnancy
19 test. We had been warned that any pregnancy I had would
20 likely be complicated and would result once again in
21 premature birth. This was clearly a stress to us.
22 However, we felt that the support of the Foetal Medicine
23 team was truly outstanding. It gave us the strength to
24 go ahead. Without the support of Mr McCormack and Jill
25 Ellis and the Foetal Medicine team, I do not think we

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1 landline number on Child C's records (which was our
2 previous landline number). It was known that I was
3 a patient under Fetal Medicine but no other attempts to
4 contact us were made, eg, by mobile or letter. In an
5 already stressful situation, coping with our loss and
6 dealing with a new pregnancy, we were put in a position
7 where we felt that the Trust did not respect our grief
8 enough to go to every possible length to inform us about
9 this investigation. More effort should have been made.
10 This caused a significant setback for us when we were
11 trying to focus on remaining positive about my pregnancy
12 and our future.

13 "Sian Williams and Alison Kelly were very pleasant
14 during this meeting and I was told I would be kept
15 informed from there on. I was surprised following this
16 that I did not hear anything from the Trust until Friday
17 3 February 2017 (seven months later) when I was called
18 by Sian Williams whilst on holiday in Lanzarote. She
19 informed me that there had been a leak of the Royal
20 College report and that an article would be going in the
21 Sunday Times. I understand that this leak was not
22 internal.

23 "She offered me the option to collect a copy of the
24 report, which I did, on Monday 6th February. When I met
25 Sian to pick up the report she advised me that there was

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1 a plan to meet families individually to go through the
 2 case reviews as these did not feature in the report.
 3 "The report from the Royal College opened up
 4 questions that I had already asked myself. I am fully
 5 aware of the fact that sometimes there are questions
 6 that do not have answers. I have asked myself over time
 7 whether it would be helpful for us to know what, if
 8 anything, went wrong, or whether that would just cause
 9 us further distress.
 10 "I have asked myself whether someone may have acted
 11 negligently, whether the respiratory support Child C was
 12 given was sufficient, were his blood gases, electrolytes
 13 and blood glucose monitored closely enough, and, indeed,
 14 was he in the right unit in the first place, or should
 15 he have been transferred to a more specialised centre?
 16 "The report does strike me as having some suspicion
 17 that there were some unusual features of the deaths of
 18 the babies on the unit and that perhaps there was
 19 something going on on the unit that caused or at least
 20 contributed to the increase in mortality.
 21 "I am unsure where the Trust is planning to take
 22 this, or how this will be concluded. I have not had a
 23 definite answer as to whether any further investigation
 24 into Child C's death is planned. Sian felt that
 25 Child C's case was probably not one of the cases that

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1 will bring.
 2 "I hope that the handling of this investigation is
 3 reviewed so that the Trust can learn from the mistakes
 4 made here and that any further action required off the
 5 back of these case reviews is undertaken promptly. That
 6 really is the least that bereaved families such as us
 7 deserve.
 8 "Yours sincerely."
 9 **Q.** The message couldn't have been clearer, could it, at the
 10 end of that?
 11 **A.** I don't think so, no. I was really angry, upset,
 12 disappointed, but also felt completely in the dark as to
 13 what was going on.
 14 **Q.** We see, just for your reference, page 58, it's a note
 15 from Debbie Dodd -- I think that's the secretary to
 16 Mr Harvey -- but either way, an agreed meeting with Ian
 17 Harvey, Monday 20 February 2017, 10.00 am.
 18 **A.** Yes.
 19 **Q.** And someone was going to collect you from the main
 20 reception and take you to Ian's office, it records
 21 there.
 22 Who went to that meeting, as far as you're aware?
 23 Who was present?
 24 **A.** So it was myself and my husband, Ian Harvey and Alison
 25 Kelly.

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1 required further investigation but she was not certain.
 2 This is something that we need to know for definite. An
 3 investigation into the death of our son is the last
 4 thing that we want or need, unless it is deemed
 5 necessary or features of concern have been identified.
 6 "Having suffered terrible grief, nine months of
 7 counselling, and having had a healthy baby in 2016, we
 8 need this chapter of our lives to be concluded so that
 9 we can focus on creating a happy, positive future for
 10 our baby.
 11 "Every time another article is printed, or piece of
 12 information comes to light, it takes us back to the
 13 worst time of our lives, when all we want is to continue
 14 moving forward. The handling of this investigation and
 15 lack of communication has added to the distress of my
 16 family and I'm sure the distress of other families who
 17 have already suffered enough. We are trying to move
 18 forward after our indescribable trauma but this is
 19 hindering us.
 20 "I would be grateful for any planned meeting to go
 21 through a review of our son's case to take place as soon
 22 as possible. We need closure on this. Although our
 23 grief will be lifelong we do not need any further
 24 prolongation of our suffering or further turmoil that
 25 delays in further investigations and poor communication

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1 **Q.** Was Mr Cross there, another male there, or not?
 2 **A.** No.
 3 **Q.** So you're very clear, it was just the four of you?
 4 **A.** Absolutely. Mr Cross was not there. I've never met
 5 Mr Cross.
 6 **Q.** Tell us what was discussed at the meeting. You deal
 7 with it at paragraph 31 of your statement.
 8 **A.** So at the meeting, Mr Harvey did apologise to us for the
 9 lack of communication. He acknowledged that us learning
 10 things from the newspaper was not satisfactory.
 11 **Q.** Pausing there. Did he give a reason for it?
 12 **A.** No.
 13 My main aim and agenda from that meeting was to
 14 understand what had been found with regards to the care
 15 of our son. And my fear, in some way, from that meeting
 16 would be that we would hear something that would have
 17 changed the outcome for him. For example, deficiencies
 18 in care so severe that, had they not occurred, he would
 19 have survived. So I had a very clear worry in my head.
 20 So during the meeting, Mr Harvey told us that there
 21 had been some minor learning points noted when Child C's
 22 care had been reviewed, that there were some things that
 23 could have been done better. And I specifically asked
 24 him: was there anything that would have changed the
 25 outcome for Child C -- because that was really my agenda

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1 in that meeting -- to which he said no, nothing had been
2 found that would have changed the outcome.

3 **Q.** When you were asking that question, what were you
4 driving at? Was it equipment failure, or a human
5 being's failure, or action? What were you getting at
6 there?

7 **A.** I didn't really know, in honesty. I think, at that
8 point, we still weren't really clear on why an
9 investigation was even happening. The impression that
10 we'd be given by Sian Williams and Alison Kelly was that
11 this was more to look at staffing levels and that sort
12 of thing.

13 **Q.** What does that mean, though, "staffing levels"? I mean,
14 the number of people on a ward, or what?

15 **A.** Well, exactly, really. You know, to make sure that they
16 were meeting all of the standards that they should have
17 been meeting, that sort of thing. So my mind didn't
18 really go there, in terms of there being something
19 worrying. I was more thinking, you know: was the
20 standard of care sufficient? Was he in the right place?
21 Was there anything that was missed that should have been
22 acted upon that contributed to his death? So they were
23 the things that were on my agenda that I was concerned
24 about.

25 So, in honesty, when we were told that none of those
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1 quite happy with what I had heard, and I believed what
2 I had heard, that me having a physical copy of that
3 report was more for my own records and more of a sort of
4 formality in that sense. So we left there feeling more
5 comfortable that we were going to get the full report,
6 that the full report would not contain any surprises,
7 because we'd had a discussion about it, and there
8 wouldn't be anything in there that was going to make us
9 more upset, really, than we already were.

10 **Q.** So you left the meeting with the impression that there
11 couldn't have been anything changed about his care that
12 would have affected the outcome and prevented his death?

13 **A.** Absolutely, yes.

14 **Q.** Mr Harvey, you say, also told you you had another
15 meeting to attend before the full report could be
16 released.

17 **A.** Yes.

18 **Q.** You've said that now, and you also say that in your
19 statement. What was that about, as far as you were
20 aware? Did he tell you?

21 **A.** I can't remember what he told us about that meeting.

22 **Q.** You use a -- you say in your statement:

23 "He was reassuring and said that after that meeting
24 a line would be drawn under the investigation."

25 **A.** Yes.

1 things were the case, we were relieved, because so far
2 as we were concerned at that time, we were hurting so
3 much from everything that had happened that anything
4 that was going to add to that was something that we were
5 going to really struggle with. But at that point, we
6 needed to know, as I said in my letter to Mr Harvey.
7 You know, we couldn't face hearing about something else
8 to do with our son's death being printed in the
9 newspaper before somebody had told us. So that was
10 really what we wanted to get out of that meeting, and we
11 left that meeting feeling like we did have some answers,
12 that there had been some minor problems with the care,
13 nothing that had affected the outcome, and we were
14 satisfied with that. You know, if you look properly at
15 any case, at any care, you should find things that could
16 have been done better, so that was no great surprise to
17 us.

18 But I asked Mr Harvey at the end of the meeting for
19 a copy of the report that was specific to Child C,
20 because I was aware that that was not enclosed in what
21 we had been given, and he said he was not able to give
22 us a copy of the report at the time because there were
23 some more meetings to follow before he would be able to
24 release that information.

25 And I didn't push this at the time because I was
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1 **Q.** Did he say a line would be drawn?

2 **A.** Yes, he did. He said that they were going to draw
3 a line under the investigation after the meeting that
4 was to come in -- I think he said it was in the
5 following week.

6 **Q.** What did you understand, if anything, from that phrase,
7 "a line would be drawn under the investigation"?

8 **A.** That it was finished. That they investigated things
9 thoroughly. That nothing of concern had been found, so
10 they were closing it, you know. That was the end of the
11 investigation. So from that end, I didn't expect to
12 hear any different or new information.

13 **Q.** When you learned that, in fact, full, in-depth case
14 review of the babies was recommended, what did that make
15 you think about this meeting?

16 **A.** Well, I didn't actually learn that for years after that
17 meeting. That absolutely horrified me, how misled we'd
18 been in that meeting and how untrue what we had been --
19 how untrue the information was that we'd been told.
20 I felt completely betrayed on every level, to be honest,
21 you know, as a human being sat with another human being
22 who knows the pain that we've suffered. You know, it's
23 evident in the letter, it's evident from the facts of
24 what we'd been through at that point that someone could
25 sit with you and tell you something untrue about the

1 death of your child is something that I cannot believe
2 happened even now. I cannot comprehend that someone
3 could do that.

4 **Q.** We see a letter to you from Mr Harvey, page 41 in the
5 bundle. Next correspondence is 3 March. I'll read that
6 to you:

7 "Dear Mother C.

8 "Further to previous correspondence, our recent
9 meeting, and the completed Review of the Neo-Natal Unit
10 carried out by the Royal College of Paediatrics in Child
11 Health at the Countess of Chester Hospital, I am writing
12 to appraise you of our current progress. You will have
13 seen within the Review that one of the recommendations
14 was that a separate independent review of the care of
15 each of the babies should be carried out. This review
16 has now been completed but has, in turn, indicated that
17 a small number of areas of investigation are required
18 and I aim to undertake this as quickly as possible.

19 I will, in due course, be sharing the findings of this
20 further review in relation to Child C with you and will
21 be offering to meet with you to discuss any concerns or
22 issues that you may have arising from both the College
23 Review and the subsequent review.

24 "I apologise for the length of time that this whole
25 process has taken. This reflects the depth to which we

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1 your return to work", when we had met with Mr Harvey, I
2 made it clear that I was due to return to work,
3 following maternity leave, and that I was eager to have
4 the physical copy of the report before then, and he'd
5 assured me that I would have it.

6 So I was really upset because this came sort of
7 around the time that I was returning to work. I wanted
8 it all concluded. I wanted all of the information in my
9 possession before then. So this just told me that this
10 was still hanging over and there were still things that
11 we were not being told and that we didn't know, despite
12 meeting face to face.

13 **Q.** You then wrote to him again on 19 April. My Lady,
14 that's at page 43 of the bundle. I'm going to read that
15 extract or parts of that:

16 "Dear Mr Harvey.

17 "Thank you for your letter dated 3rd March. I am
18 sure you are aware that being informed that there were
19 areas of further investigation required regarding our
20 son's case was a surprise to us given the information we
21 had been given by yourself and Sian Williams up to this
22 point. Whilst I am aware that things don't happen
23 instantly and reports and results take time, I really
24 would like to point out how awful this is for us."

25 You then set out the periods of delay, and you then

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1 have carried out the whole Review process. I want to
2 make sure that I can confidently respond to any concerns
3 you have in an open and transparent manner.

4 "Unfortunately, due to the depth of investigation,
5 I am not in a position to give you a definitive date for
6 any meeting but will be endeavouring to make this as
7 soon as possible and would certainly aim for this to be
8 within the next six weeks. I apologise that I can't
9 have all the details to facilitate a meeting before your
10 return to work as had been hoped."

11 What did you make of that letter?

12 **A.** When I received that letter, I was absolutely devastated
13 because it was completely contrary to what we'd been
14 told in the meeting. We were told that -- the thing we
15 were discussing in that meeting was the case review, for
16 a start, whereas this letter says, you know, that
17 they've now been completed. Well, we were under the
18 impression that they'd been completed when we were
19 speaking to Mr Harvey. And we were told that a line was
20 being drawn under the investigation, that it had been
21 completed. So what on earth were they investigating,
22 and why were we just getting this very sort of generic
23 letter that didn't give us any sort of real information?

24 So the final line that says about, you know, "not
25 having all the details to facilitate a meeting before

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1 carry on:

2 "I really cannot tolerate any further delays.
3 I have never wanted to seek legal advice over all of
4 this because, as I said in my original letter, we want
5 to move forward. However, this really is prolonging our
6 suffering. I would be grateful if you could send me
7 a copy of the report from the Royal College of
8 Paediatrics review and a copy of subsequent
9 investigations regarding Child C. This really is the
10 least we deserve at this stage."

11 You then gave an email address and suggest it could
12 be posted to you; you don't mind. You say:

13 "I need to see them in advance of any meeting anyway
14 to gather my thoughts and any questions I may have. If
15 for some reason this is not possible, I feel we will
16 have no choice but to seek legal advice."

17 Again, very clear, what you're saying it there.

18 **A.** Yeah.

19 **Q.** What happened subsequently? Were you sent a copy of the
20 report, or anything about Child C?

21 **A.** No, I was not. I think I was then sent -- so I think
22 I sent that via email to the personal assistant of Ian
23 Harvey, Debbie Dodd, and I received an acknowledgement
24 of that email saying --

25 **Q.** That's at page 45, I think, in the bundle, is it?

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1 A. Yes. 46. And her response says that she has spoken to
2 Mr Harvey, he sends his apologies for not getting back
3 to me before now but assures -- :

4 "[He] assures you that he will have the information
5 for you by the end of next week."

6 Was the reply to that letter. But that was not the
7 case at all. So I received a subsequent letter.
8 I received it on 25 April, and I emailed Debbie Dodd
9 again.

10 So the follow-up letter that he'd sent did not
11 contain the information that I'd requested, did not
12 contain the full Royal College report, did not contain
13 the report into the investigation into our son's death.
14 And at this point, I really felt that there was
15 something significant going on that we were not being
16 told about.

17 I had thought it was quite unusual that, following
18 our meeting with Ian Harvey, we never received a letter
19 detailing what we'd discussed in that meeting. That, to
20 me, is quite standard. You know, we'd seen John Gibbs,
21 and he'd sent us a letter that detailed everything we'd
22 discussed. We'd seen Jim McCormack, and he'd sent us
23 a letter detailing everything we'd discussed. We saw
24 Ian Harvey and discussed details about the death of our
25 son and did not get any kind of summarising document,

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1 have had the opportunity to read and consider the
2 contents of this latest document, together with the
3 previously sent copy of the Royal College of
4 Paediatricians and Child Health report, please contact
5 me if you wish to meet to discuss these documents and
6 any other issues you might have in greater detail. We
7 will then also be in a position to explain any of the
8 terminology that might be unclear."

9 If you look at the next two pages, did they come
10 with that letter?

11 A. They did. The next three pages came with that letter.
12 But they were not these exact pages that are shown in
13 evidence here. They had "Draft" written across them in
14 capitals, like a watermark on the page. But the
15 contents, the sort of layout of it, is otherwise the
16 same as what we'd received.

17 Q. So you now know this is an extract of Dr Hawdon's
18 report, this one.

19 A. Yes. I know that now, yes.

20 Q. When you got it, did you know who the author was? Well,
21 tell us what you did and didn't know, receiving that
22 information.

23 A. So when I received this, I was struck by a number of
24 things. I was struck by the fact that the information
25 that had been sent to us started at page number 27, so

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1 which I thought was unusual, but at this point,
2 I started to think: well, why have we not received any
3 kind of summary of that discussion? Why are we not
4 allowed a physical copy of the report that he's told us
5 apparently says that there were only minor criticisms of
6 our son's care? What on earth is actually going on
7 here?

8 So my reply back to Debbie Dodd was getting
9 increasingly frustrated and annoyed, and I suggested
10 that really if we didn't get the information within the
11 next couple of days, then I suggested that the Trust
12 itself sought its own legal advice because I was really
13 suspicious that there was something here that we weren't
14 being told that was much more significant than we'd been
15 led to believe.

16 Q. And then if we look at page 48, there's a letter to you
17 from Mr Harvey, dated 28 April 2017.

18 A. Yeah.

19 Q. "Dear Mother C.

20 "Further to my letter of 21st April 2017, I am
21 writing to you again to pass on the results of the
22 independent external review regarding the care of your
23 baby. I appreciate that, by its nature, this report
24 will contain some technical terms, but I felt it was
25 important that you saw the original report. Once you

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1 it was page 27, 28 and 29. There was no introduction to
2 the report, who had written it, what date it was written
3 on. It wasn't signed and dated by anybody. There was
4 no context. And it's, you know, like a bullet-pointed
5 list.

6 So when I received it, I was struck by how
7 superficial it looked. That, you know, we'd been told
8 that these in-depth investigations had taken place and
9 not revealed any cause for concern. Yet, we were sent
10 a couple of pages of a report that didn't look at all
11 in-depth to me, but also, where was the rest of it? You
12 know, this report starts at page 27. Where's page 1 to
13 26?

14 So it was very evident when we received this that,
15 again, this was not the complete information. We still
16 had not received the full Royal College report, and this
17 certainly could not possibly have been the full
18 investigation into the death of our son. Or, if it was,
19 then it was woefully inadequate to call that a thorough
20 investigation.

21 So I was upset, distressed, extremely annoyed,
22 perplexed. Lots of different emotions as to what on
23 earth was going on that led somebody to think that that
24 was acceptable.

25 Q. You say in your statement:

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1 "I felt at the time - and still feel now - that we
2 were being told that there was nothing to be concerned
3 about, were not being adequately informed, because the
4 Trust management did not want to deal with difficult
5 questions."

6 **A.** Yeah.

7 **Q.** Can you just expand upon that for us?

8 **A.** I think telling a bereaved parent that there is going to
9 be an investigation into the death of their child would
10 bring up a lot of questions as to why and what you are
11 investigating, and potentially, I suppose, open the
12 doors to various other things like litigation. So
13 I felt very much that they didn't want us to know
14 anything because they didn't want to be faced with
15 questions that maybe they didn't have the answers to, or
16 maybe they did, but that those answers were going to
17 hurt them in some way. So I felt very much at the
18 beginning, when I'd met Sian Williams and Alison Kelly.
19 I felt very much, as I said before, that there was
20 a breathtaking ignorance; but my thoughts and feelings
21 turned into this being something much more deliberate
22 than that, by this point.

23 **Q.** Now you say in your statement that you lost every ounce
24 of trust you could possibly ever have in the management,
25 so you didn't request any further meetings?

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1 from the Trust, from the hospital?

2 **A.** Not from the Trust, no. We received a full copy when
3 the Inquiry was started in 2023; I asked for the help of
4 Steve Barclay, the Secretary of State for Health at the
5 time, to get the full report for us. And that was when
6 we got the full reports, finally.

7 **Q.** Eight years after his death?

8 **A.** Yeah, eight years after his death.

9 **Q.** And what did you learn the first time you read that
10 report?

11 **A.** So in terms of the Royal College report, I learnt that
12 the suspicions about Letby were written within it. That
13 was the main difference. The report that we'd
14 originally been sent didn't have any appendices in them,
15 but actually, the appendices were not particularly
16 relevant to us. But the main difference was this
17 concern about the nurse, and the concern from the
18 consultants that had been raised.

19 In terms of the Jane Hawdon report, that was really
20 quite different to what we had been sent. So when we
21 received the full Jane Hawdon report, it was evident
22 that she'd written a cover letter that, you know,
23 explained about the report, and that on the pages
24 pertaining to our son there were a couple of boxes that
25 had been removed when the report had been sent to us by

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1 **A.** Yeah.

2 **Q.** Why didn't you request any further meetings? Trust was
3 one factor, but why else?

4 **A.** I think, after all the pressure that I had put on to
5 receive the thorough information -- and still, I had not
6 received the thorough information -- I felt quite
7 frankly like I was banging my head against a brick wall,
8 that nothing was going to get me that information now,
9 because I'd put it in writing, I'd followed it up with
10 emails, I'd met in person, and still there was a report
11 somewhere on somebody's desk about my dead son, and they
12 were not letting me have it. So I felt that all of the
13 morals that underpinned that decision, there was nothing
14 that I could do to persuade them that the right thing to
15 do was to be transparent and open with me.

16 So at that point, you know, against all of my
17 previous instincts, against all of my previous wishes,
18 we then felt we that no choice but to seek legal advice,
19 to actually get the full reports and to get the truth of
20 what actually had happened to our son. We hadn't been
21 looking to blame anybody. We hadn't been looking to
22 make any accusations to anybody. We just wanted the
23 truth about what happened to him, so that we could
24 grieve properly and move forward with our lives.

25 **Q.** Did you ever receive a full copy of the RCPCH report

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1 Ian Harvey. One of those boxes detailed the post-mortem
2 results for our son, and one of the comments in one of
3 those boxes said that the post-mortem result was agreed,
4 but that it didn't explain the cause of his
5 deterioration.

6 So it was good to finally have the full information,
7 but so many years after and so much had happened since
8 then, it really added to the feelings of betrayal that
9 we were being told very superficial parts of what was
10 a much more suspicious investigation.

11 **Q.** I'm going to move on to suspicions and concerns
12 regarding Letby. I don't know if you'd like a break for
13 five or ten minutes or --

14 **A.** Maybe five minutes, if that's okay.

15 **Q.** Shall we have a break?

16 **LADY JUSTICE THIRLWALL:** So five minutes. If you want ten,
17 just say.

18 **THE WITNESS:** Thank you. I think five will be okay.

19 (3.22 pm)

(A short break)

20
21 (3.27 pm)

22 **MS LANGDALE:** Suspicions and concerns regarding Letby.

23 You referred to it earlier in evidence, but I'm
24 going to quote it in full here, your husband's
25 recollection of Letby in the family room and you set out

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1 here a quote from your husband's evidence:
 2 "Although I initially had uncertainties, I am sure
 3 that Lucy Letby was the person I encountered in the
 4 Family Room at Child C's death. My initial uncertainty
 5 stemmed from the fact that the only image of Lucy Letby
 6 I had seen at the time of my police statement was in the
 7 newspaper, where she appeared differently to her work
 8 appearance, particularly regarding her hair colour.
 9 When she prompted me to place Child C in the cold cot,
 10 I responded with surprise, saying, 'He is not dead yet.'

11 "This reaction was uncharacteristic of me, but her
 12 comment caught me off guard. She seemed taken aback by
 13 my response and promptly left the family room, as my
 14 mother-in-law recalls. I distinctly remember saying
 15 goodbye to the nursing staff as we left the family room;
 16 she was among them."

17 You described that earlier, but when you look back
 18 with what you know now, what do you make of that?
 19 **A.** It's horrendous. You know, knowing what we know now, it
 20 took us aback at the time because it just didn't fit
 21 with the context of what was happening. You know, we
 22 were having this very private, sort of difficult time
 23 that went on for several hours. And, you know, my
 24 concern now is that she wanted us to leave him there,
 25 you know, which just doesn't really bear thinking about,

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1 think that this is more difficult but, you know, to not
 2 inform us at all until somebody is arrested is
 3 unforgivable. We had absolutely no idea that there had
 4 been layer upon layer upon layer of concern voiced by
 5 various people within the hospital about the conduct of
 6 Lucy Letby and her association with these deaths, and to
 7 not inform us of any of this, and for us to get a phone
 8 call out of the blue from a police officer in the early
 9 hours of the morning to tell us that they were arresting
 10 somebody, you know, it was an absolute shock that day.
 11 We hadn't anticipated that that was what was going to
 12 happen.

13 **Q.** Medical records. When did you first get access to
 14 Child C's medical records, and do you know when you
 15 requested them?

16 **A.** I'm not sure when I requested them, but certainly, in
 17 amongst the time that we've been talking about, I did do
 18 a request. I think there was an email address on the
 19 website. I can't be a hundred per cent sure, but
 20 I certainly emailed to ask for a copy of medical records
 21 and I didn't get any reply. But then, obviously, we'd
 22 appointed a solicitor and then, you know, there was
 23 a police investigation. So, you know, it became almost
 24 academic for me to read his medical records, you know,
 25 they were going to be looked at elsewhere.

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1 to be honest. It just adds an extra horror to what we
 2 already have to think about.

3 **Q.** You say you were never given any information or
 4 indication by the hospital that there was any individual
 5 linked to Child C's death, or the wider cluster of
 6 neonatal deaths?

7 **A.** Yeah.

8 **Q.** Did that remain the case?

9 **A.** Yes. The first time that we knew that there was anybody
 10 linked to our son's death was on 3 July 2018, when we
 11 were phoned by Cheshire Police to inform us that
 12 somebody had been arrested on suspicion of murdering our
 13 son. That was the first time that we had any
 14 information linking an individual. Although we knew
 15 there was a police investigation, we thought that was
 16 purely to rule out foul play, rather than that they
 17 would actually name an individual.

18 **Q.** Where do you think the transparency should have been?
 19 At what stages do you think you should have been told
 20 these things?

21 **A.** I think, in terms of the Royal College investigation, we
 22 should have been told that as soon as it was decided
 23 that our son's death was going to be looked into by
 24 anybody, and definitely before any press release was
 25 made. In terms of suspicion about an individual, I do

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1 **Q.** So you certainly, at no point before the police
 2 investigation, had looked comprehensively at his medical
 3 records and been given them?

4 **A.** I'd never seen them. No, I'd never seen them before.

5 **Q.** But, through the criminal trial, you'd learnt what you
 6 learnt?

7 **A.** Yes.

8 **Q.** What kind of evidence did you hear in the criminal trial
 9 that you didn't know before that was relevant to your
 10 child or the care it provided at the hospital?

11 **A.** In terms of the medical care I felt, and I still feel,
 12 that John Gibbs and the medical team were transparent
 13 with us about the medical care that he'd received. So
 14 there wasn't any sort of great shock there. In terms of
 15 the fact that there had been other deaths that -- well,
 16 that there had been another death that week, I had no
 17 idea until the criminal trial. I had no idea that there
 18 were various text messages flying around about the death
 19 of our son and the other collapses and things that had
 20 happened. I had no idea about the fact that there had
 21 been other internal meetings to discuss his death until
 22 the criminal trial. But in terms of kind of his medical
 23 condition, I felt that we had been given accurate
 24 information.

25 **Q.** Paragraphs 43 and 44 of your statement raise concerns in

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1 getting answers.

2 **A.** Yes.

3 **Q.** By the time the police investigation had commenced, what
4 was your view about those issues? Did you look for
5 answers or did you wait and see? What was the position?

6 **A.** We were very much not asking questions because we were
7 not in a position to receive difficult answers, is
8 probably the best way to describe it at that time.
9 Certainly when the police investigation was launched, we
10 had several visits from liaison officers to support us,
11 but they couldn't actually really give us much in the
12 way of information at that point, with it being
13 a criminal investigation. So it was more kind of -- it
14 was just more support, rather than information. It was
15 kind of telling us that we needed to do a police
16 statement, and how would we like to do that, and
17 planning for that sort of thing.

18 But in terms of asking any further questions to the
19 Countess following our meeting with Ian Harvey, it felt
20 completely pointless to do so, so we didn't.

21 **Q.** In terms of the impact upon you and your family, at
22 paragraph 45 you set out further comments about
23 rebuilding lives and impact.

24 **A.** Yeah.

25 **Q.** Would you like to describe that now?

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1 from this as much as possible. The impact and trauma of
2 the events at the Countess of Chester will be lifelong
3 for us.

4 "The impact statement gives details of the impact of
5 losing Child C but, for obvious reasons, did not touch
6 upon the impact that the initial investigation at the
7 Countess of Chester in 2016 and the lack of transparency
8 and communication with regards to this. We have
9 suffered immeasurably from the moment our son collapsed.
10 The trauma that we faced from then until now is
11 thoroughly incomprehensible to anyone who has not
12 endured it. I have been truly horrified as we have
13 learnt more and more detail of the extent of information
14 that was withheld from us by the management at the
15 Countess of Chester.

16 "A duty of candour is something I believe should be
17 inbuilt in to all those working in healthcare. Sitting
18 with a patient and discussing the truth when something
19 has gone wrong is such an integral part of the trusting
20 relationship medics should have with their patients. To
21 find out now that at the time Ian Harvey met with us in
22 February 2017 he was well aware both: of concerns about
23 Letby; and that the report about our son's death did
24 contain criticism, is an absolute disgrace. I cannot
25 understand this (*redacted*) on any human level

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1 **A.** Yeah. Can I read them? That's probably ...

2 **Q.** Yes, of course.

3 **A.** So I made an impact statement to the Criminal Court,
4 and, you know, that is still completely accurate. But
5 there are some further comments.

6 "Following on from the criminal trial, we have had
7 to try to rebuild life and regain some normality for
8 ourselves and our family, which has been very difficult.
9 As a family, we have endured years of anxiety and
10 stress, from the initial arrest of Lucy Letby to her
11 conviction. The events of that night and everything
12 that has happened since have left an indelible mark upon
13 us, one that will stay with us for the rest of our
14 lives. Returning to our everyday lives post-trial has
15 proven more difficult than expected. Despite the
16 support we received during the criminal trial, the
17 knowledge we gained about the events leading up to our
18 son's murder and the methods that were used by Lucy
19 Letby has been indescribably traumatising.

20 "We have had multiple unannounced visits to our home
21 address by members of several media organisations
22 wanting to speak to us. This has been distressing,
23 intrusive and anxiety provoking. We have had to
24 increase security at our home, at great cost, in order
25 to feel protected, and that we can protect our family

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1 whatsoever.

2 "We continue to feel thoroughly betrayed by this.
3 It has affected our grief, compounded our distress and
4 given us a general sense of distrust which we didn't
5 have before."

6 **Q.** Suggestions and recommendations. You say you think that
7 there should have been greater analysis of unexpected
8 deaths where no clear cause had been found on
9 post-mortem.

10 **A.** Yeah.

11 **Q.** Have you given any further thought to how that can be
12 ensured that that takes place, or whether patients
13 should have a voice in seeing whether that's taken
14 place, or anything like that?

15 **A.** I think it's difficult to say, without knowing the ins
16 and outs of all of the specific processes that exist at
17 the moment, but what I will say is, you know, there was
18 some discussion and debate at the time between the
19 pathologist and John Gibbs as to whether the findings on
20 the post-mortem were the cause of the collapse, or the
21 consequence of it. And with there being several strange
22 answers on post-mortem reports, or unusual answers such
23 as "unascertained" or, you know, prematurity being given
24 as a cause, I feel like there should have been something
25 that tied all these together as being an unusual

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1 collection of events, rather than looking at each one
2 individually; looking with greater scrutiny at the
3 picture as a whole, however that can happen.

4 **Q.** You also say:

5 "I do not understand why the coroner's office did
6 not recognise the increase in deaths as being an unusual
7 peak, especially when taken in the context of
8 post-mortem findings that were not 'typical' and
9 clinical details that showed the sudden and unexpected
10 nature of the deaths. When someone dies in hospital the
11 post-mortem is conducted to establish a natural cause of
12 death even in cases of unexpected death. I feel this
13 needs to change to include toxicology and a greater
14 index of suspicion for all unexpected deaths in
15 hospital."

16 **A.** Yes.

17 **Q.** Would you like to add to that all, or does it speak for
18 itself?

19 **A.** I think it speaks for itself, really. You know, I think
20 it's very sad that we have to consider that somebody
21 could come to deliberate harm in a healthcare setting,
22 but unfortunately this isn't the first, and it won't be
23 the last, time that that occurs. So the index of
24 suspicion needs to be higher.

25 **Q.** You also say:

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1 and who is accessing what and when. So I feel like that
2 would be a more straightforward thing to implement, in
3 comparison to CCTV.

4 **Q.** You were also relying on photos, weren't you, when you
5 couldn't first see your son, or having to look at
6 images. Would it have helped then, to have some kind of
7 viewing of him when you couldn't physically get up and
8 get to the unit?

9 **A.** Yes. And I think there are some countries where they
10 have cameras in the incubators so you can do constant
11 monitoring of your baby, and that certainly would have
12 helped me following my caesarean section when I couldn't
13 go down there.

14 **Q.** You say you'd like to see drug fridges locked
15 electronically and opened using swipe cards unique to
16 individuals so there is clear evidence available when
17 you access them.

18 **A.** Yes.

19 **Q.** You'd like to see a better regulation of NHS managers?

20 **A.** Yes.

21 **Q.** And greater accountability for patient safety. Would
22 you like to expand on that?

23 **A.** I think it sort of speaks for itself, really. I think,
24 you know, there is a feeling, I suppose, that NHS
25 managers can go under the radar, easily move from one

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1 "I also feel that different medical personnel being
2 on duty for the deaths prevented her from being caught
3 sooner."

4 Do you think there's merit, then, in consistency of
5 staff on units and on wards to see what's going on?

6 **A.** Yes, I think so. I think patterns would be recognised
7 much quicker.

8 **Q.** CCTV. Would you like to see that on wards, or not?

9 **A.** I think this is a difficult -- it's a difficult subject,
10 isn't it? I don't think it's very clear-cut, and
11 I think there are lots of privacy implications. But in
12 terms of knowing which staff are where, I know that some
13 places have CCTV in hospital corridors, for example, but
14 not in bays, and that helps to identify who is where and
15 when, and who's accessing drug cupboards and, you know,
16 what they're carrying. That sort of thing. So I think
17 careful thought needs to be given to it. I understand
18 that it's not a straightforward thing to implement,
19 though. But I think things like electronic swipe data
20 on fridges would be fairly easy to implement, and would
21 give accountability to people. You know, you use your
22 swipe card to get into the fridge that controls, you
23 know, where the medication is kept, rather than there
24 just being a bunch of keys that's passed around a group
25 of nurses on the ward and nobody knows who has got them,

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1 place to another, and perhaps aren't held to account in
2 the same way that doctors would be referred to the GMC,
3 nurses could be referred to the NMC. There is no body
4 to refer an NHS manager to, to my knowledge. And
5 I think something with a clear structure would
6 potentially help, and then those who were not getting
7 the support from management would have somewhere to go.

8 **Q.** You say:

9 "I would like to see the formation of an independent
10 body to whom clinicians can raise patient safety
11 concerns without fear of repercussions within their
12 workplace."

13 **A.** Yeah.

14 **Q.** How do you think that would assist them?

15 **A.** I think -- and I'm sure that there will be evidence
16 heard about difficulties in raising concerns and
17 concerns about being reported themselves for raising
18 concerns -- I think there needs to be somewhere clear
19 that clinicians can access that's actually outside of
20 their hospital Trust. You know, because often the
21 concerns will be being raised about somebody within that
22 Trust, and what if that concern is being raised about
23 the person that you need to speak to within the Trust?
24 You know, just somebody completely external to provide
25 support and guidance, and to help people's concerns be

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1 taken seriously.

2 **Q.** Do you think -- I mean, clearly all patients require
3 safety in hospital, but do you think there's argument
4 for an elevated level of reporting and assistance where
5 it is child protection concerns, in effect, the most
6 vulnerable neonates?

7 **A.** Yes.

8 **Q.** Where they can't even have their mother, in this case,
9 near them at the time --

10 **A.** Yeah, absolutely. When you have your child in hospital
11 or in a neonatal unit, you know, you're not there to
12 advocate for them. You are very much leaving your child
13 in the care of other people, and you have to be able to
14 trust them to do the right thing.

15 **Q.** You have said already in evidence you would like to see
16 bereaved families not charged for death certificates,
17 and you've said:

18 "On a personal note, I would like a personal
19 face-to-face apology from Ian Harvey."

20 **A.** Yes.

21 **Q.** Do you wish to say any more about that?

22 **A.** I feel very strongly. I felt at the time that we were
23 being misled, that we were being kept in the dark.
24 I feel very strongly now that Ian Harvey was desperately
25 trying to stop us from asking further questions by

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1 screen? So it's INQ0000111.

2 I don't know if you can read it from there, but it's
3 described as a Datix Admin and Management Form. Have
4 you seen this document before?

5 **A.** No.

6 **Q.** Okay. If we scroll down on to page 2, towards the
7 bottom, you can see here an entry dated 29 June 2017:
8 "Potential claim - neonatal."

9 **A.** Okay.

10 **Q.** Do you know anything about potential claim?

11 **A.** No.

12 **Q.** If we go on, then, to page 5. There's a reference here
13 to a Serious Incident Panel, SI Panel. Date of meeting,
14 2 July 2015. Here attended by Alison Kelly. Were you
15 aware that a meeting had taken place on 2 July 2015
16 relating to Child C?

17 **A.** Not to my recollection, no.

18 **Q.** And if we could go down, please, to the "Meeting
19 Discussion Points", and the reference beginning
20 "Coincidental Findings". It says here:

21 "Delayed cord clamping at delivery (not hospital
22 policy yet for pre-term babies).
23 "No recorded use of CPAP in delivery room.
24 "Small delay in intravenous antibiotics (one hour
25 delay) and TPN commencing.

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1 providing a whitewash gloss-over of a report and hoping
2 that we would just take his word for it and not ask any
3 more questions. I feel that we were treated extremely
4 disrespectfully, and I think it's added hugely to our
5 distress at what was already a distressing time.

6 **MS LANGDALE:** I have no further questions, my Lady. I don't
7 know if Mr Baker, King's Counsel, has now, or if he'd
8 like to consider a moment.

9 **MR BAKER:** I'd like a short break, my Lady.

10 **LADY JUSTICE THIRLWALL:** Yes, of course. We will leave so
11 you can discuss.

12 **MS LANGDALE:** I think you have to leave, as well as the
13 witness.

14 (3.46 pm)

15 (A short break)

16 (3.53 pm)

17 **LADY JUSTICE THIRLWALL:** Mr Baker, I was looking for you in
18 the wrong place.

19 **MR BAKER:** Yes, I had moved.

20 **LADY JUSTICE THIRLWALL:** Very wise.

21 **MR BAKER:** Thank you, my Lady.

22 Questions by MR BAKER

23 **Q.** Mother C, can I first of all take you to a document
24 called a Datix report and, if I can, give the INQ
25 number. Would it be possible to bring that up on the

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1 "Glucose high on one occasion, above 10, however
2 delay in repeat monitoring the glucose levels.
3 "AXR equals nasogastric tube not in place. Baby
4 lively and pulling at lines. Only settled in kangaroo
5 care.
6 "Intravenous Ranitidine prescribing.
7 "24-hour consultant to consultant discussion for
8 babies on ventilator.
9 "Learning point for when non-ventilated babies are
10 not improving."
11 Were you made aware of any of those concerns at all
12 in relation to Child C in July 2015 or afterwards?

13 **A.** No. I wasn't made aware of any of those, no.

14 **Q.** Thank you. And if we could go then finally on to
15 page 7, we have here a section entitled "Duty of Candour
16 Assessment". Can you see that?

17 **A.** Yes, I can see it. Thank you.

18 **Q.** There are a series of prompts in the left-hand column:
19 "The patient and family have been supported to deal
20 with the consequences and have a key named contact.
21 "The investigation has been appropriate to the
22 incident.
23 "The patient/family have been informed once it has
24 been known that a moderate/severe incident has occurred
25 within ten working days.

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1 "The initial notification provided face to face.
 2 "The verbal notification was accompanied by an offer
 3 of written notification ..."
 4 Boxes to the right of that are all blank. Were any
 5 of those steps taken in respect of you?
 6 **A.** No.
 7 **Q.** If we could go back now, my Lady, into the paper bundle,
 8 I think it may be slightly easier to orientate.
 9 **LADY JUSTICE THIRLWALL:** Yes, thank you.
 10 **MR BAKER:** If you could look, please, to the paper bundle
 11 you see in front of you, and to page 30. We have here
 12 a letter from John Gibbs to you dated 24 September 2015.
 13 If you turn over the page, please, to the bottom of
 14 page 31, we can see here at the paragraph that begins
 15 "The pathologist was impressed". Can you see that?
 16 **A.** Yes.
 17 **Q.** It says:
 18 "The pathologist was impressed by the patchy
 19 myocardial ischaemia in Child C's heart and, until
 20 I have discussed the PM with him by phone, he had felt
 21 that this could have caused Child C's collapse. He
 22 based this assumption on the fact that when there is
 23 a sudden cardio-respiratory collapse this will lead to
 24 myocardial ischaemia but it takes some hours for the
 25 cellular changes (histological changes) to become
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1 made sense to me, and it fitted exactly with what he had
 2 discussed with us as well, that he very much felt that
 3 the findings at the post-mortem were as a consequence of
 4 the collapse and not the cause of it, and that nothing
 5 had been found that explained the cause of Child C's
 6 initial collapse.
 7 **Q.** So you understood him there to be expressing uncertainty
 8 about the recorded cause of death within the --
 9 following the post-mortem?
 10 **A.** Yes. So at the time of this letter, the official
 11 post-mortem hadn't been concluded. This was
 12 a discussion that he'd had with the pathologist in the
 13 August, and it was the November that we got notification
 14 of the conclusion of the post-mortem, and the conclusion
 15 was -- myocardial ischaemia was put as the cause of
 16 death, but these discussions were happening in the
 17 run-up to that period of time.
 18 **Q.** You were shown the letter -- and it's at page 30 --
 19 forgive me; it's bundle-page 48. You were shown the
 20 letter from Ian Harvey enclosing sections of what you
 21 now know to be Jane Hawdon's report --
 22 **A.** Yes.
 23 **Q.** -- and those sections on page 49, 50, and 51.
 24 **A.** Yes.
 25 **Q.** There is, in fact, a copy of the full report included --
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1 apparent. Therefore, because Child C has clear signs of
 2 patchy myocardial ischaemia the pathologist had assumed
 3 this problem must have developed during the few hours
 4 before he suddenly collapsed, because if he died at or
 5 shortly after the resuscitation this would not have
 6 allowed time for the ischaemic changes as a result of
 7 that collapse to have become obvious when later
 8 examining the heart. However, when I pointed out to the
 9 pathologist that because of the slightly unusual,
 10 prolonged nature of Child C's resuscitation (even though
 11 the latter part of the resuscitation was only intended
 12 to be a relatively token effort pending the baptism),
 13 some signs of life had returned and it was some hours
 14 later that Child C finally died. This would probably
 15 have allowed the myocardial ischaemia that would have
 16 been expected at the time of Child C's collapse (and
 17 during his resuscitation) to have become established
 18 histologically since Child C's death did not occur for
 19 some hours after his collapse and resuscitation."
 20 You saw that paragraph in the letter to you. How
 21 did you interpret it?
 22 **A.** What Dr Gibbs was saying in that paragraph completely
 23 fitted with my understanding as well, you know, that
 24 we'd had this collapse with this sort of prolonged
 25 period where Child C was dying. And what he was saying
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1 I will give my Lady the INQ number in a moment. It's
 2 INQ0006862, and it's at page 31. Now, it may be helpful
 3 if you just look for a moment at the Datix report at
 4 bundle-page 48, if you still have it in front of you,
 5 and page 49 in particular, and compare it with the
 6 document that's on screen now.
 7 We can see at page 49 under "Child C" -- it begins
 8 with "IUGR, reverse EDF". And the box we can see on the
 9 screen is missing from the version that you have in
 10 front of you.
 11 **A.** Yes.
 12 **Q.** Now, when you said in response to questions from
 13 Ms Langdale, King's Counsel, that you had since seen
 14 a form that had boxes on it --
 15 **A.** Yes.
 16 **Q.** -- is that the form you were referring to?
 17 **A.** Yes.
 18 **Q.** And when did you first see this document that has the
 19 box on it?
 20 **A.** As part of disclosure for this Inquiry.
 21 **Q.** And you were giving evidence a moment ago about
 22 discussions regarding the post-mortem report.
 23 **A.** Yes.
 24 **Q.** At the end of the box there, it says:
 25 "Agreed PM report but no cause for deterioration
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1 identified."

2 **A.** Yeah.

3 **Q.** Again, when -- were you made aware of that at the time
4 of your discussions with the Countess of Chester
5 Hospital in 2017?

6 **A.** When we met with Ian Harvey, no. And when we received
7 this heavily redacted, if you like, copy of the report,
8 then no, it was not featured in the information that we
9 were given.

10 **Q.** Thank you. And my Lady, if we could go, then, to
11 page 32, the following page. You can see obviously at
12 the bottom of that page there's another box which talks
13 about "Delayed cord clamping policy. Confirm with
14 staff".

15 When was the first time that you saw that box?

16 **A.** As part of disclosure for this Inquiry.

17 **Q.** Finally, in relation to this document, the conclusion
18 section of this report, which includes a summary of
19 cases, beginning on page 55. Now, this version of the
20 report omits reference to Child C, whereas other
21 versions of this report include Child C within this
22 first box, this first section here under paragraph 1.

23 **A.** Yeah.

24 **Q.** When did you first see the summary of case section of
25 Jane Hawdon's report which sets out that Child C's death

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1 to that page -- you are here describing a discussion
2 between yourself, Alison Kelly and Sian Williams.

3 **A.** Yes.

4 **Q.** About ten lines or so from the bottom -- seven lines
5 from the bottom, you say:

6 "They advised me that the investigation was just
7 a formality to check staffing levels because there had
8 been a small increase in the number of deaths, but they
9 didn't think that it was significant."

10 What was your recollection about what they were
11 communicating to you in this particular meeting about
12 the reasons for the investigation?

13 **A.** There was absolutely no indication of anything criminal
14 being investigated, that it was more a kind of review of
15 their services to make sure that they were meeting
16 appropriate guidelines. There was nothing that they
17 said that made me think that there was anything more to
18 it than that.

19 **MR BAKER:** Thank you.

20 My Lady, I don't have any more questions, thank you.

21 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,
22 Mr Baker. So, obviously, that concludes your evidence.

23 Before you go, I just wanted to thank you and your
24 husband for coming to the Inquiry this afternoon. You
25 were asked in your evidence to give a description of

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1 could have been prevented with different care?

2 **A.** As part of disclosure for this Inquiry.

3 **Q.** Finally, then, in relation to your meeting with Ian
4 Harvey, if you could look at your witness statement,
5 please, first of all, at paragraph 31, you say in that
6 paragraph that you were not absolutely sure that Alison
7 Kelly was present at that meeting.

8 **A.** Yeah.

9 **Q.** Whereas in evidence before the Inquiry, you said you
10 were now sure --

11 **A.** Yes.

12 **Q.** -- that she was present.

13 **A.** Yeah.

14 **Q.** What has caused you to change your mind?

15 **A.** At the time that I wrote this statement for the Inquiry,
16 I was relying on my memory now, and my memory -- my sort
17 of spontaneous memory now is that I believed it to be
18 her, but I couldn't be a hundred per cent sure. Since
19 writing this statement to the Inquiry, I have re-read my
20 police statement that was written a number of years ago,
21 and in that police statement, I state that it was Alison
22 Kelly, and I would not have said that if I was not a
23 hundred per cent sure.

24 **Q.** And then finally on paragraph 23, this section is
25 actually on the following page, page 10 -- 23 carries on

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1 your experiences, and you've done so with enormous
2 clarity and great eloquence. You give reflective and
3 insightful suggestions for change. I don't
4 underestimate the effort and the huge emotional toll
5 that this has taken upon you both, on top of everything
6 that's gone before, and I just want you to know that
7 your contribution to this Inquiry is very, very
8 significant, and I wanted to thank you.

9 **(The witness withdrew).**

10 **(4.11 pm)**11 **(The hearing adjourned until 10.00 am the following day)**

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