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.

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 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

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.

"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

towards when you had your caesarean section and the birth. What was it like, your antenatal care and generally? How did you feel?

A. The antenatal care was -- I mean, I had a couple of specialists who realised it was a high-risk pregnancy, so the antenatal care was good. I was being looked after by another consultant at a different hospital for my condition.

Q. Yes. And do you --

A. But the antenatal care with the consultant was good.

Q. And you had some care at the Countess, didn't you, and some consultant care, so split care type of arrangement.

And how did you feel, knowing you were expecting twins?

A. Really excited. Even more so when I found out it was a boy and a girl, and I sort of got one of each.

Q. And you actually spent some time in the Countess of Chester before the caesarean section, didn't you?

A. Yeah.

Q. And how was that, that period of care?

A. The only time that I didn't feel very comfortable was the day that I was admitted, and somebody from the neonatal unit came and told me about -- that they were going to show me around and things and basically how high risk it was and how, you know -- because, at the

time, I was 29 weeks and basically put the fear of God in me.

Q. You actually --

A. But other than that, the actual care on the maternity ward was really good.

Q. And you had -- you tell us at paragraph 20 of your statement you had -- you were 31 plus two weeks, and you had a caesarean section; yes?

A. Yeah.

Q. And Child B and Child A were delivered at 8.30 and 8.31 pm. Child A weighed 3 lbs 12 ounces, and Child B weighed 3 lbs 11 ounces; yes?

A. Yes, that's correct.

Q. And when you came round, what do you remember? You set out from paragraph 21 what you were told about the babies and how you felt. How was it?

A. That Child A needed a little bit of extra -- no, Child B, sorry. I'm getting them mixed up. Child B needed a little bit of extra help.

Q. Yes.

A. But that Child A was doing really well for a premature baby. Really well.

Q. And you'd had a general --

A. In fact one of the nurses -- sorry.

Q. No, no. Go.

A. One of the nurses actually told my partner that she'd never seen a pre-term baby doing as well as he was.

Q. And you'd had a general anaesthetic, so what happened to you after you had had the babies?

A. Well, it was in the evening, so I was just encouraged to rest.

Q. So --

A. I remember being really thirsty, but I was on low [fluid?] restriction, so I was kind of only allowed to have a certain amount of fluid per hour. So I was sleeping and then waking up at every hour to have the amount of fluid that I was allowed. The neonatal unit brought through, because I asked -- because obviously I was going to be under a general anaesthetic, I did ask to have photos taken so that I could see them as soon as I woke up. So they brought through, like, two little cards with a photo of each.

Q. So did you see them in person that first night or not?

A. No.

Q. But you tell us your partner went into the unit and had taken some photos and you saw them?

A. **(Witness nodded)**

Yeah, on the photos, yeah, but not physically saw them.

Q. The next morning, you asked if you could go and see your

babies first thing. Were you aware able to do that?

A. No.

Q. Why not?

A. Because they told me that they were trying to insert long lines and that I would need to wait. I also asked several times throughout the day and was told that exact same thing. I was only allowed to go through when the consultant that was looking after me came through, and I actually complained to her and told her that I hadn't seen them yet and that I really wanted to, and it was quite distressing that I wasn't allowed to go through. And that was only then that that consultant went through and told them that I was able to go through and see them, but even then, I had to wait about two hours.

Q. At paragraph 26 of your statement, you say this:

"When I first went to the neonatal unit, I went to see Child B because I'd been told she'd had breathing difficulties at birth and had needed medical assistance to start her breathing. I was told by a nurse that she needed a little bit extra help. I took the nurse's comments to mean that there was now nothing to be concerned about."

Do you remember that?

A. Yeah, that's true.

Q. You tell us in your statement, from paragraph 30

onwards, later that day you were in your room, and you heard nurses discussing Child A, or you -- or Father A&B --

A. My partner.

Q. Yes, father heard. And what are you aware that he heard being said, then?

A. He heard them say there's something wrong with Child A, and discussing whether they should come and get me and my partner.

Q. Did someone come and get you? And what happened next?

A. They came to get me when he'd already crashed and there was nothing more that could be done.

Q. You say you were wheeled down to the unit by a staff member or Father A&B -- you can't remember now -- but what scene did you come across? What did you arrive to?

A. It was chaos. Absolute chaos. I couldn't even actually -- there was that many people, I couldn't even actually see Child A.

Q. You say there were many people around his cot, and one nurse asked if you were religious and if you'd like her to say a prayer. Do you remember that now?

A. Yeah, I do.

Q. What did you make of that? What did you think of that?

A. Well, I'm not religious myself. My partner is. So I felt like I sort of had to say yes, even though

I wasn't ready for -- to let go. So she was asking me to say a prayer, and I had got to accept that my child died before I even got to know what was going -- what was happening, or anything like that. And I understand she was probably just trying to make me feel better, but it made me feel so much worse. Sorry.

Q. Dr Jayaram spoke to you and said he needed permission to stop CPR. Was it him who asked you about that or spoke to you?

A. Yes.

Q. At this point, had you ever had a chance to hold Child A?

A. No. No. The only contact that I had with him before he died was -- he was crying when I went into the neonatal unit, so I went over, and I put my hand in and put my hand on his stomach, and that's the only time.

Q. Shortly afterwards, you were asked if you wanted the hospital chaplain to come to see you. What in fact was your need at that time? What did you want to do?

A. To find out what had happened. I'd been told that my baby, for a pre-term baby, was in one of the best conditions that they'd ever seen, and then hours later, he died.

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

answer. I was told that: we had to stop CPR because he was gone, and even if they managed bring him back, he could have been severely disabled, although I wouldn't have cared. I would have preferred to have him, disabled or not. But they still said that they needed to stop.

Q. Shortly afterwards, you were told they'd need to take Child A to Alder Hey Hospital for a post-mortem, "and he had to stay in a hot cot while we waited for transport to take him there."

You say you were asked, at that time, to speak to the coroner. Were you asked to do that, and how did you feel about having to do that?

A. So the -- the time that it happened to Child A, it was the evening, and my concern went straight away to Child B, and I didn't want to leave her. I didn't want to talk to anybody. I just wanted to be there with my child. I'd already been told for nearly 12 hours, maybe even longer, that I couldn't see them. I got to see them for maybe half an hour, so if he'd been alive -- so half an hour is all I got to see my child before he died. And there was no way that I wanted to leave Child B. Why would I want to leave her? I only got half an hour with my other child. But they kept coming through: "You need to talk to the coroner. You need to

talk to the coroner," and it was the last thing I wanted to do. And in the end, my partner got so sick of them pestering us, that he went and spoke to the coroner, just so that they would leave us alone.

Q. Father A&B remembers that it was Letby who brought Child A in to you.

A. Yes, I --

Q. Do you remember anything --

A. Yes, I remember vividly that it was her. I didn't remember at the time when I was first -- when the police were brought in and I was told her name, but as soon as I saw the picture of her face, I remembered straight away.

Q. We have seen the medical records and the conversations that Dr Brearey, Dr Saladi and others are having in the next few days, and to quote, for example -- my Lady, it's page 63 -- Dr Saladi: "cause of death is unknown", and Dr Brearey also saying to you -- sorry, it's Dr Saladi: "We don't have an explanation for the cause of death of Child A. We're waiting for the full post-mortem report."

Is that what they were saying to you? They did not know why --

A. Yeah.

Q. -- he had died?

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

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

A. No, never. I wasn't even aware that a Datix form had been completed.
Q. And we know -- and my Lady, it's page 28 -- the Datix form says:

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

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

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

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

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

A. Yes. Yeah. The night that it happened, they were very good at letting us stay and letting us sit there, but towards the afternoon of the second day was when they were telling us that they would allow it for now, but we would need to go back to the rules, basically.
Q. You say also in your statement -- how did hearing alarms on the ward generally make you feel, having lost Child A and when you were with Child B? What was that time like for you on the ward?
A. Unbearable. Even now, if I visit family or anybody in hospital and I hear those beeps, it makes me want to cry. It is something that we -- both myself and my partner -- we cannot deal with, hearing that noise, because that's obviously the noise that indicates something is wrong.
Q. You also tell us at paragraph 57 that the nurses would try and encourage you to go and rest when you were sat with Child B, but unless the father was there -- or you found that really difficult to do.

I think the screen is frozen.

A. -- and when I was sat by -- oh, sorry.
Q. That's okay. We lost you for a moment. I don't know if

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

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

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

Q. And you say: during the night, you set your alarm on your phone for every two hours, and you'd call the unit.
A. I would, yeah.
Q. One night, you rang at about 4.00 am, and there was a bit of a confusion about whether the call -- well, do you want to tell us what happened?
A. So I called every two hours, and me and my partner would sort of take it in turns, but most of the time it would be me because I couldn't sleep properly. I called, and I said: I'm just calling to check on Child B, which is what I did every night every 2 hours, from when I left

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

Q. Then the next day, was it explained to you that that should have been a conversation with somebody else?
A. It was, but I was made to feel like I'd done something wrong. When I walked in that unit, everybody turned their head to look at me, and I was taken off into a room to be explained that to. They did apologise, but the atmosphere when I walked into that unit was as if I'd done something wrong.
Q. Turning now to the cause of the death of A and the deterioration of B. I'm going to read some documents here to help remind you of what they say, rather than you have to turn them up, if I can.

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

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

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

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

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

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

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

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

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

that made you write that letter to Yvonne Williams?

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

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

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

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

Dr Jayaram replied:

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

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

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

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

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

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

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

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

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

Q. You then had instructed solicitors, hadn't you, and we have seen a letter written on your behalf by solicitors dated 28 September, and it was sent to coroner Mr Nicholas Rheinberg. My Lady, it's page 37 of our bundle. And the letter is dated, as I've said, 28 September, Mother A&B, and what it says is:

"Dear Mr Rheinberg. Inquest concerning the death of Child A. I write further to the disclosure of the one-page summary regarding Child A's death which was today provided by the Countess of Chester Hospital. We were of the understanding that a full investigation was taking place at the Trust regarding Child A's death which would result in a report detailing the chronology of events, the issues involved, whether any errors were

made, whether such errors could have caused or contributed to Child A's death, and the lessons learned.

"We were told in August 2016 that this investigation was ongoing and we would be provided with a Serious Untoward Incident Report. We therefore expected to receive prior to the inquest hearing a fairly lengthy and comprehensive document dated August or September 2016. We are therefore very surprised that the Trust has now provided such a short document describing only the most superficial investigation and one that bears the date 1 July 2015. Clearly, this document is not the result of the major and detailed investigation we were told was still ongoing only a few weeks ago.

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

report can be disclosed as a matter of urgency, if indeed that investigation is yet complete."

We also know, Mother A&B -- it's at page 66 -- what that one-page report was that was signed by S Brearey and dated 1 July 2015, contained a summary of your case, and learning from these changes. And underneath "Learning from these cases", it said:

"There was notable excellence in practice and record-keeping, [it says in all three cases] although the following points are unlikely to have influenced the outcome, the following points for discussion improvement in practice were noted: no record of capnograph used following intubation. However, doctor recorded see ETT pass clearly through cords and good chest movement, verified by consultant. ETT left in for PM - no comment that was incorrectly placed on preliminary PM report. Delay in debrief."

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

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

Q. Fair enough.

A. I don't remember that.

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

"Thank you for your letter which arrived whilst I

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

Later on, it continues:

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

You attended the inquest, didn't you?

A. I did, yes.

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

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

the impression that you had gained from it?

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

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

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

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

If we look at page 49 of our bundle:

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

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

Do you remember him giving that evidence?

A. Not really, to be honest.

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

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

If we go over the page, 54:

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

And if we go over the page to page 56:

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

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

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

Do you remember Dr Jayaram giving evidence?

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

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

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

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

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

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

to --
A. I remember trying -- I remember trying to get our copy and find out when we would get it, but I couldn't tell you who I spoke to.
Q. Right; so you did phone the Countess. You had solicitors, as well. So you remember that, trying to get hold of that report?
A. Yeah.
Q. There's a letter -- again, it's in the bundle, my Lady, at page 40 -- 8 February 2017, from a Mr Harvey. And you tell us you don't remember receiving that letter. This letter says, I'll read it to you, 8 February:

"Following on from your conversation with our Deputy Director of Nursing Sian Williams on Friday, please find enclosed a copy of our report. During this telephone conversation, it was explained to you that we asked for this external assessment from the Royal College of Paediatrics and Child Health and the Royal College of Nursing. This step was taken because we wanted to better understand why there had been a greater number of deaths than we would normally expect on our neonatal unit between January 2015 and July 2016. In the report, it describes no single cause or factor to explain the increase we have seen in our mortality numbers. The review makes a total of 24 recommendations across

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

And it continues. And it says at the end:

"We would really encourage you and your family to have a meeting with us to discuss anything from the report that you need further clarity on."

Do you remember getting any correspondence from Mr Harvey or not?
A. I don't. I remember that we were supposed to have a meeting with him but that it didn't happen. And I think that was because that -- the police were brought in and he was then not allowed to talk to us.
Q. So how did you get that report? Because you did get that report in the end, didn't you?
A. Yeah. I got it through the post.
Q. So you were going to have a meeting but you couldn't have. Why did you not have one, as far as you were aware?
A. Because the police were called in, and we don't think he was allowed to talk to us after that. I'm not certain that that's the reason, but --
Q. You didn't have one?
A. No, we didn't have one.

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

Do you think that's the one that was sent, that you got -- the report -- in April, or did it get it before then, or you can't remember now?
A. I can't -- I remember we received it, but I couldn't tell you when, to be honest.
Q. What appears -- and again, do you remember this or not, say if you don't -- attached to that letter is a one-page typed notes of Child A and with cause of death unascertained. Do you remember getting that, a summary --
A. No.
Q. -- in any report?
A. No.
Q. And it may be that you did, you just don't remember now.
A. It may be that I did, but I don't remember.
Q. You were, we can see, with the instruction of your solicitor and your attendance at the inquest, trying to find answers as to why Child A died. Did you feel at any of these moments getting the report or communicating with the hospital you got any answers?
A. No. It feels as if the more they tried to sort of --

like I say, with Dr Jayaram's reply to me and everything, it just felt really half-hearted, and that's why I wanted to say: we are human beings, and we'd lost our child, and at no point did I think that anybody was trying. I think it was just a case of: he was a patient. He died. That's the end of it. Move on. I don't think that they ever tried to understand how it was affecting us, and the fact that we never had a reason -- to me, it was really important for them to try and do everything they could to give us a reason, and to me, they just didn't care. They just did not care. We weren't even -- I just didn't even feel like they thought of us as people, that they thought of Child A as an actual baby that had died. It was just a patient.
Q. When you say "they didn't care", you obviously spoke to Dr Saladi, Dr Brearey and Dr Jayaram at the inquest. When you say "they", who do you mean by "they"? Do you think -- do you include everyone at the hospital, or do you think the doctors were talking with you and showed care?
A. At the inquest, Dr Jayaram was -- approached us and was very nice, and, you know, but just, in general, when we were on -- I mean, what you have to understand is: I had to walk through them doors and sit there all day every

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

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

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

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

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

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

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

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

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

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

Can you tell us a bit more --

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

Q. Right. So do you --

A. But not as -- [audio disruption]

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

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

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

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

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

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

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

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

A. When the police called me.

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

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

Q. And then --

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

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

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

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

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

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

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

Q. You --

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

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

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

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

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

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

A. Yes, I agree with that.

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

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

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

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

up sooner.

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

A. Yeah.

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

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

Q. And finally, you say in your statement:

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

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

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

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

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

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

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

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

happened.
Q. They are all the questions I have for you, Mother A&B. Is there anything you would like to add that I perhaps haven't asked you about, or something else that you would like the judge to know about?
A. Just on the -- you know how I was saying about the independent review, I also think that there needs to be given more information to the parents, because as I've stressed the whole time, we are people, and that is our child. That's our world. And I was never given an opportunity to sit in an official setting and ask questions that I wanted answered. It was almost -- and they didn't -- they didn't roll their eyes, but you know that's how I felt. Like: "Here comes this woman again asking the same questions that we can't answer" and never even tried to answer. And we were just supposed to accept that one of the most important things in the world to us was gone, and that's it.

So I think, in hindsight, there needs to be more emphasis on treating parents as individuals. As I said, some of the parents on the neonatal unit probably had a great experience, but I didn't. I lost a child on that unit. And there was never any thought given, when I walked through them doors every day, that I had lost a child on that unit, you know. There was never any

thought given to that. And I just think, instead of treating me as this hysterical woman, put yourself in my shoes. How you would feel if you had to walk into the place every day where your child died. And I would have done it because obviously Child B was there, so nothing would have kept me out of that unit, but it was hard. It was really hard.

And I just think, treat us as people because that's what we are. And not everybody is under the same circumstances. And if I'm asking a question over and over again, it's because I need an answer. I need you to -- I need to know that you care. I need you to know that Child B and Child A are people. They're the most important people in my life. And I just think that that is something that's been overlooked through this whole process, in the press, in the trial. We had to act a certain way in the trial. We couldn't just be the parents of these babies. And all we want to do -- all we want to do is find out what happened, and we never ever want it to happen again.

And it just feels like we have been given no power throughout this whole process, throughout all this time. We've got no power. And I just think that this Inquiry is finally the chance that we are listened to, and we can give our side of things. And my side of it is: I am

a person, and they are my babies, and I've lost one of them, and I very nearly lost one of the others. And that's what needs to be at the focus of everything, not Lucy Letby. Why is anybody talking or thinking about her? We're human beings, and that's how we should have always been treated.
Q. That concludes your evidence from my perspective. What we're going to do is, we're going to stop now, the Chair is going to leave the room, your lawyers will have a conversation and may have some more questions or may not. But if you maybe go and have a cup of tea or something and come back in ten minutes, the link will still be here, and we'll know if there's more questions or if we will be concluding. Does that work for you?
A. Okay.
Q. Does that work for you?
A. Yeah. I'll go and grab a drink and have a walk around the house.
Q. Yes, exactly. Okay, see you shortly.
A. Okay, thank you.
(11.17 am)
(A short break)
(11.40 am)
LADY JUSTICE THIRLWALL: Welcome back Mother A&B. I understand there are going to be some more questions

for you, so I hope you've had a drink and a chance to relax insofar as anyone can do that.
A. Okay, thank you.
LADY JUSTICE THIRLWALL: Now, Mr Skelton?
Questioned by MR SKELTON
MR SKELTON: Mother A&B, may I ask you just briefly about Child B again.

In your statement, you describe wanting to stay with her after Child A had died.
A. Yes.
Q. And could you describe what happened the first time you left her.
A. She collapsed and had to be resuscitated and was attempted to be murdered.
Q. What did you feel about the fact that that occurred the only time you weren't there?
A. It was an absolute nightmare. I just -- my brain -- my first thought was: "Not again", and that night, I refused to leave the bedside all night. And the whole time that Child B was in hospital, that is the best night's sleep I'd ever got because I was right there with her.
Q. You mention in the statement at paragraph 52, and you have mentioned in evidence in answer to Ms Langdale, that you recall her having a particular rash that you

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

first become aware that there had been an unexpected increase in mortality in the neonatal unit?
A. When the police were called.
Q. Would you have wanted to know about that increase in mortality much sooner?
A. Yes, because maybe then it would have been easier for us as parents to push for something more to be done.
Q. Would you have expected to have been told about it in 2015 when it became a concern internally within the hospital?
A. Well, we attended an inquest in 2016, and it was not even mentioned then, and it had clearly -- it clearly had been an increase of a lot by then, and it still was not mentioned.
Q. I'll come on to the inquest in a minute, but just focusing on 2015, if you had been told that there'd been an unusual spike in the deaths on the unit in 2015, what would you have wanted to have happen?
A. The same as I would have wanted to have happened as soon as it happened with -- twice with Child A and Child B: an investigation. A thorough investigation. Not just looking into the unit as a whole; looking into those deaths.
I understand that there was a report given to us that was an independent review, but it was not a review

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

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

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

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

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

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

concerned?
A. Yes, they are.
Q. I am going to take you now, if I may, through that statement and take you to some other documents that you refer to in the statement as well.
A. Okay.
Q. You begin by setting out your baby's delivery and your pregnancy. Can you tell us about the circumstances of your pregnancy, how it was going, and the care you received there?
A. Yeah, so my pregnancy with Child C was my first pregnancy, and it wasn't going very well, unfortunately. I went for my routine 20-week scan at the Countess of Chester Hospital, and we were told at that scan that my baby was measuring much smaller than would be expected, and so from that point on, we were very closely monitored under the care of foetal medicine, that was predominantly Jim McCormack, and the foetal medicine midwife at the time was Jill Ellis. They saw us very regularly and gave us really excellent support, we were very grateful for that, but the pregnancy was very precarious, really. The scans were to monitor growth but also to monitor blood flow to weight, up until the point where the situation was critical and the baby would need delivery. So it was made very clear that my

baby was going to be born early and that that would have to be by caesarean section. So I felt the communication and the support was really excellent, to be honest, but it was a very scary time.
Q. And it was a day in June 2015 when you'd been in for a scan, in fact, with Mr McCormack that the delivery ensued; is that right?
A. Yes. So I -- in these kind of routine -- well, in these monitoring appointments that I was having -- I'd been for one on 5 June -- Mr McCormack was actually on holiday. It was Sara Brigham that I saw that day, and she felt that I needed admission to hospital for the remainder of my pregnancy because some of the parameters had worsened. So I was admitted on that day, and it was the following week that things had become critical. Mr McCormack was seeing me daily, things had become critical, and he said that delivery needed to happen that day.
Q. Was there any discussion about where the delivery should take place, which hospital, and why?
A. So prior to my admission to hospital -- so I couldn't tell you exactly when, but during that pregnancy, I did ask Mr McCormack at one point whether I needed a transfer to somewhere like Liverpool Women's or a different unit, but he didn't feel that that was

necessary. He said that he would monitor things closely and that if that changed then we would change the plan, and I completely trusted him and his judgment.
Q. When Child C was delivered by caesarean, when did you see him, and where did you go next?
A. So when he was delivered, I heard him cry, so I knew that he'd been born, you know, breathing and screaming, like I had hoped. But I didn't see him when I was in theatre. He was sort of whisked off to the neonatal unit. And my caesarean was completed, and then I was taken up to the postnatal ward where I was told that I was not allowed to go down and see him until I was able to stand unassisted. I'd had an anaesthetic into my spine, so my legs were numb, and I was in pain and recovering.

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

the hospital, so it did represent some challenge with that.
Q. And how did you hear how your son was in those few hours? Via his father, or via a doctor, or did anyone talk to you about how he was?
A. Yeah, so my husband was up and down, so he was kind of updating me a little bit, but we had some updates from Dr Sally Ogden, who was the registrar, so she came and spoke to me in theatre a couple of times to sort of say where things were up to, and she let me know that he was doing really well, he was born in good condition, and that he had had a brief period where he was ventilated so that he could have surfactant, which helps the lung development, but that he was fighting it so much and that he was so lively that they didn't feel that ventilating him was necessary, so this was only for a brief period, so he was breathing by himself.
Q. You say in paragraph 6 of your statement that Dr Gibbs was present a lot on the ward and spoke to you a number of times over Child C's short life. What did he say to you about how he was?
A. So I don't recall seeing Dr Gibbs on the day that he was born, but in subsequent days, certainly we saw him a number of times on the ward, and we felt that he was very open and honest with us, that Child C was very

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

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

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

A. Yes.

Q. How was he, and how was that?

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

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

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

A. Yes. So we'd had a few days where he was nil by mouth and receiving nutrition via his lines. Because of his sort of size and gestation, they felt that they needed to rest the bowel to reduce his risk of complications. So it was on 13 June so his *(redacted)* -- *(redacted)* day of life that he was given his first milk feed. We'd had a really good day that day. We'd spent a lot of time holding him. My parents had come in to visit, which -- we'd not had anybody in to visit until that point because we wanted to kind of settle in ourselves, and we wanted our privacy, but because things were going so well, they'd come to visit that day. John Gibbs had come to see us and had said, you know, if this day continues to go well, then we'll give him his first milk feed this evening, which is what happened.

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

A. Yeah.

Q. What happened later that evening?

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

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

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

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

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

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

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

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

A. Yeah.

Q. Tell us about that.

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

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

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

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

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

A. Yes.

Q. Tell us about what happened then.

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

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

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

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

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

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

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

A. Yes.

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

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

A. Yeah.

Q. What were they doing?

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

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

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

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

trial, that she wasn't supposed to be looking after Child C?

A. Yes.

Q. Your husband has said in your joint statement:

"At some point while Child C was dying, I remember a nurse plugging in a 'cold cot', a ventilated moses basket, in the corner of the room ..."

And he said this:

"I vividly remember when Lucy Letby prompted me to place Child C in the cold cot. At the time, I reacted curtly to her suggestion, and she promptly removed herself from the family room. My mother-in-law also recalls this incident. Reflecting on it now, I believe she wanted to savour my son's dying moments for herself, which fills me with both emotion and anger. Had I not challenged her, she would have further intruded on our private goodbye to Child C."

A. Yeah.

Q. Do you have any recollection now of her presence and doing that?

A. I do. It's not something that I recollected at the time of my police statement spontaneously, but when I read Father C's police statement, I do have memories of that. They are not as clear as his. I remember the cold cot being plugged in, and it was actually next to my

mother's legs, and she complained about it because it sort of makes a noise, and it's very cold, and we were in this really difficult situation where, you know, our son was dying, and it was certainly jumping the gun to bring that in and plug it in. And I remember snapping at one of the nurses, but I couldn't give any more specific detail than that. I do know that my mother made a complaint to the Bereavement Office, I think just a verbal one by phone call, to say that that must never happen to anybody else, that, you know, when a child is dying, you shouldn't come in and plug in a basket for when they are deceased to put them in it.

Q. After Child C died, you were given a memory box. Tell us about the memory box and how that was put together, what was in it, and who was doing that.

A. Yeah, so that memory box was put together by Melanie Taylor and Lucy Letby, and it consisted of hand and footprints that were sort of ink on paper. It had some clay hand and footprints. It had a little box with some of Child C's hair and some water from the baptism. It had a teddy with it, as well, and the blankets that had been used during that evening, a hat and a little dummy.

Q. So all of the physical memories of your son in that.

A. Yes, so I haven't got any physical memories of my son that were not packed in that box by Lucy Letby.

Q. You say at paragraph 16 of your statement:

"During the events of this night Dr Gibbs had advised us of the need for a post-mortem examination due to the sudden, unexpected and inexplicable nature of Child C's collapse, and that we would hear from the coroner's office with regards to this."

A. Yes.

Q. So Dr Gibbs told you that immediately, in effect?

A. Yes. Yes, he did. One thing that I remember that night was him sort of running through a list of causes of collapse out loud and sort of stating each one that wasn't applicable, and he sort of ran out of things in the list. So he was very, very clear on that night that this was not something that had been expected, and that he had no explanation, and that he was perplexed as to how Child C hadn't responded at all to very vigorous resuscitation and then had these signs of life later.

Q. Well, he wrote to you, didn't he? If we look at page 23 in this bundle, on the 20 July 2015, Dr Gibbs writes to Mother and Father C. It says at the beginning:

"I expect you are still coming to terms with Child C's sad death ..."

And invites a meeting.

A. Yes.

Q. If we go over the page at 24, three paragraphs down, he

explains:

"You might be aware that in addition to any sudden and unexpected death needing to be reported to the Coroner, there is also a separate investigative process that needs to be undertaken for every sudden unexpected death in infancy. This is known as the SUDI (Sudden Unexpected Death in Infancy) process."

He sets out:

"I'm afraid that one important aspect of the SUDI process is to consider whether an infant's (or older child's) death could possibly have been due to child abuse and also whether there are safeguarding implications for any other children in the family. Clearly, there are no child protection or safeguarding concerns related to Child C's death, but the SUDI process, albeit in an abbreviated version, has to be followed for every sudden and unexpected death in an infant."

And he goes on to say at the end of that page that it was a sudden and unexpected death, again.

A. Yes.

Q. So when you read this letter, what messages did you take from this? It was the invitation to the meeting, but what was being said in this letter, as far as you were concerned?

A. I was still very much deep in grief when receiving any of the correspondence, really, that we're going to talk about. But this supported what we'd been told in person, you know, that this was unexpected and unexplained. So I just took from this that this was the process that was kind of expected following that, really, just the meetings that were going to happen that were sort of standard meetings in these kind of circumstances. So I didn't think too deeply, really, about the fact that these -- what sounded like fairly standard routine meetings for unexpected events were going to happen.

Q. And we know from your statement that in fact you had two meetings on 21 August 2015. One was with Dr McCormack, and another one with Dr Gibbs.

A. Yeah.

Q. You set out at paragraph 17 the one with Dr McCormack, and if you want to -- I'm not suggesting you need to -- the notes of that meeting are at 27 and 28 in the bundle. But what did Dr McCormack say to you in that meeting?

A. So as I've alluded to already earlier on, you know, he was always a great support to us, and when we met with him at this point, it was no different. He expressed his shock at what had happened and his surprise, really,

that this had been what had occurred, that Child C had collapsed and died very suddenly. He was much more concerned with, you know, what had happened in pregnancy and why Child C had been born prematurely, so that was very much his focus of that meeting, was to understand the pathology that had caused that and to look at ways of preventing that problem in a future pregnancy.

But he was very supportive. He offered to refer us for some counselling. He made a plan for any future pregnancy. And, yeah, we knew we could contact him at any stage if we needed to or wanted to discuss things further. He had a very approachable manner.

Q. And then you saw Dr Gibbs, and a summary of that meeting we see at page 30. Thirty onwards is Dr Gibbs's letter to you.

A. Yeah.

Q. He sets out a number of things in that letter. It's a fairly lengthy letter.

A. Yeah.

Q. But if we look at page 2, he sets out at paragraph 2:

"Although there were several risk factors in Child C, that increased the probability of death following his delivery, it still was not expected that he would die (at least until a severe complications, such as NEC had developed), and it certainly was

unexpected when he experienced a cardiorespiratory arrest at the end of the *(redacted)* day of life."

In the paragraph above that, he refers to what you referred to earlier and says that when the resuscitation efforts were being made, he says:

"By that stage, a little surprisingly, Child C did have a weak pulse and was making gasping respiratory efforts."

A. Yes.

Q. What did you make of that at the time? You know now of the significance of that. When you read that, what did you understand by that?

A. I wasn't really in a position to consider anything we were being told in great depth at that point because I was trying very much to deal with this intense grief. I felt that Dr Gibbs was quite perplexed as to what had happened and why. I feel this letter reflects that, reflects the fact that he couldn't explain or didn't understand why Child C had collapsed in the first place but also then didn't respond as expected but then showed signs of life later. He made it very clear to us that he found that very unusual, but I didn't really think anything deeper than that at the time.

Q. On page 32, the last paragraph, he refers to this and says:

"I was sorry to learn of your negative experience with the Bereavement Office at Alder Hey Children's Hospital. I do hope you're able to go ahead, as intended, to feed back on your experience to the staff in that office."

What was the experience that you had there?

A. So when Child C was having his post-mortem over at Alder Hey, I received a phone call from the Bereavement Office, and the lady that spoke to me was obviously trying to be lovely and supportive and kind, but she made a comment about how they had dressed Child C and that he looked beautiful. I found this comment particularly difficult because in his life he had never been dressed and he had never been dressed by me. And if anyone was going to dress him, it should have been me, as his mother. So at that time, you know, I know that there was no malice in that at all, but I found that really difficult, that my son was elsewhere, and he'd been dressed by somebody, and it wasn't me.

Q. In the conversations you had with Dr Gibbs around that time about Child C, did you know if there had been any other deaths or unexpected deaths recently, or not?

A. No, I didn't. He did sort of mention that. I remember him making a comment about how it's very rare that they had unexpected or unexplained things happening on the

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

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

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

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

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

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

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

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

A. No, not for something so essential.

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

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

Q. Would you have been easy to contact?

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

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

A. Yeah.

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

A. Yeah.

Q. What happened when you did that?

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

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

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

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

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

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

Q. You say in your written evidence:

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. Do you think this might be then?

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

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

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

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

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

A. Yeah.
Q. -- which set out clearly what your views were at the time and what you were thinking.
A. Yeah, I will read it. So I wrote this letter the day after receiving the copy of the report that we were given, which as we mentioned, did not contain everything:

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

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

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

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

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

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

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

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

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

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

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

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

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

a plan to meet families individually to go through the case reviews as these did not feature in the report.

"The report from the Royal College opened up questions that I had already asked myself. I am fully aware of the fact that sometimes there are questions that do not have answers. I have asked myself over time whether it would be helpful for us to know what, if anything, went wrong, or whether that would just cause us further distress.

"I have asked myself whether someone may have acted negligently, whether the respiratory support Child C was given was sufficient, were his blood gases, electrolytes and blood glucose monitored closely enough, and, indeed, was he in the right unit in the first place, or should he have been transferred to a more specialised centre?

"The report does strike me as having some suspicion that there were some unusual features of the deaths of the babies on the unit and that perhaps there was something going on on the unit that caused or at least contributed to the increase in mortality.

"I am unsure where the Trust is planning to take this, or how this will be concluded. I have not had a definite answer as to whether any further investigation into Child C's death is planned. Sian felt that Child C's case was probably not one of the cases that

required further investigation but she was not certain. This is something that we need to know for definite. An investigation into the death of our son is the last thing that we want or need, unless it is deemed necessary or features of concern have been identified.

"Having suffered terrible grief, nine months of counselling, and having had a healthy baby in 2016, we need this chapter of our lives to be concluded so that we can focus on creating a happy, positive future for our baby.

"Every time another article is printed, or piece of information comes to light, it takes us back to the worst time of our lives, when all we want is to continue moving forward. The handling of this investigation and lack of communication has added to the distress of my family and I'm sure the distress of other families who have already suffered enough. We are trying to move forward after our indescribable trauma but this is hindering us.

"I would be grateful for any planned meeting to go through a review of our son's case to take place as soon as possible. We need closure on this. Although our grief will be lifelong we do not need any further prolongation of our suffering or further turmoil that delays in further investigations and poor communication

will bring.

"I hope that the handling of this investigation is reviewed so that the Trust can learn from the mistakes made here and that any further action required off the back of these case reviews is undertaken promptly. That really is the least that bereaved families such as us deserve.

"Yours sincerely."

Q. The message couldn't have been clearer, could it, at the end of that?

A. I don't think so, no. I was really angry, upset, disappointed, but also felt completely in the dark as to what was going on.

Q. We see, just for your reference, page 58, it's a note from Debbie Dodd -- I think that's the secretary to Mr Harvey -- but either way, an agreed meeting with Ian Harvey, Monday 20 February 2017, 10.00 am.

A. Yes.

Q. And someone was going to collect you from the main reception and take you to Ian's office, it records there.

Who went to that meeting, as far as you're aware? Who was present?

A. So it was myself and my husband, Ian Harvey and Alison Kelly.

Q. Was Mr Cross there, another male there, or not?

A. No.

Q. So you're very clear, it was just the four of you?

A. Absolutely. Mr Cross was not there. I've never met Mr Cross.

Q. Tell us what was discussed at the meeting. You deal with it at paragraph 31 of your statement.

A. So at the meeting, Mr Harvey did apologise to us for the lack of communication. He acknowledged that us learning things from the newspaper was not satisfactory.

Q. Pausing there. Did he give a reason for it?

A. No.

My main aim and agenda from that meeting was to understand what had been found with regards to the care of our son. And my fear, in some way, from that meeting would be that we would hear something that would have changed the outcome for him. For example, deficiencies in care so severe that, had they not occurred, he would have survived. So I had a very clear worry in my head.

So during the meeting, Mr Harvey told us that there had been some minor learning points noted when Child C's care had been reviewed, that there were some things that could have been done better. And I specifically asked him: was there anything that would have changed the outcome for Child C -- because that was really my agenda

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

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

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

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

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

So, in honesty, when we were told that none of those

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

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

And I didn't push this at the time because I was

quite happy with what I had heard, and I believed what I had heard, that me having a physical copy of that report was more for my own records and more of a sort of formality in that sense. So we left there feeling more comfortable that we were going to get the full report, that the full report would not contain any surprises, because we'd had a discussion about it, and there wouldn't be anything in there that was going to make us more upset, really, than we already were.

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

A. Absolutely, yes.

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

A. Yes.

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

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

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

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

A. Yes.

Q. Did he say a line would be drawn?

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

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

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

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

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

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

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

"Dear Mother C.

"Further to previous correspondence, our recent meeting, and the completed Review of the Neo-Natal Unit carried out by the Royal College of Paediatrics in Child Health at the Countess of Chester Hospital, I am writing to appraise you of our current progress. You will have seen within the Review that one of the recommendations was that a separate independent review of the care of each of the babies should be carried out. This review has now been completed but has, in turn, indicated that a small number of areas of investigation are required and I aim to undertake this as quickly as possible. I will, in due course, be sharing the findings of this further review in relation to Child C with you and will be offering to meet with you to discuss any concerns or issues that you may have arising from both the College Review and the subsequent review.

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

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

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

What did you make of that letter?

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

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

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

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

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

"Dear Mr Harvey.

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

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

carry on:

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

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

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

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

A. Yeah.

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

Q. "Dear Mother C.

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

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

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

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

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

A. Yes. I know that now, yes.

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

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

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

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

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

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

Q. You say in your statement:

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

A. Yeah.

Q. Can you just expand upon that for us?

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

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

A. Yeah.

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

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

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

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

from the Trust, from the hospital?

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

Q. Eight years after his death?

A. Yeah, eight years after his death.

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

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

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

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

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

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

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

Q. Shall we have a break?

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

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

(3.22 pm)

(A short break)

(3.27 pm)

MS LANGDALE: Suspicions and concerns regarding Letby.

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

here a quote from your husband's evidence:

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

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

You described that earlier, but when you look back with what you know now, what do you make of that?

A. It's horrendous. You know, knowing what we know now, it took us aback at the time because it just didn't fit with the context of what was happening. You know, we were having this very private, sort of difficult time that went on for several hours. And, you know, my concern now is that she wanted us to leave him there, you know, which just doesn't really bear thinking about,

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

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

A. Yeah.

Q. Did that remain the case?

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

getting answers.
A. Yes.
Q. By the time the police investigation had commenced, what was your view about those issues? Did you look for answers or did you wait and see? What was the position?
A. We were very much not asking questions because we were not in a position to receive difficult answers, is probably the best way to describe it at that time. Certainly when the police investigation was launched, we had several visits from liaison officers to support us, but they couldn't actually really give us much in the way of information at that point, with it being a criminal investigation. So it was more kind of -- it was just more support, rather than information. It was kind of telling us that we needed to do a police statement, and how would we like to do that, and planning for that sort of thing.

But in terms of asking any further questions to the Countess following our meeting with Ian Harvey, it felt completely pointless to do so, so we didn't.
Q. In terms of the impact upon you and your family, at paragraph 45 you set out further comments about rebuilding lives and impact.
A. Yeah.
Q. Would you like to describe that now?

A. Yeah. Can I read them? That's probably ...
Q. Yes, of course.
A. So I made an impact statement to the Criminal Court, and, you know, that is still completely accurate. But there are some further comments.

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

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

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

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

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

whatsoever.

"We continue to feel thoroughly betrayed by this. It has affected our grief, compounded our distress and given us a general sense of distrust which we didn't have before."
Q. Suggestions and recommendations. You say you think that there should have been greater analysis of unexpected deaths where no clear cause had been found on post-mortem.
A. Yeah.
Q. Have you given any further thought to how that can be ensured that that takes place, or whether patients should have a voice in seeing whether that's taken place, or anything like that?
A. I think it's difficult to say, without knowing the ins and outs of all of the specific processes that exist at the moment, but what I will say is, you know, there was some discussion and debate at the time between the pathologist and John Gibbs as to whether the findings on the post-mortem were the cause of the collapse, or the consequence of it. And with there being several strange answers on post-mortem reports, or unusual answers such as "unascertained" or, you know, prematurity being given as a cause, I feel like there should have been something that tied all these together as being an unusual

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

Q. You also say:

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

A. Yes.

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

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

Q. You also say:

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

Q. You say:

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

A. Yeah.

Q. How do you think that would assist them?

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

taken seriously.
Q. Do you think -- I mean, clearly all patients require safety in hospital, but do you think there's argument for an elevated level of reporting and assistance where it is child protection concerns, in effect, the most vulnerable neonates?
A. Yes.
Q. Where they can't even have their mother, in this case, near them at the time --
A. Yeah, absolutely. When you have your child in hospital or in a neonatal unit, you know, you're not there to advocate for them. You are very much leaving your child in the care of other people, and you have to be able to trust them to do the right thing.
Q. You have said already in evidence you would like to see bereaved families not charged for death certificates, and you've said:
"On a personal note, I would like a personal face-to-face apology from Ian Harvey."
A. Yes.
Q. Do you wish to say any more about that?
A. I feel very strongly. I felt at the time that we were being misled, that we were being kept in the dark. I feel very strongly now that Ian Harvey was desperately trying to stop us from asking further questions by

providing a whitewash gloss-over of a report and hoping that we would just take his word for it and not ask any more questions. I feel that we were treated extremely disrespectfully, and I think it's added hugely to our distress at what was already a distressing time.
MS LANGDALE: I have no further questions, my Lady. I don't know if Mr Baker, King's Counsel, has now, or if he'd like to consider a moment.
MR BAKER: I'd like a short break, my Lady.
LADY JUSTICE THIRLWALL: Yes, of course. We will leave so you can discuss.
MS LANGDALE: I think you have to leave, as well as the witness.
(3.46 pm)
(A short break)
(3.53 pm)
LADY JUSTICE THIRLWALL: Mr Baker, I was looking for you in the wrong place.
MR BAKER: Yes, I had moved.
LADY JUSTICE THIRLWALL: Very wise.
MR BAKER: Thank you, my Lady.
Questions by MR BAKER
Q. Mother C, can I first of all take you to a document called a Datix report and, if I can, give the INQ number. Would it be possible to bring that up on the

screen? So it's INQ0000111.
I don't know if you can read it from there, but it's described as a Datix Admin and Management Form. Have you seen this document before?
A. No.
Q. Okay. If we scroll down on to page 2, towards the bottom, you can see here an entry dated 29 June 2017: "Potential claim - neonatal."
A. Okay.
Q. Do you know anything about potential claim?
A. No.
Q. If we go on, then, to page 5. There's a reference here to a Serious Incident Panel, SI Panel. Date of meeting, 2 July 2015. Here attended by Alison Kelly. Were you aware that a meeting had taken place on 2 July 2015 relating to Child C?
A. Not to my recollection, no.
Q. And if we could go down, please, to the "Meeting Discussion Points", and the reference beginning "Coincidental Findings". It says here:
"Delayed cord clamping at delivery (not hospital policy yet for pre-term babies).
"No recorded use of CPAP in delivery room.
"Small delay in intravenous antibiotics (one hour delay) and TPN commencing.

"Glucose high on one occasion, above 10, however delay in repeat monitoring the glucose levels.
"AXR equals nasogastric tube not in place. Baby lively and pulling at lines. Only settled in kangaroo care.
"Intravenous Ranitidine prescribing.
"24-hour consultant to consultant discussion for babies on ventilator.
"Learning point for when non-ventilated babies are not improving."
Were you made aware of any of those concerns at all in relation to Child C in July 2015 or afterwards?
A. No. I wasn't made aware of any of those, no.
Q. Thank you. And if we could go then finally on to page 7, we have here a section entitled "Duty of Candour Assessment". Can you see that?
A. Yes, I can see it. Thank you.
Q. There are a series of prompts in the left-hand column:
"The patient and family have been supported to deal with the consequences and have a key named contact.
"The investigation has been appropriate to the incident.
"The patient/family have been informed once it has been known that a moderate/severe incident has occurred within ten working days.

"The initial notification provided face to face.

"The verbal notification was accompanied by an offer of written notification ..."

Boxes to the right of that are all blank. Were any of those steps taken in respect of you?

A. No.

Q. If we could go back now, my Lady, into the paper bundle, I think it may be slightly easier to orientate.

LADY JUSTICE THIRLWALL: Yes, thank you.

MR BAKER: If you could look, please, to the paper bundle you see in front of you, and to page 30. We have here a letter from John Gibbs to you dated 24 September 2015. If you turn over the page, please, to the bottom of page 31, we can see here at the paragraph that begins "The pathologist was impressed". Can you see that?

A. Yes.

Q. It says:

"The pathologist was impressed by the patchy myocardial ischaemia in Child C's heart and, until I have discussed the PM with him by phone, he had felt that this could have caused Child C's collapse. He based this assumption on the fact that when there is a sudden cardio-respiratory collapse this will lead to myocardial ischaemia but it takes some hours for the cellular changes (histological changes) to become

apparent. Therefore, because Child C has clear signs of patchy myocardial ischaemia the pathologist had assumed this problem must have developed during the few hours before he suddenly collapsed, because if he died at or shortly after the resuscitation this would not have allowed time for the ischaemic changes as a result of that collapse to have become obvious when later examining the heart. However, when I pointed out to the pathologist that because of the slightly unusual, prolonged nature of Child C's resuscitation (even though the latter part of the resuscitation was only intended to be a relatively token effort pending the baptism), some signs of life had returned and it was some hours later that Child C finally died. This would probably have allowed the myocardial ischaemia that would have been expected at the time of Child C's collapse (and during his resuscitation) to have become established histologically since Child C's death did not occur for some hours after his collapse and resuscitation."

You saw that paragraph in the letter to you. How did you interpret it?

A. What Dr Gibbs was saying in that paragraph completely fitted with my understanding as well, you know, that we'd had this collapse with this sort of prolonged period where Child C was dying. And what he was saying

made sense to me, and it fitted exactly with what he had discussed with us as well, that he very much felt that the findings at the post-mortem were as a consequence of the collapse and not the cause of it, and that nothing had been found that explained the cause of Child C's initial collapse.

Q. So you understood him there to be expressing uncertainty about the recorded cause of death within the -- following the post-mortem?

A. Yes. So at the time of this letter, the official post-mortem hadn't been concluded. This was a discussion that he'd had with the pathologist in the August, and it was the November that we got notification of the conclusion of the post-mortem, and the conclusion was -- myocardial ischaemia was put as the cause of death, but these discussions were happening in the run-up to that period of time.

Q. You were shown the letter -- and it's at page 30 -- forgive me; it's bundle-page 48. You were shown the letter from Ian Harvey enclosing sections of what you now know to be Jane Hawdon's report --

A. Yes.

Q. -- and those sections on page 49, 50, and 51.

A. Yes.

Q. There is, in fact, a copy of the full report included --

I will give my Lady the INQ number in a moment. It's INQ0006862, and it's at page 31. Now, it may be helpful if you just look for a moment at the Datix report at bundle-page 48, if you still have it in front of you, and page 49 in particular, and compare it with the document that's on screen now.

We can see at page 49 under "Child C" -- it begins with "IUGR, reverse EDF". And the box we can see on the screen is missing from the version that you have in front of you.

A. Yes.

Q. Now, when you said in response to questions from Ms Langdale, King's Counsel, that you had since seen a form that had boxes on it --

A. Yes.

Q. -- is that the form you were referring to?

A. Yes.

Q. And when did you first see this document that has the box on it?

A. As part of disclosure for this Inquiry.

Q. And you were giving evidence a moment ago about discussions regarding the post-mortem report.

A. Yes.

Q. At the end of the box there, it says:

"Agreed PM report but no cause for deterioration

identified."
A. Yeah.
Q. Again, when -- were you made aware of that at the time of your discussions with the Countess of Chester Hospital in 2017?
A. When we met with Ian Harvey, no. And when we received this heavily redacted, if you like, copy of the report, then no, it was not featured in the information that we were given.
Q. Thank you. And my Lady, if we could go, then, to page 32, the following page. You can see obviously at the bottom of that page there's another box which talks about "Delayed cord clamping policy. Confirm with staff".
When was the first time that you saw that box?
A. As part of disclosure for this Inquiry.
Q. Finally, in relation to this document, the conclusion section of this report, which includes a summary of cases, beginning on page 55. Now, this version of the report omits reference to Child C, whereas other versions of this report include Child C within this first box, this first section here under paragraph 1.
A. Yeah.
Q. When did you first see the summary of case section of Jane Hawdon's report which sets out that Child C's death

could have been prevented with different care?
A. As part of disclosure for this Inquiry.
Q. Finally, then, in relation to your meeting with Ian Harvey, if you could look at your witness statement, please, first of all, at paragraph 31, you say in that paragraph that you were not absolutely sure that Alison Kelly was present at that meeting.
A. Yeah.
Q. Whereas in evidence before the Inquiry, you said you were now sure --
A. Yes.
Q. -- that she was present.
A. Yeah.
Q. What has caused you to change your mind?
A. At the time that I wrote this statement for the Inquiry, I was relying on my memory now, and my memory -- my sort of spontaneous memory now is that I believed it to be her, but I couldn't be a hundred per cent sure. Since writing this statement to the Inquiry, I have re-read my police statement that was written a number of years ago, and in that police statement, I state that it was Alison Kelly, and I would not have said that if I was not a hundred per cent sure.
Q. And then finally on paragraph 23, this section is actually on the following page, page 10 -- 23 carries on

to that page -- you are here describing a discussion between yourself, Alison Kelly and Sian Williams.
A. Yes.
Q. About ten lines or so from the bottom -- seven lines from the bottom, you say:
"They advised me that the investigation was just a formality to check staffing levels because there had been a small increase in the number of deaths, but they didn't think that it was significant."
What was your recollection about what they were communicating to you in this particular meeting about the reasons for the investigation?
A. There was absolutely no indication of anything criminal being investigated, that it was more a kind of review of their services to make sure that they were meeting appropriate guidelines. There was nothing that they said that made me think that there was anything more to it than that.
MR BAKER: Thank you.
My Lady, I don't have any more questions, thank you.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Baker. So, obviously, that concludes your evidence.
Before you go, I just wanted to thank you and your husband for coming to the Inquiry this afternoon. You were asked in your evidence to give a description of

your experiences, and you've done so with enormous clarity and great eloquence. You give reflective and insightful suggestions for change. I don't underestimate the effort and the huge emotional toll that this has taken upon you both, on top of everything that's gone before, and I just want you to know that your contribution to this Inquiry is very, very significant, and I wanted to thank you.
(The witness withdrew).
(4.11 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X

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